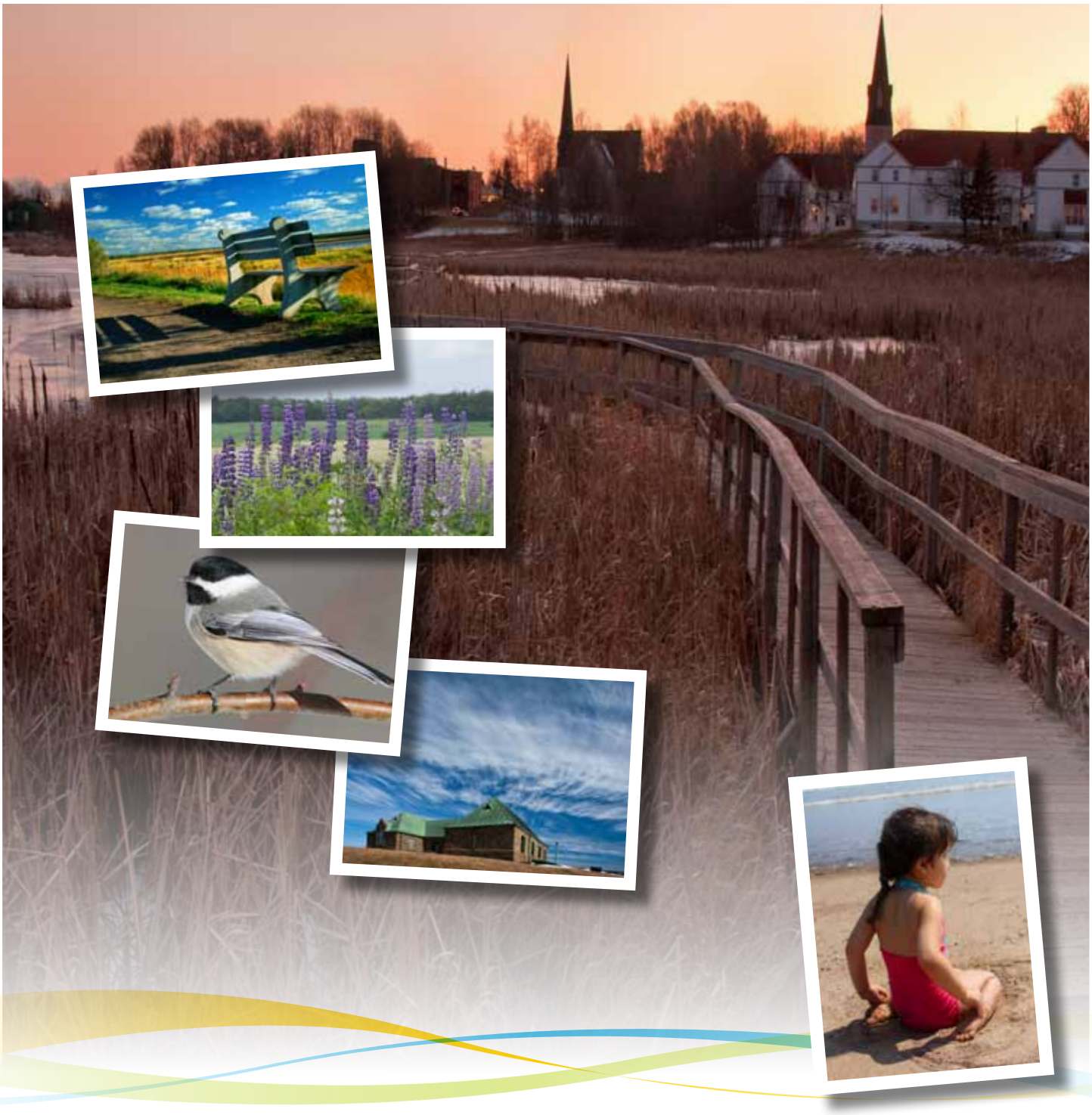
TANTRAMAR AREA

COMMUNITY HEALTH NEEDS ASSESSMENT



RÉSEAU DE SANTÉ Horizon HEALTH NETWORK

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Produced by

Horizon Health Network's

Community Health Assessment Team

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LIST OF ABREVIATIONS

CHA Team – Community Health Assessment Team

CHNA – Community Health Needs Assessment

NBHC – New Brunswick Health Council

CAC – Community Advisory Committee

ID – Interpretive Description

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1.0 EXECUTIVE SUMMARY

Introduction

The Tantramar Area gets its name from the famous Tantramar Marsh; one of the largest tidal salt marshes on the Atlantic coast. The hub of the Tantramar Area is the town of Sackville. Historically, Sackville was home to two foundries, which manufactured stoves and furnaces; the economy is now driven by Mount Allison University and Tourism. The rest of the Tantramar area is made up of more rural communities which historically relied on the farming and fishing industries. According to the Canadian Census, the population of the Tantramar Area in 2011 was 11,042, which is a 2% increase from 2008 (10,822). The median household income in the Tantramar Area is $48,300, and 18% of residents are in the low income bracket. Data shows that the community has elevated rates of arthritis, gastric reflux (GERD), depression and asthma.

Background

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

Community Health Needs Assessment

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

While the CHNA process is designed to be flexible and accommodate unique differences in each community, Horizon's Community Health Assessment (CHA) Team uses a 12-step process to conduct CHNAs that takes into account the following 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 the 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 endeavors to improve the health of the entire population and to reduce health inequities by examining and acting upon the broad range of factors and conditions that have a strong influence on our health, often referred to as the **determinants of health.** Horizon's CHA Team uses determinant of health categorizations from the Public Health Agency of Canada and the New Brunswick Health Council (NBHC).

Methodology

Quantitative data review and qualitative data collection, review and analysis were used by Horizon's CHA Team. Data compilations produced by the NBHC such as *My Community at a Glance* and *The Primary Health Care Survey* were used to review currently available

quantitative data as many of the indicators are broken down to the community level. Based on limitations of the quantitative data review, a qualitative data collection plan was established by the CHA Team in partnership with the Tantramar Area Community Advisory Committee. Five key stakeholder groups were identified for consultation through the focus group interview method:

- Seniors & Senior Support Services
- Primary Health-Care Providers
- Professionals working with Child & Youth
- Representatives from Mount Allison University
- Professionals Providing Social Support Services

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

Results & Recommendations

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

Table 1: Tantramar Area CHNA Identified Priority Areas and Recommendations

Priority → → → → → → →	Recommendation
1. A decrease in mental resiliency and coping skills in children and youth in the community.	Further consult with parents and educators about the types of mental resiliency and coping skills children and youth are missing and, through partnerships, plan how to fill these learning gaps in the community.
2. The need for support staff in the community to help coordinate and implement prevention/health promotion type programming, particularly in outer rural communities.	Examine how other similar communities are providing this resource (including a review of the role of Horizon's Community Developers), and determine how best to provide this resource.
3. Community transportation issues that impact health.	Examine the health challenges faced in the community due to limited transportation, review how other communities are addressing this challenge and work with key community stakeholders to develop a strategy to improve transportation.
4. The need for a CHC model of care in the community. [1A]	Establish a working group that includes primary health-care providers, Horizon leaders and community members to review the CHC model of care and create a plan for the establishment of the center.
5. Food insecurity in the community.	Working with key community partners, review the various elements of food insecurity affecting the community identified during the CHNA, and develop a plan of action for addressing food insecurity in the community.
6. Lack of affordable home-care services in the community.	Assess the current provision and current need of home-care services in the community and develop a plan of action to fill any gaps in home-care service.

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.*[2] The framework states that this vision will be achieved through an enhanced integration of existing services and infrastructure and the implementation of patient-centered primary health-care teams working collaboratively with regional health authorities to meet identified health needs of communities. The framework highlights "conducting community health needs assessments" as an important first step towards achieving these improvements and states that, "community health needs assessments have the potential to not only bring communities together around health care but to collectively identify community assets, strengths and gaps in the system[3]"

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 community health needs assessments 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 community advisory committees
- 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[4].

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

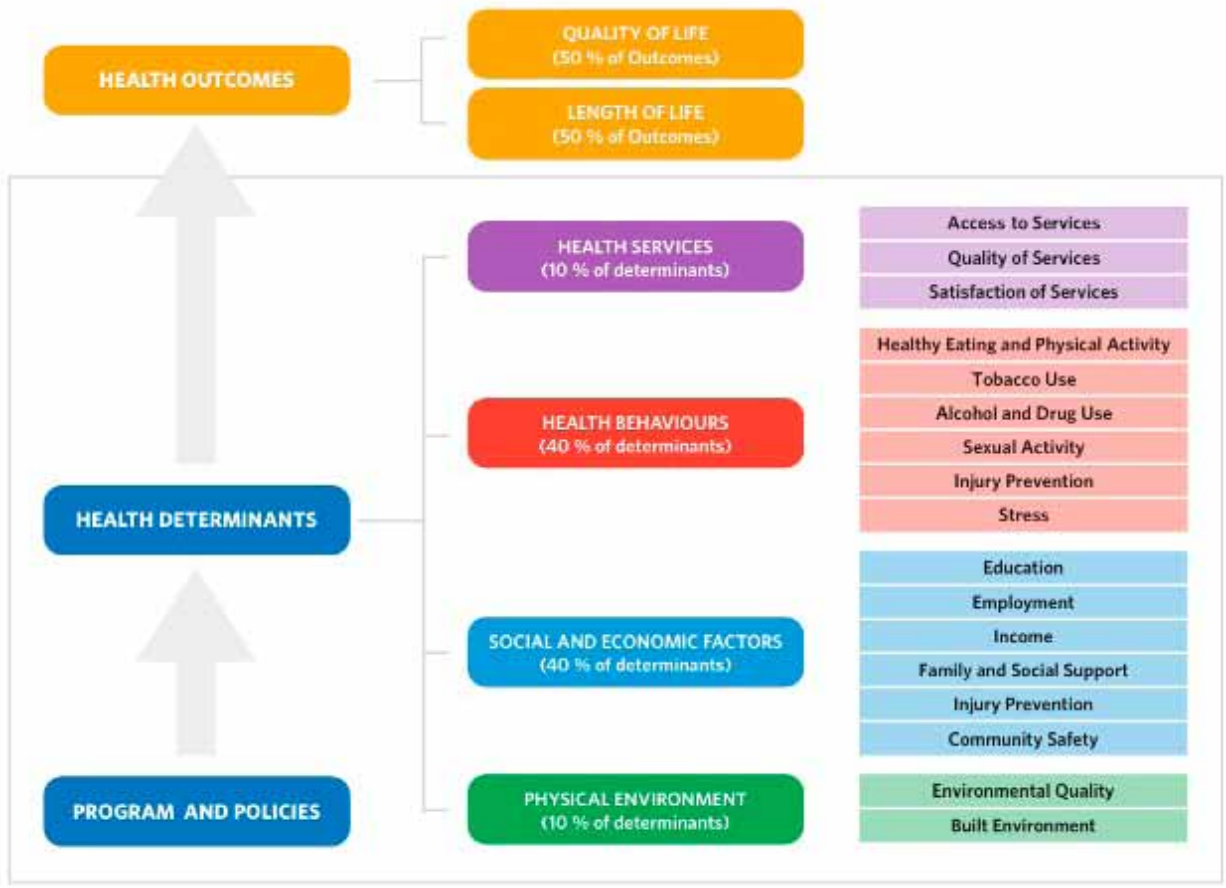
Health is a complex subject, and assessing the health of a community goes far beyond looking at rates of disease and the availability of health-care services. Therefore, CHNAs conducted within Horizon communities are guided by the population health approach. This approach endeavors to improve the health 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[5]. 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[6]

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

FIGURE 1: POPULATION HEALTH MODEL

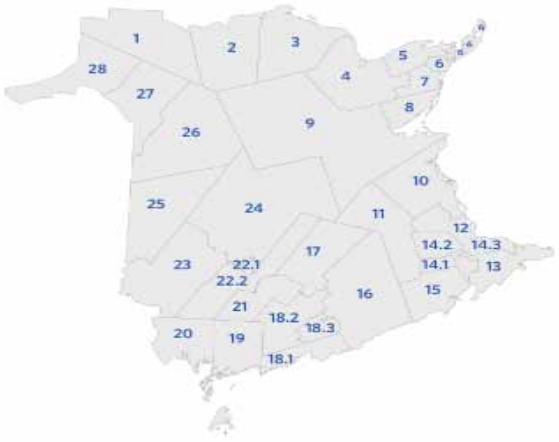


2.5 Defining Communities

For CHNAs, individual community boundaries are defined by the New Brunswick Health Council (NBHC). The NBHC works at arm's 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.[7]

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, CHCs, 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[8].

FIGURE 2: NBHC COMMUNITIES



2.6 The Tantramar Area

One of the NBHC communities selected by Horizon for assessment during 2014-2015 is community 13, identified by the NBHC as the Sackville Area. Based on feedback from key community stakeholders, for the sake of the CHNA, this community was renamed the **Tantramar Area** to better represent the full geographic region covered by the CHNA. Figure 3 below shows the Tantramar Area and lists the smaller communities that fall within it.

FIGURE 3: TANTRAMAR AREA

Aulac	Bayfield
Botsford	Cape Spear
Cape Tormentine	Dorchester
Little Shemogue	Melrose
Midgic	Murray Corner
Point de Bute	Port Elgin
Sackville	Timber River
Upper Cape	Westmorland

The Tantramar Area gets its name from the famous Tantramar Marsh; a tidal salt marsh around the Bay of Fundy. At 20,230 hectares, the marsh is one of the largest on the Atlantic coast. The hub of the Tantramar Area is the town of Sackville. Historically, Sackville was home to two foundries, which manufactured stoves and furnaces; the economy is now driven

by Mount Allison University and Tourism. The rest of the Tantramar area is made up of more rural communities which historically relied on the farming and fishing industries. According to the Canadian Census, the population of the Tantramar Area in 2011 was 11,042, which is a 2% increase from 2006 (10,822). The Tantramar Area presents a unique demographic in that a large majority of the population is above the age of 65. However, for 8 months of the year, the town of Sackville is heavily populated by young adults attending Mount Allison University (student population of Mt. Allison University is 2,694). The median household income in the Tantramar Area is $48,300, and 18% of residents are in the low income bracket. However, CAC members and focus group participants discussed how income would be higher in the town of Sackville and lower in the outlying rural communities. Data shows that the community has elevated rates of arthritis, gastric reflux (GERD), depression and asthma.

TABLE 2: CHRONIC HEALTH CONDITIONS IN THE TANTRAMAR AREA[9]

Chronic Health Conditions[1]	2011 (%)	2014 (%)	2014[2] (#)	NB (%)
One or more chronic health conditions[3]	57.6 (51.1 – 64.1)	64.0 (58.1 – 69.9)	5,905	61.6 (60.8 – 62.4)
High blood pressure	24.9 (19.4 – 30.4)	22.7 (17.6 – 27.9)	2,097	27.0 (26.2 – 27.7)
Arthritis	20.8 (15.6 – 25.9)	22.0 (16.9 – 27.1)	2,028	17.4 (16.8 – 18.0)
Gastric Reflux (GERD)	13.4 [E] (9.1 – 17.8)	17.5 (12.9 – 22.2)	1,618	16.4 (15.8 – 17.0)
Depression	12.4 [E] (8.2 – 16.6)	16.6 (12.0 – 21.2)	1,534	14.9 (14.3- 15.5)
Asthma	12.5 [E] (8.3 – 16.8)	16.3 (11.7 - 20.8)	1,502	11.8 (11.3 – 12.4)
Chronic pain	15.8 (11.2 – 20.5)	12.6[E] (8.5 – 16.6)	1,159	14.0 (13.5 – 14.6)
Diabetes	8.0 [E] (4.6 – 11.5)	9.7[E] (6.1 – 13.4)	897	10.7 (10.1- 11.2)
Heart disease	9.0 [E] (5.3 – 12.7)	8.3[E] (4.9 – 11.7)	768	8.3 (7.9 – 8.8)
Cancer	9.1 [E] (5.4 – 12.7)	7.6[E] (4.3 – 10.8)	697	8.3 (7.8 – 8.7)
Mood disorder other than depression	F	4.2[E] (1.7- 6.6)	383	3.0 (2.7 – 3.2)
Emphysema or COPD	F	F	228	3.0 (2.7 - 3.3)
Stroke	F	F	139	90.7 (33.3 - 38.3)

Primary health-care services in the Tantramar Area are provided through the Port Elgin Health Center, private physician offices. As well, many residents utilize the Sackville Memorial Hospital emergency room to access primary health-care services. Some residents from the Tantramar Area also travel to other communities such as Moncton or Amherst, Nova Scotia to access primary health-care services. Based on data from the NBHC's *Primary Health Care Survey of New Brunswick*, residents in the Tantramar Area find it easy to call their family doctor's office during regular practice hours but are finding it more difficult to get an appointment on the same day, next day or within five days compared to the provincial rate. In the Tantramar area, doctor/patient communication indicators such as *how often family doctor explains things in a way that is easy to understand* and *how often a family doctor involves citizens in decisions about their health care* are ranked higher than the provincial rate. These indicators can be found in Table 3 below.

TABLE 3: PRIMARY HEATLH CARE SURVEY INDICATORS FOR THE TANTRAMAR AREA[10]

Primary Health Care Survey Indicator	2011	2014	NB
Calling family doctor's office during regular practice hours (% very easy or somewhat easy)	79.5	83.6	78.3
How quickly appointment can be made with family doctor (% on same day or next day)	13.6	21.6	30.1
How quickly appointment can be made with family doctor (% within 5 days)	44.0	55.9	60.3
How often family doctor explains things in a way that is easy to understand (% always)	73.6	81.0	80.2
How often family doctor involves citizens in decisions about their health care (% always)	67.1	72.7	68.2

3.0 STEPS IN THE CHNA PROCESS

CHNAs are a community driven process where community members' opinions are valued and taken into account for planning purposes. Therefore, the CHNA process needs to be flexible in order to meet the needs of individual communities. Each community is unique and therefore the same approach to conducting CHNAs is not always possible. When communities feel that it has a role in driving the CHNA process, it is 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 which tends to work well for most communities while staying flexible to accommodate the unique needs of the communities they work with. These 12 steps are:

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

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

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

Step Two:
Select CAC members with the assistance of the management committee.

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

Step Three:
Establish CAC.

Coordinated by Horizon's CHA Project Coordinator, the first CAC meeting is established. Both the project coordinator and the management committee play a role in inviting CAC members to participate. At the first meeting, the research team shares the goals and objectives of the CHNA with the CAC and 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 utilized many of their data compilations, which come from multiply surveys and administrative databases. The team reviews this data looking for any indicators that stand out in the selected community.

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

Highlights from the data review are shared with CAC members and they are asked to reflect on these indicators. Often this leads to good discussions 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 themes that emerged from the analysis and 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 and priorities, 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 TANTRAMAR 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 Tantramar Area CAC is:

> *To enhance community engagement throughout the Tantramar Area Community Health Needs Assessment process and provide advice and guidance on health and wellness priorities in the community.*

The specific functions of the Tantramar Area CAC are to:

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

As explained in step 2 of the CHNA 12-step process above, 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.

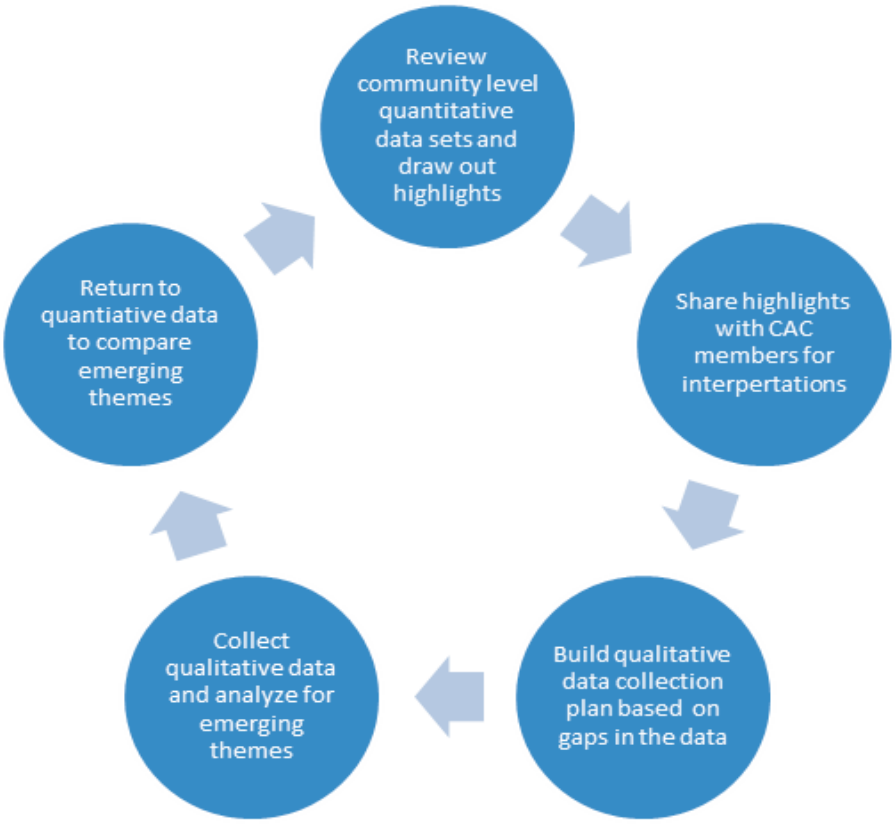
Membership for the Tantramar Area CAC consisted of representation from:

- Sackville Memorial Hospital Foundation
- Sackville Memorial Hospital Services
- Primary Health-Care Providers
- Extra Mural Program
- Mental Health & Addictions
- Public Health
- Port Elgin District Voluntary Action Council (PEDVAC)
- Marshville Middle School
- Tantramar Regional High School
- Mt. Allison University Representative
- Sackville Town Council
- Middle Sackville Baptist Church
- RCMP
- Healthy & Inclusive Communities

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 APPORACH



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 a particular area. The information included in these profiles comes from a variety of provincial and federal sources, i.e. Surveys or administrative databases.[11] 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 in 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.[12]

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.[13] The products of ID studies have application potential in the sense that professionals, such as clinicians or decision makers could understand them, allowing them to provide a backdrop for assessment, planning and interventional strategies. Because it is a qualitative methodology and because it relies heavily on interpretation, ID does not create facts, but instead creates "constructed truths." Thorne and her colleagues argue that the degree to which these truths are viable for their intended purpose of offering an extended or alternative understanding depends on the researcher's ability to transform raw data into a structure that makes aspects of the phenomenon meaningful in some new and useful way.[14]

5.3 Qualitative Data Collection

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

- Seniors & Senior Support Services
- Primary Health-Care Providers
- Professionals working with Child & Youth
- Representatives from Mount Allison University
- Professionals Providing Social Support Services

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

There are several advantages to using focus group interviews:

- Data collection is cost-effective. In one hour you can gather information from several people instead of one.

- Interactions among participants enhances data quality
- The extent to which there is a relatively consistent, shared view or great diversity of views can be quickly assessed
- Focus groups tend to be enjoyable for participants, drawing on human tendencies as social animals.

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

The CHA research lead acted as the moderator for the Tantramar 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 Tantramar 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.[16] 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 divided into general categories that emerge through the review. At this stage it is more 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 (at this stage the list for the Tantramar Area was 18 key issues). With the list complete, the CHA Team develops a summary of the discussion for each key issue. Once the of key issues and summaries is developed, the CHA Team returns to the quantitative data sets to see how certain indicators compare to what was shared through qualitative data collection. Sometimes the quantitative indicators support what is being said and sometimes they do not; either way the indicators related to the key issues are highlighted and incorporated into the key issue summaries.

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

6.0 RESULTS

Data analysis resulted in the identification of six priority issues:

1. A decrease in mental resiliency and coping skills in children and youth in the community
2. The need for support staff in the community to help coordinate and implement prevention/health promotion type programming, particularly in outer rural communities
3. Transportation issues in the community that impact health
4. The need for a CHC model of care in the community
5. Food insecurity in the community
6. Lack of affordable home care services in the community

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

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

1. Income and Social Status
2. Social Support Networks
3. Education and Literacy
4. Employment and Working Conditions
5. Social Environment
6. Physical Environment
7. Personal Health Practices and coping skills
8. Healthy Child Development
9. Biology and Genetic Endowment
10. Health Services
11. Gender
12. Culture[17]

Table 4: Tantramar Area CHNA Identified Priority Areas and Recommendations

	Priority → → → → → → →	Recommendation
1.	A decrease in mental resiliency and coping skills in children and youth in the community.	Further consult with parents and educators about the types of mental resiliency and coping skills children and youth are missing and, through partnerships, plan how to fill these learning gaps in the community.
2.	The need for support staff in the community to help coordinate and implement prevention/health promotion type programming, particularly in outer rural communities.	Examine how other similar communities are providing this resource (including a review of the role of Horizon's Community Developers), and determine how best to provide this resource.
3.	Community transportation issues that impact health.	Examine the health challenges faced in the community due to limited transportation, review how other communities are addressing this challenge and work with key community stakeholders to develop a strategy to improve transportation.
4.	The need for a Community Health Center (CHC) model of care in the community. [18]	Establish a working group that includes primary health-care providers, Horizon leaders and community members to review the CHC model of care and create a plan for the establishment of the centre.
5.	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 for addressing food insecurity in the community.
6.	Lack of affordable home care services in the community.	Assess the current provision and current need of home care services in the community and develop a plan of action to fill any gaps in home care service.

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

Participants discussed the growing rate of mental health issues among children and youth in the community and connected it to a decrease in mental resiliency and coping skills in this age group. Educators noted that students are entering the school system without the basic coping skills which were traditionally learned at home or through lived experiences. Educators expressed concern that they are not trained to teach this skill set as part of the curriculum. Educators also shared that much of the time they are meant to be teaching they are busy "putting out fires" related to mental health issues in their students. Some participants discussed the link between this trend and the growing use of technology with children and youth, and made the observation that children are "wired differently" than they use to be. They also noted that many are not equipped to deal with basic life challenges.

- Children moderate to high level of mental fitness **82%**
- Youth moderate to high level of mental fitness **76%**
- Youth able to solve problems without harming themselves and others (i.e. using drugs or being violent) **41%**
- Youth satisfied with mental fitness needs related to school **65%**
- Youth know where to go in their community to get help **24%**

DETERMINANTS OF HEALTH:
Healthy Child Development, Personal Health Practices and coping skills & Social Environment

"They're not as resilient as they used to be, they don't have the coping skills."

"Children seem to be wired differently now than they were and they have very little in the way of self-regulation, very little… no one is actually teaching them the problem-solving and the coping skills and you know the interpersonal skills, all of those things that make you realize 'it's gonna be ok' and 'I can handle it.'"

"I think technology it encourages that a bit too because everything has to be immediate and kids anxiety levels go up."

"We're being asked in the school system to deal with things that we've not been trained to deal with, we're not equipped to deal with and we didn't sign up to deal with…we're trying to put a bandage on every, you know to make it a little bit better than what are we doing."

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

South East Regional Wellness Consultant:

act as a connector and facilitators to help communities, families, organizations, schools and workplaces enhance their wellness, and can help guide to the right resource

6.2 The need for support staff in the community to help coordinate and implement prevention/health promotion type programming, particularly in outer rural communities

Participants discussed the need to have some form of support in place in the community to help coordinate, implement and drive some work around prevention and health promotion. HCPs discussed how much of what they see could have been prevented but that they don't have the time and resources to coordinate and implement any type of community-based preventative programming. Through consultations, many great programs were shared and discussed by participants but the frustration was around finding the right person to coordinate them. Participants shared how there are a number of great volunteers in the Tantramar area but expressed how these volunteers are being used to their full capacity and some are burning out.

DETERMINANTS OF HEALTH:
Social Environment, Physical Environment, Personal Health Practices and Coping Skills & Health Services

"We would love to get out there and do some health promotion on the kids, on the adults that aren't managing well but we have no time and we have no ability to do it. You know, it is frustrating on that level, so we do need support for that."

RECOMMENDATION
Examine how other similar communities are providing this resource (including a review of the role of Horizon's Community Developers), and determine how best to provide this resource.

6.3 Transportation issues in the community that impact health

Transportation issues were discussed by many participants as being a barrier to good health. Many discussed that since much of the community is rural and covers a large area, getting somewhere is a challenge. It was shared how this challenge was particularly concerning for seniors in the community, and how many who live in the farther rural pockets of the community are seniors. It was discussed how lack of transportation means many members in more rural communities don't have a lot of access to healthy foods. Participants also shared how many health services must be accessed in Moncton and how this leads to missed appointments which cost the system money and also puts the health of patients at risk. It was also discussed that transportation becomes a barrier for many students to be involved in afterschool activities because many in rural areas have a long commute home. Participants also discussed how looking at income level can be misleading in many of the rural areas because you have to take into consideration the cost of fuel and vehicle maintenance.

- Had transportation problems in getting health care when needed **9%**
- Health service not available in your area when needed **24.3%**

DETERMINANTS OF HEALTH:
Employment and Working Conditions, Personal Health Practices and Coping Skills, Physical Environment & Health Services

"Our biggest problem in Dorchester is transportation, you know to get somewhere, and there are mostly seniors in Dorchester, all the young people are out west, so it's a transportation thing for a lot of people there."

"Because the other thing is that you have to look at is that some people may be making more than that but they're traveling an hour, an hour and a half to get there and that eats up a good deal of what you're making so at the end of the day you end up being below that average even though your data says you're above."

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

6.4 The need for a community health centre model of care in the community[19]

Participants discussed the need for a community health centre model of care in the community. They described an interdisciplinary team based model with physicians, nurse practitioners, registered nurses, physiotherapists, dietitians and mental health workers. They described it as a centralized place where patients could feel more personalized and connected. They discussed how this could take the strain off of the emergency room and how it would be better equipped to handle some of the communities' needs. Participants discussed the barriers experienced when trying to access their primary health-care provider and many felt this was due to the current set up where many local doctors are covering ER shifts on a regular basis and not able to keep full time office hours. They felt that this is why so many residents rely on the local emergency room for primary health care; because they can't get in to see their own family doctor. They also felt that within this model there should be room for after-hours primary health-care services.

DETERMINANTS OF HEATLH:
Personal Health Practices and Coping Skills, Social Environment & Health Services

"I think Sackville needs a community health centre…with a nurse practitioner; there would be better access, some mental health people, so have it in a real interdisciplinary kind of way, a real community health centre, not just a health clinic"

"A community health centre would be in a position to look more at mental health and those other issues because in a hospital setting, that's really hard to do because they're so acute focused."

"I think that this community is a prime spot for a community health centre…it would take that strain that's all on emerge of all those things walking through the door."

"People don't see the medical system as friendly anymore. They don't see themselves as being personalized within it and I just feel that there has to be a way to create a space where people don't depend on one doctor but they depend on a clinic of mixed supporters that can all take on their cases and registered nurses can take the lead for a lot of things and then you could have, you know your physio, your mental health workers, everything mixed in so that type of centralized care model I think could be very useful here."

"Yeah because people will call their family doctor and the next available appointment will be two months from now."

RECOMMENDATION
Establish a working group that includes primary health care providers, Horizon leaders and community members to review the CHC model of care and create a plan for the establishment of the centre.

6.5 Food insecurity in the community

Participants shared concerns about food insecurity in the Tantramar community. They discussed challenges surrounding having enough food to eat, and also having quality food to eat. They discussed the growing rate of food bank clients in the community and noted that, when considering food insecurity, just looking at the food bank demographic was not sufficient. There is a growing demographic that is part of the working poor who are not accessing food bank services but are living on a below standard diet. Given the rural, spread out nature of the community, there was also discussion around limited access to outlets that sell fresh whole foods. HCPs discussed how this impacts what they see with patients and how food insecurity impacts the rate of diabetes in the community. As a possible solution, participants discussed the idea of spreading the Sackville area "Fresh for Less" program into some of the more rural areas of the Tantramar community. Also mentioned was the fact that much of the community is made up of students from Mt. Allison University who have a very limited food budget to work with and are relying on lower quality foods as part of their diet.

- Members of the community living in low income **18%**
- Diabetes rate **9.7%**
- Adults who eat fruits and vegetables, five or more daily **38%**

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

"…hidden behind that is a large number of working poor who are maybe not to the point that they have to access a food bank but the quality of the food that they're getting is, you know the quality of their nutrition is way below standard."

"When you look at what constitutes a healthy lifestyle, there's a certain degree of affluence to be able to maintain that and we probably generally don't have that."

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

Westmorland-Albert Food Security Network:

providing support through food banks, school lunch programs, Christmas food boxes, and more.

6.6 Lack of affordable home care services in the community

Participants described the limited availability of home care services in the community as a "major gap." They discussed the difficulty in finding services and explained that in many cases, this is why seniors are not discharged from hospital - because there is no family support and limited home care services available in the community. They talked about how having more of these services could improve the quality of life for many seniors in the area and could help many to stay in their homes longer.

- Seniors, 65 years and over, as a proportion of the total population **17%**
- Seniors living alone **22%**

DETERMINANTS OF HEALTH:
Social Support Networks, Personal Health Practices and Coping Skills & Health Services

"It's almost impossible to get home services through Red Cross. There is one private company that will give services but it's very hard to find anyone… and many seniors find it unaffordable."

"…there are patients who are able to be discharged but there's no nursing home beds and there just seems to be a gap with the home care…"

"Home making services is a big one because… there is a real gap in services here to keep people in their homes longer."

RECOMMENDATION

Assess the current provision of home care services and the current need in the community and develop a plan of action to fill any gaps.

REFERENCES

1 "The need for a community health center model of care in the community" was a theme that emerged through qualitative data analysis. Tantramar CAC members prioritized this theme and it was approved by Horizon's Board of Directors. At a later CAC meeting, some members expressed a desire to change the language of this priority to state, "The need for an improved primary health care model of care in the community." However, this change was not made because not all members of the CAC who originally participated in prioritization were present for this discussion. We still felt it was important to note that this discussion took place and that this was the view of some CAC members.

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