Nackawic, Harvey, McAdam, Canterbury Area

COMMUNITY HEALTH NEEDS ASSESSMENT

RÉSEAU DE SANTÉ Horizon HEALTH NETWORK

11/2016

Produced by

Horizon Health Network's

Community Health Assessment Team

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CHA Team – Community Health Assessment Team

CHNA – Community Health Needs Assessment

NBHC – New Brunswick Health Council

CAC – Community Advisory Committee

ID – Interpretive Description

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1.0 EXECUTIVE SUMMARY

Introduction

The Nackawic, Harvey, McAdam, Canterbury Area is located in the western part of the province. It is a rural area with some communities scattered along the Saint John River, the various lakes in the area, and the border of Maine, U.S. The main employment industries in the area are in the sectors of manufacturing, construction, and forestry. Data indicates that the area has increasing rates of asthma, depression, cancer, heart disease, chronic pain, and emphysema or Chronic Obstructive Pulmonary Disease (COPD), when compared to the provincial averages.

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 for conducting 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, which take 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 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

CHNAs conducted within Horizon communities are guided by the population health approach, which endeavours 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 Nackawic, Harvey, McAdam, Canterbury Area Community Advisory Committee (CAC). As part of this plan, key informant interviews were held with stakeholders in the area of primary health care and key stakeholder groups were consulted through the focus group interview method:

- Mental Health and Addictions Professionals
- Seniors and Senior's Supports
- Professionals working with Children and Youth
- Recreation
- Social Supports in the Community
- Nackawic, Harvey, McAdam, Canterbury Area Clergy
- Nackawic Health Centre staff
- Harvey Health Centre staff
- McAdam Health Centre staff

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 Nackawic, Harvey, McAdam, Canterbury Area CAC for feedback, and CAC members were asked to participate in a prioritization exercise of the key issues based on their own experience in the community. The priorities that emerged from the exercise are used to finalize the list of priorities and recommendations for the Nackawic, Harvey, McAdam, Canterbury area.

Results & Recommendations

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

Table 1: Nackawic, Harvey, McAdam, Canterbury Area CHNA Identified Priority Areas and Recommendations

Priority → → → → → → → Recommendation	
1. A decrease in mental resiliency and coping skills among children and youth in the community	Further consult with parents, educators and mental health professionals about the types of mental resiliency and coping skills that children and youth are missing and, through partnerships, develop a plan to fill these learning gaps in the community.
2. The need to review the way in which mental health and addictions services are currently being delivered in the community to improve access to these services	Further consult with mental health professionals, health centre staff, and primary health care providers working in the community to determine what additional services are needed. Review outcomes with Horizon's Mental Health and Addictions leadership to determine how best to fill these gaps in service.
3. Food insecurity in the community	Working with key community partners, review the various elements of food insecurity affecting the community and develop a plan of action.
4. The need for improved supports in the community for families who are struggling and experiencing difficulties	Using a multi-sector approach that includes family support services, public health, educators, and community partners, revisit the current model of providing family support services and develop a more up-to-date approach to provision that better aligns with the challenges being faced by families in the community today.
5. The need to enhance collaboration between health centre staff, allied health professionals and other partners in the community	Initiate a working group with staff and leadership representation from Nackawic, McAdam and Harvey health centres, the DECRH, other health care providers as well as community partners to develop a plan to improve communication and collaboration between these groups.
6. The need for more consistent access to physicians and nurse practitioners in the community to improve continuity of care	Review current access issues, wait list and status of the primary health care provider pool in the community and, working with Horizon and community leaders, determine a strategy to maintain and improve access to primary health care services in the community.
7. The need for more preventive, educational type programming and services	Examine how other similar communities are addressing this issue. Further build preventive/ educational type programming into the work of the community's health centres, and enhance key community partnerships with individuals and organizations already working in this area.

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-centred 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

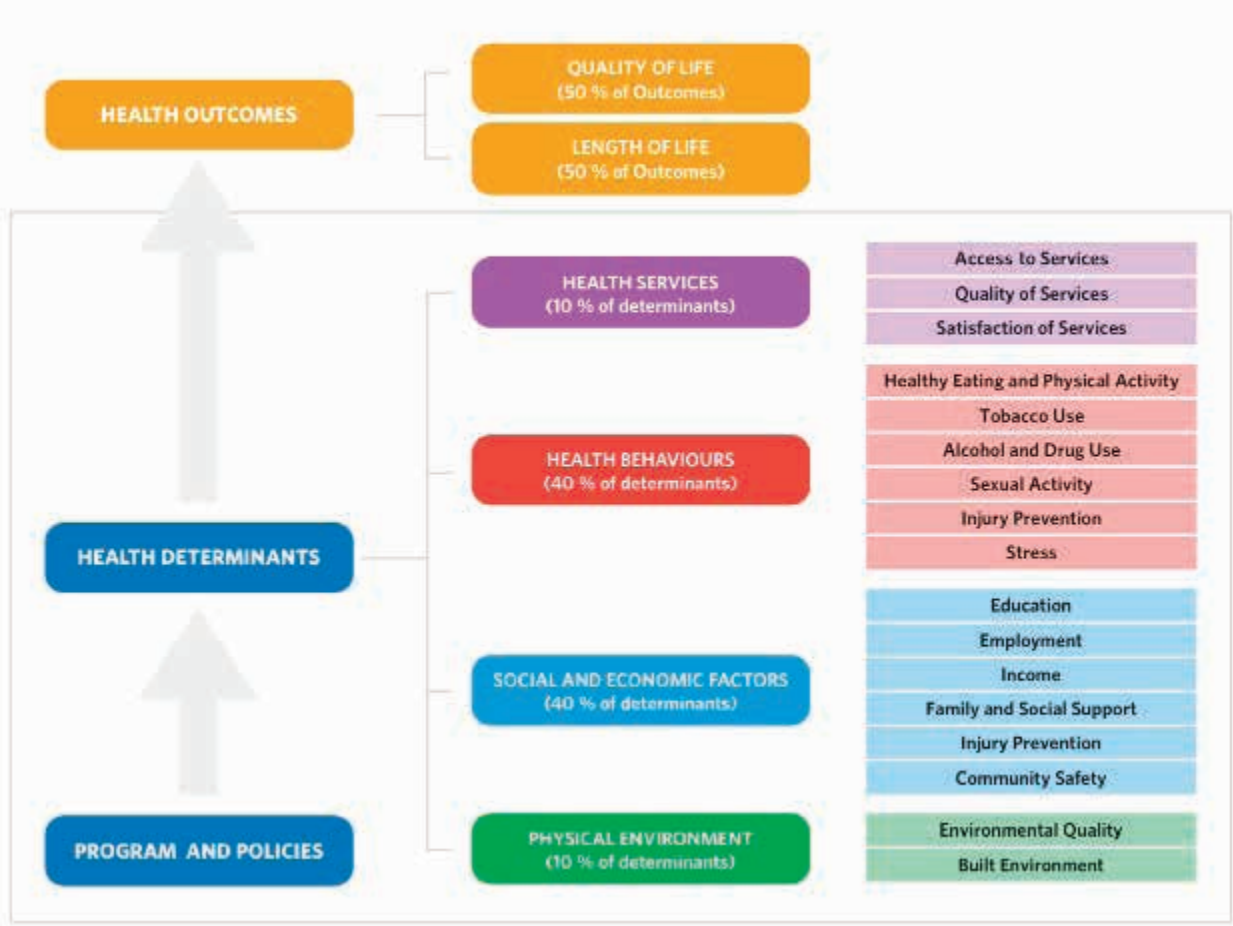
Health is a complex subject and assessing the health of a community goes far beyond looking at rates of disease and the availability of health care services. Therefore, CHNAs conducted within Horizon communities are guided by the population health approach. This approach endeavors to improve the health 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 behaviours 40%, social and economic factors 40%, and physical environment 10%.

FIGURE 1: POPULATION HEALTH MODEL

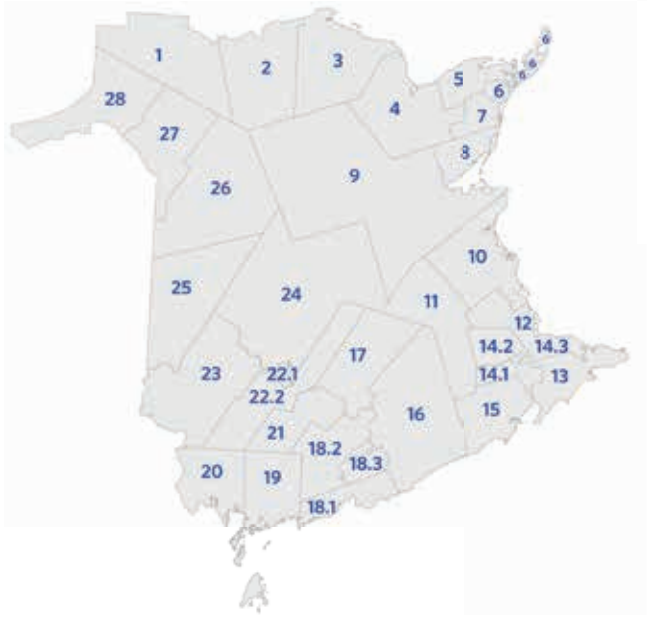


2.5 Defining Communities

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].

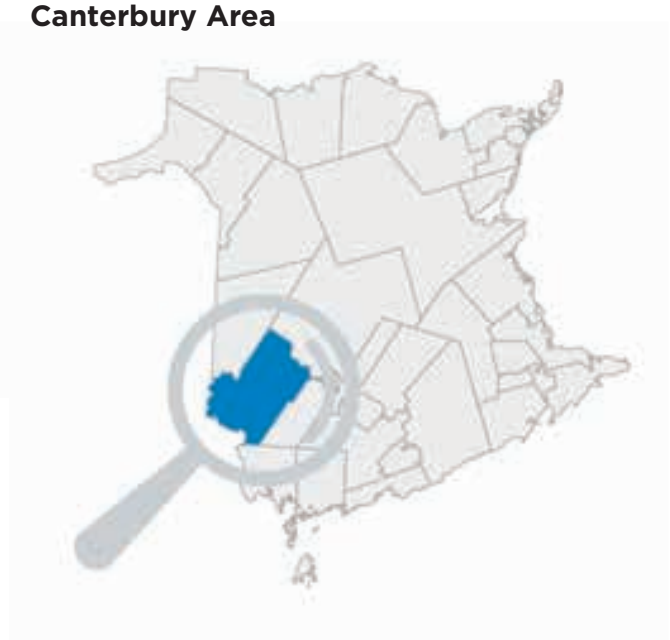
FIGURE 2: NBHC COMMUNITIES



2.6 The Nackawic, Harvey, McAdam, Canterbury Area

One of the NBHC communities selected by Horizon for assessment in 2016 was community 23, identified by the NBHC as the Nackawic, McAdam, Canterbury Area. Based on feedback from key community stakeholders, the community of the Village of Harvey Station and Surrounding Area (Harvey area) was included in this CHNA, even though it was not part of the NBHC's Community 23. Therefore, the community was named the Nackawic, Harvey, McAdam, Canterbury Area to better represent the full geographic region covered by the CHNA. Figure 3 below shows the Nackawic, Harvey, McAdam, Canterbury Area and lists the smaller communities that fall within it.

FIGURE 3: Nackawic, Harvey, McAdam, Canterbury Area



Bright	Millville
Bear Island	Nackawic
Canterbury	North Lake
Dumfries	Prince William
Harvey Station	Queensbury
Keswick Ridge	Skiff Lake
Lake George	Southampton
Mactaquac	Temperance Vale
McAdam	Upper Queensbury
Meductic	Zealand

The Nackawic, Harvey, McAdam, Canterbury Area is located in the western part of the province. It is a rural area with some communities scattered along the Saint John River, the various lakes in the area, and the border of Maine, U.S. The main employment industries in the area are in the sectors of manufacturing, construction, and forestry. The population of Community 23* is 11,266 and has seen a decrease of 1% from 2006 to 2011. The median household income in the community is $54,506 and 17% of the population is living in low-income households.

As seen in Table 2 below, data from the Primary Health Care Survey of New Brunswick shows rates for many chronic diseases increasing between 2011 and 2014 in the Nackawic, Harvey, McAdam, Canterbury Area. The data shows separate rates for the Nackawic, McAdam, Canterbury Area (Community 23) and the Harvey Area (region represented by the postal code E6K). Especially concerning are the increasing rates of asthma, depression, cancer, heart disease, chronic pain, and emphysema or Chronic Obstructive Pulmonary Disease (COPD).

TABLE 2: CHRONIC HEALTH CONDITIONS IN THE NACKAWIC, HARVEY, MCADAM, CANTERBURY AREA[8]

Chronic Health Conditions	Community 23		Harvey and Surrounding Area		NB
	2011 (%)	2014 (%)	2011 (%)	2014 (%)	2014 (%)
High blood pressure	28.4	25.3	26.9	37.2	27.0
Depression	12.4	19.2	9.0	11.1	14.9
Gastric Reflux (GERD)	15.3	19.1	14.9	18.8	16.4
Arthritis	18.8	18.7	21.5	27.1	17.4
Chronic pain	17.7	18.1	18.6	15.7	14.0
Asthma	7.3	15.0	5.4	17.1	11.8
Diabetes	7.1	11.9	11.2	15.8	10.7
Heart disease	7.3	10.3	7.0	15.9	8.3
Cancer	7.1	9.2	9.9	8.6	8.3
Mood disorder other than depression	2.8	3.0	0.9	4.0	3.0
Emphysema or COPD	F	2.7	2.0	2.8	3.0
Stroke	F	2.4	F	4.8	2.5

E
Use with caution (coefficient of variation between 16.6% and 33.3%)
F
Too unreliable to be published (coefficient of variation greater than 33.3%)

*A limitation in including the community of Harvey and surrounding area in this CHNA is that not all of the data reported for Community 23 is available at the community level. Some of the data sources used for this report do not break down data based on postal code regions and in other instances, the samples sizes were too small to report. Therefore, we are not able to report all of the demographic information and health indicators for Harvey and surrounding area.

Primary health care services in the Nackawic, Harvey, McAdam, Canterbury Area are provided through the Extra-Mural Program, family physicians, Public Health, the Nackawic Health Centre, the Harvey Health Centre, the McAdam Health Centre and Mental Health and Addictions. Based on data from the NBHC's *Primary Health Care Survey of New Brunswick,* 95.1% of respondents from Community 23 and 94.0% from the Harvey area had a personal family doctor in 2014, compared to 92.1% for the province. As shown in Table 3 below, the Nackawic, Harvey, McAdam, Canterbury Area does well on some primary health care indicators but needs some improvement on others.

TABLE 3: PRIMARY HEALTH CARE SURVEY INDICATORS FOR THE NACKAWIC, HARVEY, MCADAM, CANTERBURY AREA[9]

Primary Health Care Survey Indicator	Community 23		Harvey and Surrounding Area		NB
	2011	2014	2011	2014	2014
Family Doctor has after-hours arrangement when office is closed (% yes)	18.6%	14.2%	23.8%	8.8%	18.2%
How quickly appointments can be made with family doctor (% on same day or next day)	39.9%	37.6%	51.3%	47.3%	30.1%
How quickly appointments can be made with family doctor (% within five days)	68.9%	64.0%	73.7%	71.7%	60.3%
Model of care used most often when sick or in need of care from a health professional (% hospital emergency department)	6.0%	8.8%	3.5%	10.2%	11.5%
How often family doctor explains things in a way that is easy to understand	76.0%	85.1%	80.0%	82.4%	80.2%
How often a family doctor involves citizens in decisions about their health care (% always)	72.1%	73.5%	72.7%	71.6%	68.2%
How often family doctor gives citizens enough time to discuss feelings, fears and concerns about their health	78.1%	75.8%	82.0%	79.4%	71.9%
Satisfaction with services from personal family doctor (% 8, 9, or 10 on a scale of 0 to 10)	86.4%	88.0%	88.9%	87.8%	83.9%

3.0 STEPS IN THE CHNA PROCESS

CHNAs are a community driven process whereby 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. The 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 pre-existing issues in the community that may impact the CHNA.

Step Two: Select Community Advisory Committee (CAC) members with the assistance of the management committee. Using the CAC membership selection guide, 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 is 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 discuss 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 multiple 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. 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 emerging themes from the analysis which 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 NACKAWIC, HARVEY, MCADAM, CANTERBURY 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 Nackawic, Harvey, McAdam, Canterbury CAC is:

> *To enhance community engagement throughout the Nackawic, Harvey, McAdam, Canterbury Area CHNA process and provide advice and guidance on health and wellness priorities in the community.*

The specific functions of the Nackawic, Harvey, McAdam, Canterbury CAC are to:

- attend approximately five two-hour meetings
- perform a high-level review of currently available data on the Nackawic, Harvey, McAdam, Canterbury 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

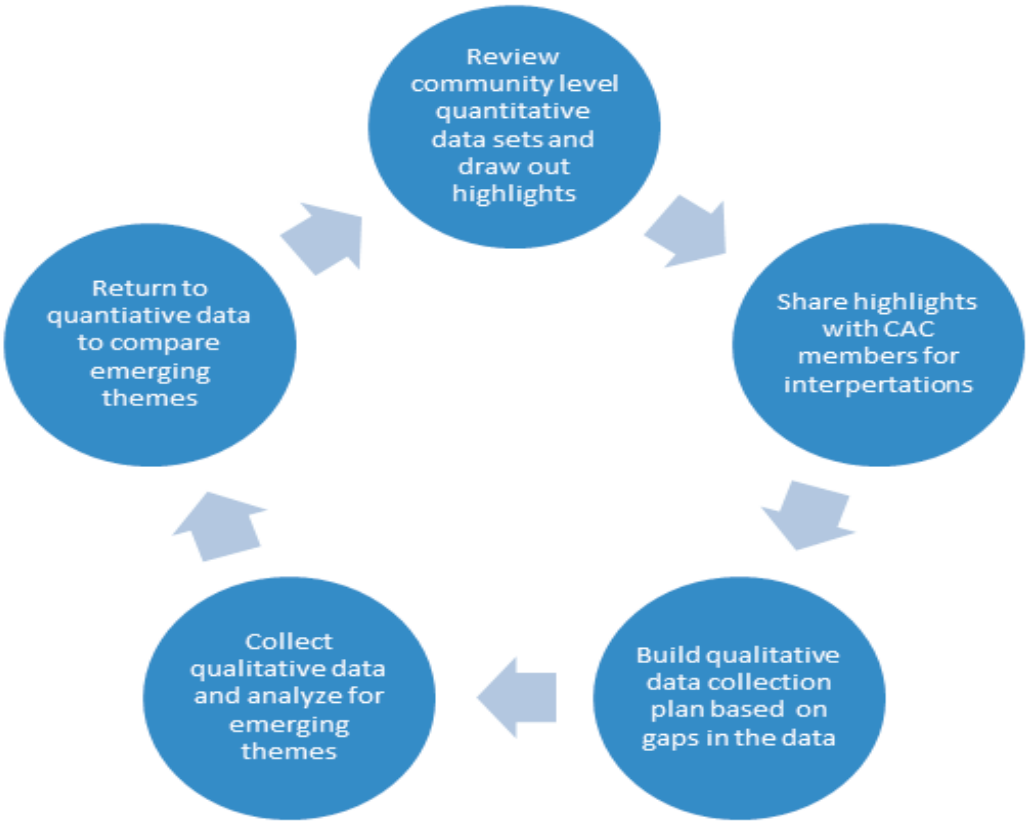
As explained in Step Two of the CHNA 12-step process, CAC members are chosen in collaboration with key community leaders on the CHNA Management Committee. This is done with the use of the CAC membership selection guide which can be found in the technical document. To help ensure alignment with the population 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 Nackawic, Harvey, McAdam, Canterbury Area CAC consisted of representation from:

Extra Mural Program
Primary Health Care Program
Nackawic Health Centre
Harvey Health Centre
Aditya Birla Group
McAdam Health Centre
Lakeland Resource Centre
Pharmacist
Town of Nackawic
Nackawic Lions Club
High School Administration
Recreation Department, Nackawic
Community Development, Harvey & McAdam
Family Physician
Harvey Community Foundation
Mental Health and Addictions
Public Health
Wellness Branch, Social Development
Ambulance NB
Village of McAdam

5.0 RESEARCH APPROACH

As outlined in section 3.0 above, 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 above, 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 care 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." In "The Analytic Challenge in Interpretive Description", 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 Seven 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 Nackawic, Harvey, McAdam, Canterbury Area CHNA, key informant interviews were held with stakeholders in the area of primary health care and key stakeholder groups were consulted through the focus group interview method:

- Mental Health and Addictions Professionals
- Seniors and Senior's Supports
- Professionals working with Children and Youth
- Recreation
- Social Supports in the Community
- Nackawic, Harvey, McAdam, Canterbury Area Clergy
- Nackawic Health Centre staff
- Harvey Health Centre staff
- McAdam Health Centre staff

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 they allow the interviewer to obtain a variety of perspectives and they increase one's 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, the researcher 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 beings

It is also important to note that there are some limitations when 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 Nackawic, Harvey, McAdam, Canterbury 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 Nackawic, Harvey, McAdam, Canterbury 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 broad 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. 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 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. A decrease in mental resiliency and coping skills among children and youth in the community
2. The need to review the way in which mental health and addictions services are currently being delivered in the community to improve access to these services
3. Food insecurity in the community
4. The need for improved supports in the community for families who are struggling and experiencing difficulties
5. The need to enhance collaboration between health centre staff, allied health professionals and other partners in the community
6. The need for more consistent access to physicians and nurse practitioners in the community to improve continuity of care
7. The need for more preventive, educational type programming and services

Table 2 below outlines the seven 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 to the determinant of health area(s) that is strongly influenced by or impacts the priority issue being discussed. As discussed in section 2.4, 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[16]

Table 4: Nackawic, Harvey, McAdam, Canterbury Area CHNA Identified Priority Areas and Recommendations

Priority → → → → → → → Recommendation		
1.	A decrease in mental resiliency and coping skills among children and youth in the community	Further consult with parents, educators and mental health professionals about the types of mental resiliency and coping skills that children and youth are missing and, through partnerships, develop a plan to fill these learning gaps in the community.
2.	The need to review the way in which mental health and addictions services are currently being delivered in the community to improve access to these services	Further consult with mental health professionals, health centre staff, and primary health care providers working in the community to determine what additional services are needed. Review outcomes with Horizon's Mental Health and Addictions leadership to determine how best to fill these gaps in service.
3.	Food insecurity in the community	Working with key community partners, review the various elements of food insecurity affecting the community and develop a plan of action.
4.	The need for improved supports in the community for families who are struggling and experiencing difficulties	Using a multi-sector approach that includes family support services, public health, educators, and community partners, revisit the current model of providing family support services and develop a more up-to-date approach to provision that better aligns with the challenges being faced by families in the community today.
5.	The need to enhance collaboration between health centre staff, allied health professionals and other partners in the community	Initiate a working group with staff and leadership representation from Nackawic, McAdam and Harvey health centres, the DECRH, other health care providers as well as community partners to develop a plan to improve communication and collaboration between these groups.
6.	The need for more consistent access to physicians and nurse practitioners in the community to improve continuity of care	Review current access issues, wait list and status of the primary health care provider pool in the community and, working with Horizon and community leaders, determine a strategy to maintain and improve access to primary health care services in the community.
7.	The need for more preventive, educational type programming and services	Examine how other similar communities are addressing this issue. Further build preventive/educational type programming into the work of the community's health centres, and enhance key community partnerships with individuals and organizations already working in this area.

6.1 A decrease in mental resiliency and coping skills among children and youth in the community

Consultation participants discussed how many children and youth in the community have limited mental resiliency and lack adequate coping skills to deal with challenges. Educators explained that these skills were traditionally taught in the home environment, but that often parents themselves lack the skills and are unable to teach them to their children. Therefore, a lot of the children coming into the school system have difficulty dealing with life's basic challenges and this affects learning in the classroom. Educators also expressed how access to guidance counsellors and mental health services in schools is limited. Consultation participants also discussed an increased use of technology, social media and new forms of bullying and the effects it has on the mental health of children and youth. CAC members discussed the importance of not only providing supports in schools, but also reaching children and parents before school years, with early childhood development services, public health and child care.

"I'd like to see more of the ability to provide more group type work for those students who need a little bit of support as opposed to those heavy support needs and we could reach that much larger group of those kids that are on the fringe. Whether it be coping skills or life training skills, because those are the students that we're missing."

"There's a significant increase of stress in teens, and the pressure of all the social media that exists. So cyber bullying definitely is an issue."

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

Moderate to high level of mental fitness, grade 4 to 5

- Community 23 **78%** (NB **80%**)
- Harvey & Surrounding Area **73%** (NB **80%**)

Satisfaction with mental fitness, grade 6 to 12, Community 23

- High level of family-related mental fitness **66%** (NB **76%**)
- High level of friend-related mental fitness **75%** (NB **83%**)
- High level of school-related mental **51%** (NB **58%**)

Has been bullied, grade 6 to 12

- Community 23 **64%** (NB **65%**)

RECOMMENDATION
Further consult with parents, educators and mental health professionals about the types of mental resiliency and coping skills that children and youth are missing and, through partnerships, develop a plan to fill these learning gaps in the community.

6.2 The need to review the way in which mental health and addictions services are currently being delivered in the community to improve access to these services

Consultation participants discussed how the way in which mental health and addictions services are currently being delivered in the community is not adequately supporting the growing rate of mental health issues across all age groups. Participants shared that mental health workers assigned to the communities often change, which makes it difficult for patients to build rapport with their provider and can negatively impact the progress of vulnerable patients. Moreover, health care providers discussed how limited collaboration with Mental Health and Addictions affects their ability to support their patients. Concerns were also raised regarding access to timely mental health services. Given that the mental health workers are coming to the community once a week, they are not available for emergency cases on other days. Participants also shared that in certain areas, such as Nackawic and Canterbury, there are no mental health services provided in the community, therefore patients have to travel to Woodstock and Fredericton. They discussed how some patients may not have the means of transportation or have working hours which makes it difficult for them to attend appointments outside of their community. Another major concern raised by consultation participants is that there is no addictions counsellor available in the schools or in the community. Participants discussed how collaboration and access to mental health services could be improved by having a consistent mental health service provider in the community.

"They're kind of just working separately. It would be nice to know who is coming in. We usually get asked the questions. So the service is just not organized to meet the need."

"The biggest challenge I find is just lack of access in Nackawic and Canterbury. A lot of families either work in Woodstock or Fredericton and they don't have the ability to drive their kid to a different centre to get their child services. Transportation is a huge issue in those areas; getting time off from work and those types of things can be very challenging for families to accommodate."

DETERMINANTS OF HEALTH:

Income and Social Status, Social Support Networks, Employment and Working Conditions, Personal Health Practices & Coping Skills and Health Services

Depression

- Community 23 **12.4%** (NB **14.9%**)
- Harvey & Surrounding Area **9.0%** (NB **14.9%**)

Health service not available in your area when needed

- Community 23 **20.7%** (NB **17.4%**)
- Harvey & Surrounding Area **19.7%** (NB **17.4%**)

Evaluation of care received for mental or emotional health (% very or somewhat helpful)

- Community 23 **95.5%** (NB **90.8%**)
- Harvey & Surrounding Area **100%** (NB **90.8%**)

Adults who have seen a health professional about mental or emotional health

- Community 23 **11.5%**
- Harvey & Surrounding Area **24%**

RECOMMENDATION

Further consult with mental health professionals, health centre staff, and primary health care providers working in the community to determine what additional services are needed. Review outcomes with Horizon's Mental Health and Addictions leadership to determine how best to fill these gaps in service.

6.3 Food insecurity in the community

Consultation participants discussed many issues associated with food insecurity and its connection to the overall health of residents in the community. They shared how challenging it can be for individuals, families, and seniors to afford a fresh whole foods diet, particularly when on a limited income. Participants discussed that there is a limited number of grocery stores in the region, and that fresh produce often comes at an increased cost, which leads many to rely on prepackaged and processed foods. Moreover, educators shared how a lot of children and youth are coming to school with unhealthy, processed foods and that some do not even have sufficient food intake throughout the day, which affects their learning. They explained that they try to promote healthy eating and wellness in the school environment, but it is difficult because for a lot of students that is not consistent in the home. Consultation participants also expressed concerns for seniors that are isolated or living alone who could benefit from a Meals-on-Wheels program in the community. They also discussed the importance of food bank services in these communities and that many community members are unaware that there are drop sites available in Canterbury and Nackawic where they can access food bank services from Volunteer Family Services (Woodstock). Participants discussed a need to increase awareness of these drop sites so that community members can access this outreach service. Another aspect of food insecurity that was discussed is that a lot of individuals are lacking the basic skills to prepare fresh whole foods, and that the community could benefit from cooking classes for parents and their children.

"They're very rural, how far is it to a grocery store and what they get there, how expensive is it, is it on sale, how fresh is it? As we all know when we're buying groceries it's much cheaper to buy junk food, prepared junk food, than it is to buy fruits and vegetables."

"We have students coming to school hungry and when they come to school hungry they don't function properly; they're not learning to the best of their abilities."

DETERMINANTS OF HEALTH:

Income & Social Status, Education & Literacy, Employment & Working Conditions, Physical Environment, Personal Health Practices & Coping Skills and Healthy Child Development

Food Insecurity in homes with or without children present, moderate and severe

- Community 23 **14%** (NB **9%)**

Food Insecurity in homes with children 0 to 5 present, moderate and severe

- Community 23 **7%** (NB **11%**)

Food Insecurity in homes with children less than 18 present, moderate and severe

- Community 23 **11%** (NB **10%**)

POTENTIAL COMMUNITY ASSET

Lakeland Resource Centre, McAdam provides food and clothing to families and individuals living in the community with limited income.

Volunteer Family Services, Woodstock provides supports to families and individuals in the community, including food delivery to outreach locations.

RECOMMENDATION

Working with key community partners, review the various elements of food insecurity affecting the community and develop a plan of action.

6.4 The need for improved supports in the community for families who are struggling and experiencing difficulties

Consultation participants discussed the need for more supports in the community for families experiencing difficulties. They shared how there is a high rate of unemployment in the community and that many families are living in low-income households. They expressed that many could benefit from support services such as employment counselling, as well as budgeting and parenting classes. Participants also discussed that there are a lot of single parent families and unhealthy family environments in the community and the negative impacts that this can have on children. They felt that a mentorship program in the community to provide positive role models in the lives of children and youth could be beneficial. Consultation participants also discussed that many individuals experiencing difficulties will turn to drugs and alcohol as a form of self-medication. They shared how substance abuse and mental health issues affect the entire family unit and that children and youth may start using drugs and alcohol because their parents or older siblings are using. Participants discussed that often parents do not know how to deal with their child's substance abuse issues, have trouble navigating the system, and often lose faith in trying to get help because of negative experiences in trying to access services in the past.

"If you can't contribute to your community, if you can't find work, if you can't have a decent income to support yourself and your family, these are all determinants to good mental health as well as good physical health."

"One of the other major problems that we have in our community is drugs and alcohol. That's what the younger kids who are troubled, from broken families, they're turning to that and they're self-medicating."

DETERMINANTS OF HEALTH:
Social Environment, Income & Social Status, Healthy Child Development, Personal Health Practices & Coping Skills, Social Support Networks and Employment and Working Conditions

Unemployment rate
- Community 23 **12 %** (NB **11%**)

Living in low income
- Community 23 **17%** (NB **17%**)

Single parent families
- Community 23 **12%** (NB **16%**)

Moderate to high level of mental fitness, grade 4 to 5
- Community 23 **78%** (NB **80%**)
- Harvey & Surrounding Area **73%** (NB **80%**)

Satisfied with mental fitness needs related to family, grade 6 to 12
- Community 23 **66%** (NB **76%**)
- Have people I look up to, grade 6 to 12
- Community 23 **40%** (NB **47%**)

Depression, adult
- Community 23 **12.4%** (NB **14.9%**)
- Harvey & Surrounding Area **9.0%** (NB **14.9%**)

RECOMMENDATION
Using a multi-sector approach that includes family support services, public health, educators, and community partners, revisit the current model of providing family support services and develop a more up-to-date approach to provision that better aligns with the challenges being faced by families in the community today.

6.5 The need to enhance collaboration between health centre staff, allied health professionals and other partners in the community

Consultation participants discussed how they would like to see better communication and information sharing between partners within and outside of the community to address some of the health and social problems that exist throughout the area. They shared how there are some very strong partnerships already established in the community, but that there are opportunities for collaboration with more partners and with other communities. Participants also discussed how staff from the health centres have an opportunity to be leaders in health and wellness in the community, and that increased partnerships are crucial in this. They identified various agencies and organizations in the community that would be valuable as partners to collectively address social issues that impact health, including food banks, churches, Mental Health and Addictions, local service districts and councils, the RCMP, Extra-Mural Program, Ambulance NB, etc. Moreover, health care providers in the community identified a need for better collaboration with hospitals in larger centres, in the emergency departments and in discharge planning, to better support their patients when they return to the community from the hospital. They discussed that a lot of the staff in larger centres are probably not aware of the services that are available at the Nackawic, Harvey and McAdam health centres. CAC members also discussed the importance of increasing partnerships and recognized the opportunity for communities to learn from each other regarding initiatives and programs already established in other areas within the Nackawic, Harvey, McAdam, Canterbury Area.

DETERMINANTS OF HEALTH:

Social Environment, Physical Environment and Health Services

How often a family doctor helps citizens coordinate the care from other health care providers and places (% always)

- Community 23 **76.2%** (NB **70.7%**)
- Harvey & Surrounding Area **80.9%** (NB **70.7%**)

RECOMMENDATION

Initiate a working group with staff and leadership representation from Nackawic, McAdam and Harvey health centres, the Dr. Everett Chalmers Regional Hospital (DECRH), other health care providers as well as community partners to develop a plan to improve communication and collaboration between these groups.

6.6 The need for more consistent access to physicians and nurse practitioners in the community to improve continuity of care

Consultation participants discussed various concerns over access to primary health care providers in the community. They shared how there is no permanent physician currently practicing in the community of McAdam and how this affects continuity of care. Professionals discussed how community members often express their concerns about not having a primary health care provider. Moreover, participants shared how continuity of care and follow-up is difficult for seniors or patients with multiple conditions who may require complex care. They also discussed concerns for methadone patients who do not have a consistent primary health care provider and the effects this can have on their care. Moreover, consultation participants discussed a need for increased access to primary health care providers in the community of Nackawic. Participants also discussed some of the women's health services provided by the nurse practitioner at the Harvey Health Centre, and explained that women and girls in the community could benefit from having increased access to this provider. After consultations were completed, CAC members noted changes to primary health care services in the community that occurred during the time of this CHNA. In McAdam, there is now a nurse practitioner in the community and recruitment efforts for a physician are ongoing. Moreover, in Nackawic, a nurse practitioner and two part-time physicians have begun practicing in the community. Therefore, although access to physicians and nurse practitioners is expected to increase, it is important to maintain services already available and improve access to these services to ensure continuity of care for community members.

DETERMINANTS OF HEALTH:
Health Services, Social Environment and Physical Environment

Has a family doctor
- Community 23 **95.1%** (NB **92.1%**)
- Harvey & Surrounding Area **94.0%** (NB **92.1%**)

Visited a hospital emergency department
- Community 23 **36.6%** (NB **41.3%**)
- Harvey & Surrounding Area **26.6%** (NB **41.3%**)

Visited a nurse practitioner
- Community 23 **4.4%** (NB **7.7%**)
- Harvey & Surrounding Area **13.9%** (NB **7.7%)**

Visited an after-hours clinic or walk-in clinic
- Community 23 **13.6%** (NB **24.3%**)
- Harvey & Surrounding Area **7.3%** (NB **24.3%**)

RECOMMENDATION
Review current access issues, wait list and status of the primary health care provider pool in the community and, working with Horizon and community leaders, determine a strategy to maintain and improve access to primary health care services in the community.

6.7 The need for more preventive, educational type programming and services

Consultation participants discussed the need to have more prevention and health promotion programming in the community. Professionals shared how they often do not have the time or resource to coordinate and implement community-based preventive programming. They expressed concerns for children and youth experiencing mental health issues, and that they wish they had the capacity to implement programming around building mental resiliency and teaching coping skills (as discussed in section 6.1). They also noted how mental health promotion and education can greatly help to reduce stigma. Consultation participants also discussed chronic conditions (e.g. diabetes, heart disease, depression, etc.) and the importance of physical activity and healthy eating as preventive health measures. They identified a need for more wellness programs in the community for children and youth, as well as for seniors. Moreover, they shared that there is a need to engage the community in preventive and educational programming to empower individuals and involve them in improving their own health.

"The prevention, community aspect, developing these programs and implementing, monitoring, getting the community involved has kind of gone to the back row because we don't have time in the day to do it."

DETERMINANTS OF HEALTH:

Social Environment, Personal Health Practices & Coping Skills, Education & Literacy and Health Services

Discuss regularly with a health professional on improving health or preventing illness (% always or usually)

- Community 23 **26.8%** (NB **25.4%**)
- Harvey & Surrounding Area **33.3%** (NB **25.4%**)

Citizens with a chronic health condition who know what each of their prescribed medications do (% strongly agree)

- Community 23 **52.7%** (NB **47.7%**)
- Harvey & Surrounding Area **48.6%** (NB **47.7%**)

How often a family doctor explains things in a way that is easy to understand (% always)

- Community 23 **85.1%** (NB **80.2%**)
- Harvey & Surrounding Area **82.4%** (NB **80.2%**)

How often a family doctor involves citizens in decisions about their health care (% always)

- Community 23 **73.5%** (NB **68.2%**)
- Harvey & Surrounding Area **71.6** (NB **68.2%**)

How often a family doctor gives citizens enough time to discuss feelings, fears, and concerns about their health (% always)

- Community 23 **75.8%** (NB **71.9%**)
- Harvey & Surrounding Area **79.4%** (NB **71.9%**)

POTENTIAL COMMUNITY ASSET

The Wellness Consultant (Social Development) acts as a connector and facilitator to help communities, families, organizations, schools and workplaces enhance their wellness, and can help guide to the right programs and resources.

RECOMMENDATION

Examine how other similar communities are addressing this issue. Further buildpreventive/ educational type programming into the work of the community's health centres, and enhance key community partnerships with individuals and organizations already working in this area.

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