

# BROADENING OUR FOCUS:

Identifying regional  
priorities from the  
needs of our  
communities.

April 2017



Produced by  
Horizon Health Network's  
Department of Population Health Promotion  
& Chronic Disease Management

# Message from Horizon's Manager of Population Health

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It feels great to be preparing this report and to be at this stage of the process!

In 2012, when Horizon Health Network's (Horizon's) Community Health Needs Assessment (CHNA) portfolio became housed in our department of Population Health Promotion and Chronic Disease Management, I provided oversight to the consultant groups we outsourced the work to. After trying that approach, my team and I began to rethink the process and make plans to build capacity within Horizon for conducting CHNAs. In 2014, I took a leave from my current position as Manager of Population Health to become Research Lead for the CHNA portfolio full time. It was a challenging experience by times, but a decision I do not regret.

Given my previous education and work experience, I have a strong understanding of the concept and theory of population health. I also thought my understanding on a personal level was strong. I was mistaken. My understanding of population health has deepened and changed significantly during my time with the CHNA portfolio. Deep listening, holding space, reading transcript, hearing stories and then rehearsing them through the analysis process; seeing and hearing what the concept of population health looks and feels like on the ground in people's lives, took my understanding from one of an intellectual knowing to one that I could actually feel, connect with and experience. There were difficult realities shared, tough conversations had, some rather unpleasant exchanges, and even some tears. There were times, at this level of knowing, that I was emotionally impacted and shaken. However, through it all the experience has further enlightened me and I believe there is potential for the experience to also be an enlightening one for our organization. That is why we felt it was important to create this report.

Like many Canadians, I deeply value our public health care system and personally know the importance of quality health care delivery. My daughter was born in this system and the support given to me as a young mother, by the amazing

maternity floor staff, is an experience I still hold close to my heart. As a young adult, one of my closest friends was in an ATV accident and, even today, when we get the chance to catch up, I am grateful for the emergency services that saved her life. My mother's rare form of cancer brought my family and I to many parts of Horizon's oncology system; during her illness, the Extra-Mural nurses felt like family members and during her death, the staff of the palliative care unit were... well I wouldn't even have the words to describe their capabilities. I get it! As an organization, we need to prioritize the provision of quality health care services. But as our rates of chronic disease rise, this essential system I deeply value is threatened and experiencing more and more strain. We've all tried our hand at patching holes in it, but ultimately our only long-term option is to make the bold and courageous decisions needed to reverse this trend.

As an organization with the mission of **Helping People Be Healthy**, I believe we have the ability and responsibility to work further upstream and improve the health status of the individuals, communities and populations that we serve. As important as they are, we know that traditional health care services play a very small role in what actually makes an individual and a population **Be Healthy**. Through the CHNA experience I've met many staff that "get it" and witnessed them striving towards this goal; so much amazing work, so many great ideas and committed people. But, given how grand the challenge is before us, I can't help but wonder how much impact these individual examples can have at a population level. A transformation is required on a larger scale. My hope for this report is that it brings the real issues that have a significant impact on health status to the forefront of our discussions, our decision-making, our actions and our investments, and in that context, our organization and population thrive.



Allison Holland  
Manager of Population Health

# Acknowledgments

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The undertaking of Community Health Needs Assessments on a regional scale was a large endeavour for Horizon and there are many people to thank: the Horizon staff who supported us in each community, the 374 Community Advisory Committee members who actively guided us through each assessment, the over 1,200 New Brunswick residents who gave of their time to participate in consultations, Horizon's Communications team, the New Brunswick Health Council, the team members of the department of Population Health Promotion and Chronic Disease Management, and, of course, the three amazing project coordinators who joined our team and kept each assessment moving forward. Your contribution was greatly appreciated!

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# 1. Introduction

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The practice of Community Health Needs Assessment (CHNA) is not a new endeavour. In fact, many communities across Canada and globally have utilized CHNA to do community health planning for many years, including within the province of New Brunswick. Some CHNA work in New Brunswick was initiated and sourced by individual community coalitions; some were government-funded, and others were completed in correlation with the development of the Community Health Centre model of care. In 2012, the province of New Brunswick announced that there would be a new round of CHNAs conducted; a recommendation under the *Primary Health Care Framework for New Brunswick*.<sup>1</sup> Shortly after that announcement, the *Community Health Needs Assessment Guidelines for New Brunswick*<sup>2</sup> were developed to help standardize the process across the province. These guidelines state that the process for conducting CHNAs is best understood and executed using a population health approach which endeavours to improve the health of the entire population and to reduce health inequities among population groups by examining and acting upon the broad range of factors and conditions that have a strong influence on health. The guidelines will be further discussed in section 2.1. Understanding the benefit to the organization, CHNA work was built into Horizon Health Network's Strategic Plan 2015-2020 which states that "all communities served by Horizon will have had completed a community health needs assessment," as an item under strategic priority 3.<sup>3</sup> When you consider the amount of effort and investment conducting CHNAs and following through on CHNA priorities takes, this strategic commitment was a great undertaking and demonstrated Horizon's strong dedication to the communities it serves.

Within Horizon, the responsibility for administering CHNAs sits with the department of Population Health Promotion and Chronic Disease Management (PHP-CDM) and, using community boundaries set by the New Brunswick Health

Council, 22 communities within Horizon have participated in the CHNA process. To provide some context, section 3 of this report shares what the CHNA process looked like at the individual community level. Each participating community, through a Community Advisory Committee, set local level priorities based on the available data and data collected; reflected in a final report for each community.<sup>4</sup> For this particular report, however, the main focus is not on these local level CHNAs and their resulting priorities. Section 4, *Broadening our Focus and Taking a Regional View*, delves into the purpose of this report by looking at the consultation reach achieved at a regional level, the process used for a regional level analysis, and the resulting 20 regional level priorities that emerged. Section 5 discusses what this all means for Horizon moving forward and the need to wholeheartedly accept these priorities as our priorities if we are to have an impact on the health of our population. This section highlights: our core value, *We Act with Integrity and are Accountable*, the importance of maintaining community engagement, the need to invest in relationship, and the Collective Impact approach to collaboration.<sup>5</sup>

As ample research has demonstrates, both within our province and nationally, a shift in perspective and the redirection of health care spending is needed if we are to improve the health status of our population and continue to afford our extremely valuable health care system. However, with such a broad range of factors that impact health, it can be overwhelming and hard to know where to begin; where to invest. For Horizon, this report can serve as a starting point; a guide to help the organization begin to plan and redirect funding with confidence, knowing that these priorities reflect what the experts have been telling us for many years<sup>6 7 8 9</sup> but, more importantly, they reflect what our communities have told us as well.

It is important to note that this report is not a “how-to” guide; you will not find any mapped out processes or recipes here for addressing the regional priorities presented. However, section 5.5 is a clear call to action for the “how-to” and highlights the need for Horizon, supported by its PHP-CDM department, to begin creating action and financial plans around these regional level priorities in order to impact change, improve the health of the population, and maintain a thriving health care system. To begin, the following background provides context.

# 2. Background

In 2012, when the province of New Brunswick announced that there would be a CHNA conducted in each community within the province as a recommendation under the *Primary Health Care Framework for New Brunswick*,<sup>10</sup> funding and responsibility for CHNAs was given to the Regional Health Authorities (RHA) to complete assessments within each of their catchment areas. After the announcement, a working group was formed with representation from Horizon Health Network, Vitalité Health Network, the Department of Health and the New Brunswick Health Council to jointly create the *Community Health Needs Assessment Guidelines for New Brunswick*.<sup>11</sup> When developing the guidelines, the working group examined CHNA practices from other jurisdictions.

## 2.1 COMMUNITY HEALTH NEEDS ASSESSMENT GUIDELINES FOR NEW BRUNSWICK

The purpose of the *Community Health Needs Assessment Guidelines for New Brunswick* is to describe a framework for conducting CHNAs and to guide the RHAs and local committees in their efforts to conduct these assessments. The guidelines provide a high level, standardized process for conducting CHNAs, and a common set of guidelines, indicators and data sources. The guidelines state that, “The CHNA process will assist in providing baseline information about health and wellness and the factors that influence the overall health of the community, encourage collaboration with community members, stakeholders and a wide variety of partners involved in the decision-making

process.”<sup>12</sup> The guidelines define CHNA, provide a high-level outline for conducting CHNAs, include a guide for using qualitative methods as part of the CHNA process, and state that CHNA involves:

- Gathering information about health and wellness (facts and opinions)
- Gathering information about health and community resources (assets)
- Determining community priorities
- Building partnerships to work on addressing community wellness and health needs<sup>13</sup>

The guidelines also state that the process is one best understood and executed using a population health approach.

## 2.2 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. The *Community Health Needs*

*Assessment Guidelines for New Brunswick* state that the process for conducting CHNAs is best understood and executed using a population health approach. This approach strives to improve the health of the entire population and to reduce health inequities among population groups by examining and acting upon the broad range of factors and conditions that have a strong influence on health.<sup>14</sup> These factors

and conditions are often referred to as the determinants of health<sup>15</sup> and are categorized by the Public Health Agency of Canada as:

### CHNA DEFINED

“CHNA is a dynamic, ongoing process undertaken to identify the strengths and needs of the community and to enable community-wide establishment of wellness and health priorities that improve the health status of the population.”

Community Health Needs Assessment Guidelines for New Brunswick

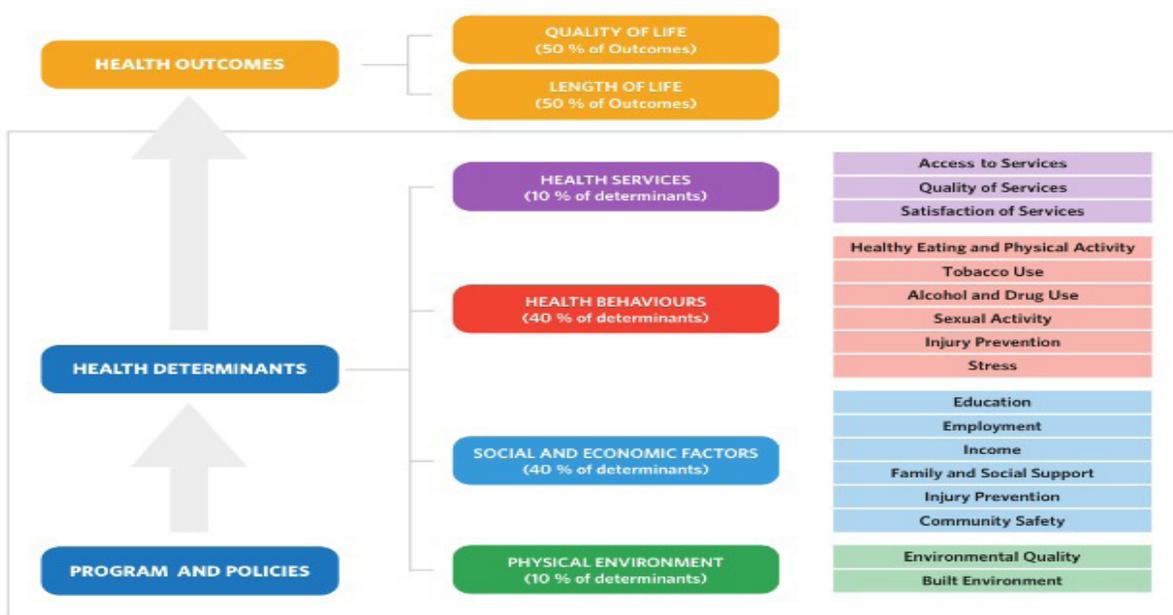
1. Income and Social Status
2. Social Support Networks
3. Education and Literacy
4. Employment and Working Conditions
5. Social Environment
6. Physical Environment
7. Personal Health Practices and Coping Skills
8. Healthy Child Development
9. Biology and Genetic Endowment
10. Health Services
11. Gender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

Although categorized into 12 areas, it is important to highlight the interconnectivity of the determinants of health. For example, level of income can greatly impact the physical environment you live in and can impact the level of education you attain, with employment and work conditions, there are clear inequities based

on gender, and healthy childhood development can impact future personal health practices and coping skills. There are multiple connections when considering this list of determinants and there is often more than one having an impact on health at a time.

CHNAs conducted within Horizon communities are also informed by the population health model of the New Brunswick Health Council which is adapted from the model used by the University of Wisconsin's Population Health Institute. This model, shown in figure 1, 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: New Brunswick Health Council's Population Health Model<sup>16</sup>**



As stated in the *Community Health Needs Assessment Guidelines for New Brunswick*, this approach also highlights the need to use a health inequity lens. Health inequity is the systematic and unfair differences in health status between groups that occupy different positions on the social hierarchy, where the more socially disadvantaged groups experience poorer health.<sup>17</sup> This lens has

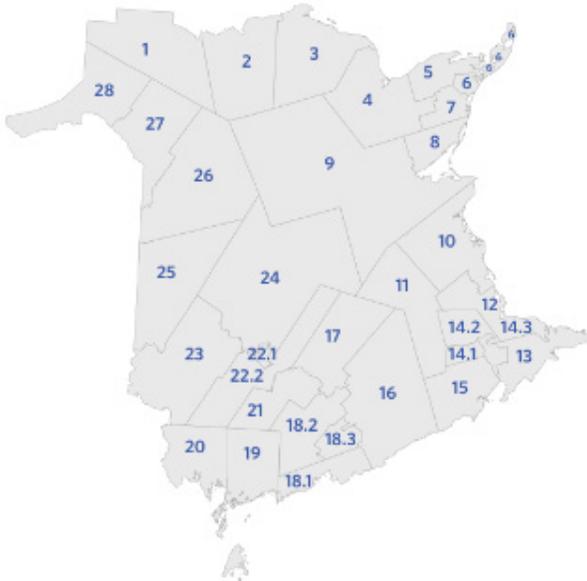
added significant value to the CHNA process, and many of the outcomes have shed light on health inequities and how they impact, not only the health of particular populations, but also prevent whole communities from thriving. In the report, *Health Inequities in New Brunswick* by New Brunswick's Office of the Chief Medical Officer of Health, it states that, "In the end, everyone -

not just the more socially disadvantaged groups - benefits from reduced health inequities. This is because health inequity affects the cost and availability of health care for everyone; it affects crime and everyone's sense of community safety; it affects whether communities thrive socially and economically; it affects tourism and our ability to attract economic investments; and it leaves less money available for new social programs and services, other social development initiatives and public priorities."<sup>18</sup> The regional priorities presented in section 4.3 are also viewed through a healthy inequity lens, and attention is drawn to those where health inequity is having significant impact.

### 2.3 DEFINING COMMUNITY BOUNDARIES

As stated in the *Community Health Needs Assessment Guidelines for New Brunswick*, assessments were to be conducted based on

**FIGURE 2: New Brunswick Health Council Community Boundaries Map**



the community boundaries defined by the New Brunswick Health Council (NBHC). The NBHC has divided the province into 28 communities, with the three largest urban cores further subdivided to ensure a better perspective of regional and local differences, for a total of 33 communities. These community divisions can be seen in figure 2 and table 1 below. The NBHC used catchment areas of health care centres, community health centres, and hospitals to determine the geographical areas for each community. Census subdivisions were then merged together to match these catchment areas. The communities were further validated by the NBHC with various community members to ensure communities of interest were respected from all areas of New Brunswick. No communities were created with fewer than 5,000 people (as of Census 2011) to ensure data availability, stability, and anonymity for various indicators. The NBHC uses these community boundaries as the basis for work and analysis done at the community level.<sup>19</sup>

**TABLE 1: New Brunswick Health Council Community Number and Name**

ABBREVIATED NAME	
1 Kedgwick	16 Sussex
2 Campbellton	17 Minto
3 Dalhousie	18.1 Saint John
4 Bathurst	18.2 Grand Bay-Westfield
5 Caraquet	18.3 Quispamsis
6 Shippagan	19 St. George
7 Tracadie-Sheila	20 St. Stephen
8 Neguac	21 Oromocto
9 Miramichi	22.1 Fredericton
10 Bouctouche	22.2 New Maryland
11 Salisbury	23 Nackawic
12 Shediac	24 Douglas
13 Sackville	25 Florenceville-Bristol
14.1 Riverview	26 Perth-Andover
14.2 Moncton	27 Grand Falls
14.3 Dieppe	28 Edmundston
15 Hillsborough	

# 3. Community Health Needs Assessments in Horizon

## 3.1 COMMUNITIES WITHIN HORIZON

Geographically, 24 of the NBHC communities shown in figure 2 are within the Horizon region. However, given that 3 of these communities are sub-divided (see table 2 below), the total number of communities is actually 19. The province of New Brunswick is divided into 2 RHAs (Vitalité and Horizon Health Networks), but it is also further broken down into 7 health service zones. Only in health service zone 1 (Moncton area) are communities serviced by both RHAs, and therefore both are sharing responsibility for CHNAs within that zone. Two of the zone 1 communities, Bouctouche (#10) and Shediac (#12), will have their CHNAs conducted by the Vitalité team, which left Horizon with a total of 17 communities for CHNA.

## 3.2 CHNA LEADERSHIP IN HORIZON

After the announcement in 2012 from the *Primary Health Care Framework for New Brunswick* that there would be a CHNA conducted in each community in the province, Horizon took its commitment and leadership for this work a step further by building it into their Strategic Plan (2015-2020) which states that “all communities served by Horizon will have had completed a community health needs assessment,” as an item under strategic priority 3.<sup>20</sup> Within Horizon, responsibility for the CHNA portfolio was housed in Horizon’s PHP-CDM department. In the beginning, although the PHP-CDM department provided oversight, external consultants were hired to conduct the CHNAs. As you can see in table 3 below, the first 6 CHNAs were conducted in this manner. After these were completed in 2014, Horizon decided to build internal capacity for conducting CHNAs in order to refine the process and make it more consistent, build better relationships with communities, and make it more cost-effective. Horizon’s Community Health Assessment Team was developed in 2014 and the final 11 assessments were led and conducted by this team.

**TABLE 2: Communities within Horizon**

NBHC-#	NBHC COMMUNITY NAME
21	Oromocto
22 (22.1 & 22.2)	Fredericton & New Maryland
11	Salisbury
20	St. Stephen
14 (14.1, 14.2 & 14.3)	Riverview, Moncton & Dieppe
18 (18.1, 18.2 & 18.3)	Saint John, Grand Bay-Westfield & Quispamsis
17	Minto
13	Sackville
24	Douglas
8	Neguac
9	Miramichi
15	Hillsborough
25	Florenceville-Bristol
26	Perth-Andover
19	St. George
23	Nackawic
16	Sussex

**TABLE 3: Overview of CHNA Leadership in Horizon**

YEAR	NBHC #	NBHC COMMUNITY NAME	LEAD
2011	21	Oromocto	Verlé Harrop
2012	22 (22.1 & 22.2)	Fredericton & New Maryland	
2014	11	Salisbury	Harbour Front Health Group
	20	St. Stephen	
	14 (14.1, 14.2 & 14.3)	Riverview, Moncton & Dieppe	
	18 (18.1, 18.2 & 18.3)	Saint John, Grand Bay-Westfield & Quispamsis	
2015	17	Minto	Horizon's CHA Team
	13	Sackville	
	24	Douglas	
	8	Neguac	
	9	Miramichi	
2016	15	Hillsborough	Horizon's CHA Team
	25	Florenceville-Bristol	
	26	Perth-Andover	
	19	St. George	
	23	Nackawic	
	16	Sussex	

### 3.3 HORIZON'S CHNA PROCESS

All 3 groups involved in leading and conducting CHNAs in Horizon followed the *Community Health Needs Assessment Guidelines for New Brunswick* and created similar processes based on the five key activities outlined in the guidelines which are:

1. Community Engagement
2. Data Collection
  - Current indicators and data sources
  - Gathering new information
3. Analysis
4. Develop Recommendations/Priorities
  - Criteria to assess importance
  - Share and facilitate CHNA findings
5. Report Back to Community

CHNAs are a community centred process whereby community members' opinions are valued and taken into account for planning purposes. Although the guidelines provided the RHAs with these broad key activities, the CHNA process needs to be flexible in order to meet the needs of individual communities. Each community is unique and therefore a cookie-cutter approach was not always possible. When communities feel they have a role in driving the CHNA process, they are more likely to feel a sense of ownership for the results and have a higher level of engagement. That being said, CHNAs conducted in Horizon communities generally followed a 12-step process that tended to work well for most communities, while staying flexible to accommodate the unique needs of individual communities.

**TABLE 4: Horizon’s CHNA 12-Step Process**  
(Appendix A provides a detailed description of each step)

1.	Develop a 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 quantitative 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 jointly identify priorities
11.	Finalize themes, recommendations, and final report
12.	Share final report with CAC members and the larger community and begin work planning

At the end of this process when each CAC approved the final CHNA priorities and report, the results for each were shared with Horizon’s Governance, Nominating and Planning Committee. Following this, the results for each community were presented to Horizon’s Board Members. Each of the 17 completed CHNAs presented to the Board received formal Board endorsement, demonstrating the Board’s strong understanding and deep commitment to community level issues, to the individual communities served by Horizon, to a population health approach, and to Horizon’s mission of **Helping People Be Healthy.**

### 3.4 CHNA AS AN ONGOING PROCESS: REGIONAL ACTIONS TAKEN

As discussed above, the *Community Health Needs Assessment Guidelines for New Brunswick* considers CHNA an “ongoing” process. With all 17 CHNAs now completed in Horizon, a first step taken by the organization to keep the work ongoing and maintain community engagement is the creation of a Regional Facilitator for CHNA position whose responsibilities include providing oversight to communities with regards to their community level priorities, and acting as an important connection between individual communities and the larger organization. As well, Horizon is working collaboratively as part of a working group with the Department of Health and Vitalité Health Network to determine the next steps with regards to updating and/or conducting future CHNAs in the province. Another way Horizon is ensuring that CHNA remains an ongoing process is through the work of their Communications team with the publication, “In Your Community.” This publication highlights different communities in each edition, and showcases the work undertaken to collectively address CHNA priorities.<sup>21</sup>

By looking at the background information, the community boundaries for Horizon, CHNA leadership, and the CHNA process used, the sections above provide a brief overview of what Horizon has been deeply invested in over the last four years, and what took place at the individual community level. It is important to share this context because it provides an overview of where the organization has come from with regards to CHNAs. However, as stated in the introduction, the main focus of this report is not on these local level CHNAs and their resulting priorities, but a much broader regional perspective.

# 4. Broadening our Focus and Taking a Regional View

At this point, we zoom out and lay a different lens over the entirety of this work by focusing on what it all means to Horizon as an organization; what it means on a regional scale. Although partnership is an undeniable component of the work that lies ahead (as will be discussed in section 5), the intention of this regional view is to provide a guide for us, for Horizon; not something to pass on or turn over to our external partners. It is meant to be an important tool to help move our organization's mission of **Helping People Be Healthy** forward. The *Community Health Needs Assessment Guidelines for New Brunswick* state that, "the CHNA process must not only be responsive to the local context but also provide a broader understanding of the health of New Brunswick residents."<sup>22</sup> This "broader understanding" is what we have tried to achieve in what follows.

In this section, we begin by looking at the scope of consultation that took place on a regional scale, present the regional analysis process used, and finally, present the findings from this analysis through the 20 regional level priorities that have emerged.

## 4.1 OUR REACH: A REGIONAL LOOK AT COMMUNITY CONSULTATION

The reach accomplished through the CHNA consultation process was extensive. More important than the large numbers consulted, was the depth. Many circumstances in our communities are not reflected in the quantitative data sources available to us, but they are well known by community members and professionals working and living them every day. The qualitative information collected provided significant context around the quantitative data;

Over 1272 New Brunswick residents consulted, from more than 336 cities, towns and villages within the Horizon Health region; this is the voice of our communities

it provided the story behind the numbers. This required a great deal of flexibility. The team strived to engage individuals, communities and under-served groups by reaching out to them, on their terms and in their settings. Consultation through focus group interviews and key stakeholder interviews were held in community settings that were familiar, comfortable, and accessible to participants. Urban centres were covered, but this work also took the team to many small pockets of Horizon's catchment area, like our First Nations communities, the Canadian Forces Base, small Acadian villages, rural New Brunswick regions and islands only accessible by ferry such as Grand Manan and Deer Island.

Throughout the CHNA process, 16 Community Advisory Committees (CACs) were created with membership ranging from 15-46 members per CAC for a total of 374 community members guiding CHNAs at the community level. To help ensure alignment with the population health approach and to ensure comprehensive representation, the 12 determinants of health listed in section 2.3 guided the membership selection process. The mandate of the CACs in each community was *to enhance community engagement throughout the CHNA process and provide advice and guidance on health and wellness priorities in the community*. CACs played a significant role in the process as they were an important link between the community and Horizon's CHNA Team.

With the help of CAC members, a qualitative data collection plan was developed for each community and possible consultation participants were identified and invited to participate in focus groups and key stakeholder interviews. In total, 113 focus groups were held,

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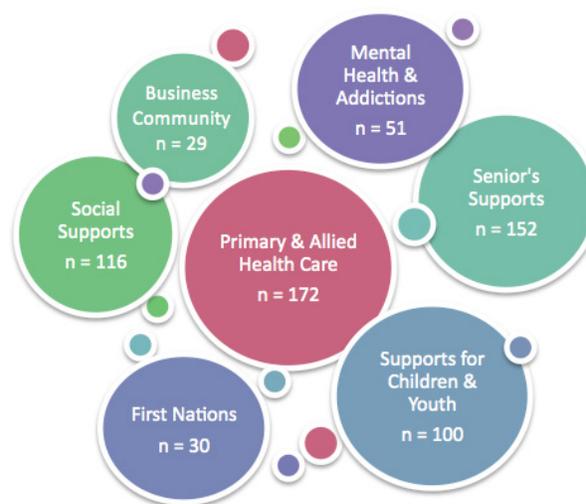
with over 956 participants. Table 2 outlines the number of each focus group type held throughout Horizon's region.

**TABLE 5: Focus Group Sessions**

Focus Group Types	Number of Focus Group Sessions
Primary and Allied Health Care	21
Seniors and Seniors' Supports	17
Professionals working with Children & Youth	15
Social/Community Supports	14
Mental Health and Addictions Professionals	10
First Nations Communities	6
Business Community	4
Parents and Families	3
Spiritual Leaders and Clergy	3
Issues of Domestic Violence	3
Young Adults and Post-Secondary Education	3
Recreation	2
Newcomers	2
Patients with Chronic Disease	2
Geographic Area Specific	8

The most common types of focus groups held were in the areas of Primary and Allied Health Care, Seniors and Seniors' Supports, Social and Community Supports, Mental Health and Addictions, Supports for Children and Youth (including Education), First Nations, and business communities. The total number of individuals who participated in focus groups in each of these areas is represented in figure 3.

**FIGURE 3: Focus Group Participants**



Community members and professionals consulted in these most common focus groups came from diverse backgrounds and represented various organizations and community groups:

- Primary and allied health care focus groups (172 participants) included physicians, nurse practitioners, dietitians, first responders, nurses, various health centre staff (administrators, clerks, community developers), physiotherapists, and other health care professionals.
- Seniors' supports focus groups (152 participants) included seniors from the community, nursing home staff and administration, home care organizations, Horizon's Extra-Mural Program, hospice representatives, Department of Social Development and various members of other seniors' organizations, clubs and groups.
- Social supports focus groups (116 participants) included food banks, affordable transportation organizations, low-income housing operators, Department of Social Development, Community Inclusion Networks, shelters, multicultural associations, and community volunteers.
- Mental health and addictions focus groups (51 focus group participants) included adult and child mental health professionals, addictions counsellors, private counsellors, public health, social workers, guidance counsellors,

law enforcement representatives, Canadian Mental Health Association representatives, and other community organizations providing mental health and addictions supports.

- Professionals working with children and youth focus groups (100 participants) included teachers, principals, librarians, coaches, Public Health, guidance counsellors, dietitians, Early Childhood Development, family resource centres, and representation from other community youth groups and clubs.
- First Nations representatives focus groups (30 participants) included health centre staff, nurses, mental health and addiction professionals, band council members, community members, and first nations liaisons.
- Business communities focus group (29 participants) included local business owners, employees and Human Resources representatives from key employers in communities, as well as workplace health and wellness representation.

Other less common focus groups were in the area of parents and families, spiritual leaders and clergy, issues of domestic violence, young adults, post-secondary education, recreation, newcomers, patients with chronic disease, and geographic area-specific focus groups.

Moreover, 55 key stakeholder interviews were conducted with various primary health care providers, allied health professionals, educators, social support providers, members from law enforcement, first responders, and other professionals and community members.

## 4.2 REGIONAL DATA ANALYSIS

Section 3.3 discusses the process used by Horizon's team during local CHNAs. A major part of the process was the review of available quantitative data, the development and execution of qualitative data collection plans in consultation with Community Advisory Committees, and the analysis of this qualitative data grounded in the methodology of Interpretive Description.<sup>23</sup> The local CHNA reports for each community outline in more detail the research methodology and approach used at that level.<sup>24</sup> This resulted in

individual lists of themes for each of the 17 CHNAs conducted in Horizon. These 17 lists of themes formed the data set used for this regional level analysis; where before the individual communities were considered the subject under study, now the region of Horizon has become our subject under study.

Although the subject changed, the qualitative methodology of Interpretive Description was maintained. *Interpretive Description (ID)* methodology focuses on the smaller scale qualitative study with the purpose of capturing themes and patterns from subjective perceptions. 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." 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.<sup>25</sup>

In total, the 17 theme lists contained 527 themes. *Content Analysis*, which refers to qualitative data reduction and sense-making efforts that take a volume of qualitative material and attempts to identify core consistencies and meanings,<sup>26</sup> was completed on this data set using an open coding method. This data reduction exercise categorized the 527 themes into a category list of 41.

To get from our list of 41 to our final list of the 20 priorities presented in this report, a *Key Issues* analytical framework was applied using the filters of frequency, significance and applicability, laid over each of the 41 categories; each being tested against these 3 filters.<sup>27</sup> Afterwards, the 20 resulting priorities were cross-referenced with regional, provincial and national quantitative data where available. Because the filters of frequency, significance and applicability are equally weighted in this form of qualitative data analysis, the resulting list of 20 priorities presented below

are not listed in any particularly order; some are there for their high frequency, others for their significance, and others for a combination of high significance and applicability.

### 4.3 HORIZON'S REGIONAL PRIORITIES

For those closely connected with communities, some of the regional priorities presented here will not be surprising. In fact, some are well-known concerns at the community level. In those instances, these results can provide momentum and reassurance that working and investing in these areas aligns with the needs of communities, because it is the voice of communities. Others may find the priorities surprising or may feel that they are outside the reach of a Regional Health Authority. This reaction is understandable; however, we are not just any Regional Health Authority, we are an organization that has defined

our mission as **Helping People Be Healthy** and, as ample research has demonstrated, health is not a product of health services alone, but of a broad range of factors and conditions that lay outside of health service provision. At this point, before examining these priorities, we can reflect back to how we framed the CHNAs around a population health approach as recommended by the *Community Health Needs Assessments Guidelines for New Brunswick*, and recall the NBHC's population health model which shows what influences our health (10% health services, 40% health behaviours, 40% social and economic factors, and 10% physical environment). As discussed, there is great interconnectivity with regards to the determinants of health and what influences our health status. That will become even clearer through these regional priorities; many do not work in isolation and you will often find they web together, magnifying their impact on health status.

**TABLE 6: Horizon's Regional Priorities** (not in any order of priority)

REGIONAL PRIORITY	PAGE	REGIONAL PRIORITY	PAGE
 Food Insecurity	17	 Awareness of Services & System Navigation	21
 Transportation	17	 Social Supports to Help Individuals Move Out of Poverty	22
 Mental Resiliency and Coping Skills Among Children & Youth	17	 Housing	22
 Addictions & Mental Health Services	18	 Collaboration with First Nations	23
 Alcohol and Drug Use/Abuse	18	 Supporting the New Family Reality	23
 Expansion of Sexual Health Services & Sexual Abuse Treatment/Prevention	19	 Senior Isolation and Lack of Community/Social Supports for Seniors	24
 Access to Primary Health Care Services	19	 Senior Home Care and Outreach Services	24
 A Shift to More Comprehensive, Team Based Primary Health Care	20	 Recreation	24
 More Focus on Chronic Disease Prevention	20	 Enhanced Collaboration, Communication & Connectedness	25
 Healthy Eating & Physical Activity	21	 Continual Community Engagement	25



## FOOD INSECURITY

In Canada, measurement of food insecurity is done through Statistics Canada's Canadian Community Health Survey which states that "food insecurity exists within a household when one or more members do not have access to the variety or quality of food that they need due to lack of money."<sup>28</sup> Food insecurity impacts health through poor growth and development, increased likelihood of developing chronic disease, stress and other mental health issues, and can impact the ability to properly manage chronic disease. Key points about food insecurity from CHNA data were:

- the need to increase accessibility to fresh, whole foods (particularly in rural communities)
- the need to make fresh whole foods more affordable
- the need to improve the population's connection to their food sources
- the need to increase skills around gardening (particularly with children and youth)
- the need to improve the skill set around handling, preparing and storing fresh, whole foods
- the need to enhance connections to local food sources

According to results from the 2014 Canadian Community Health Survey, within New Brunswick, 15.2% of households experience food insecurity, the second highest provincial rate in Canada<sup>29</sup> and 21% of children live in food insecure households<sup>30</sup> (keeping in mind rates do not include the homeless population or those living in First Nation communities). Although food insecurity demonstrates a clear health inequity because being able to afford a fresh, whole foods diet is very much dependent on income, there is also inequity in accessibility between communities. Within many of Horizon's rural communities, accessibility to food retail sources is becoming limited compared to urban communities; some referring to themselves as "food deserts" due to the distance that must be travelled to access food retailers or retailers offering fresh, whole foods.



## TRANSPORTATION

According to The New Brunswick Economic and Social Inclusion Plan 2014-2019, "lack of access to transportation poses significant challenges for many New Brunswickers. Whether creating barriers to employment and training, limiting participation in sports and community activities or restricting access to health and other essential services typically less available in rural areas, transportation challenges lead to exclusion."<sup>31</sup> Key points about transportation from the CHNA data were:

- the need to build transportation infrastructure into health service delivery
- the need to remove "lack of transportation" as a barrier to participation in recreational activities
- the need to make transportation options more affordable
- the need to provide more accessible transportation options for the disabled population
- the need to invest in community walkability and active transportation

According to the 2011 National Health Survey, in New Brunswick, adults walking or biking as a form of transportation to and from work or school is 5.8% and adults utilizing public transportation is 2.2%.<sup>32</sup> The NBHC's 2014 Primary Health Care Survey shows that 7.1% of respondents cited transportation problems as a health service barrier.<sup>33</sup>



## MENTAL RESILIENCY AND COPING SKILLS AMONG CHILDREN & YOUTH

Mental resiliency is broadly defined by the NBHC as the ability to bounce back from adversity. It is also in part the capacity of individuals to find the right supports, programs and services for their needs.<sup>34</sup> One of the Public Health Agency of Canada's 12 determinants of health is *Personal Health Practices and Coping Skills* which refers to those actions by which individuals can prevent diseases and promote self-care, cope with challenges, develop self-reliance, solve problems and make choices that enhance health.<sup>35</sup> Key

points about mental resiliency and coping skills among children and youth from CHNA data were:

- a perceived growth in the rate of mental health issues among children and youth
- an increase in the use of mental health services by children and youth
- the perception that many children and youth are not learning and developing mental resiliency and coping skills at home
- the need for more supports in schools to build mental resiliency and coping skills curriculum
- the need to address sleep deprivation in youth
- the need to mitigate the effects of technology on child and youth mental health
- the need to take a proactive approach to prevent mental health issues in our future adult population

According to the 2016 NBHC report, *Protective Factors as a Path to Better Youth Mental Health*, the percentage of New Brunswick students in grades 6-12 with moderate-to-high resilience scores is 67%.<sup>36</sup>



## **ADDICTIONS & MENTAL HEALTH SERVICES**

Within Horizon, addictions and mental health services are part of the Community Portfolio. Services provided include acute inpatient psychiatric care, inpatient alcohol and other drug withdrawal management, methadone maintenance treatment, alcohol and other drug rehab programs, emergency psychiatric services and mobile crisis units as well as many outpatient services for adults and youth experiencing addiction or mental health. Key points about addictions and mental health services from CHNA data were:

- the need to promote more understanding and awareness around mental health and reduce stigma in the general public and with Horizon staff
- the need to improve the process for referral and timeliness of accessing mental health services
- the need to increase availability of mental health professionals

- the need to make mental health services more mobile to address rural communities
- the need for more investment in programs and initiatives that promote positive mental health and prevention

According to the Canadian Community Health Survey results, in New Brunswick, perceived mental health status (very good or excellent) is at 64.8%.<sup>37</sup>



## **ALCOHOL AND DRUG USE/ABUSE**

According to the report, *Mental Health and Substance Use Disorders in New Brunswick*, substance use disorders can have biological, psychological and social components. The use of substances such as alcohol, prescription pharmaceuticals and other drugs occurs along a continuum from beneficial use to problematic use.<sup>38</sup> CHNA findings showed concerns at various stages along the continuum from experimentation with substance use by youth to addiction concerns within the young adult and adult population. Key points about alcohol and drug use/abuse from CHNA data were:

- the need to address the long-standing “culture” of alcohol and drug use in many rural communities
- the need to address youth alcohol consumption with attention to rural communities
- the need to provide more recreational opportunities for children and youth
- the need to address prescription drug availability and abuse in the population
- the need to decrease accessibility to alcohol for youth
- the need for more investment in programs and initiatives that prevent alcohol and drug use/abuse

As stated in the report *Mental Health and Substance Use Disorders in New Brunswick*, for the population 15 years and older, alcohol use is 16.1%, cannabis use is 11.0%, and the use of other drugs is 6.8%.<sup>39</sup> According to the *New Brunswick Student Drug Use Survey*, the rate for youth who ‘drank alcohol more than once per

month' is 25.7%, 'used cannabis more than once a month' is 11.6%, and 'used prescription pain relievers to "get high" in the past 12 months' is 11.1%.<sup>40</sup>



### **Expansion of Sexual Health Services & Sexual Abuse Treatment/Prevention**

Sexual health is an important aspect of overall health and well-being and healthy sexuality involves acquiring knowledge and adopting behaviours that contribute to positive sexual and reproductive health and sexual experiences across the life course; including the ability to make healthy choices and respect the choices of others.<sup>41</sup> Connecting with the priority issue above, use of alcohol or drugs among students is frequently associated with increased risk of unplanned or unprotected sex.<sup>42</sup> Sexual health services in Horizon are provided through the primary health care program and Horizon's public health program focuses on promotion and population health approaches to sexual health. Key points about sexual health from the CHNA data were:

- the need to provide more women's health and sexual health services in communities
- the need to provide more sexual health services for youth
- the need to provide more sexual health education in communities

According to a population health bulletin published by the Office of the Chief Medical Officer of Health on youth sexual health in 2011, the provincial teen pregnancy rate was 24.9 per 1000 females aged 15-19; ranking New Brunswick as 6<sup>th</sup> when compared to rest of Canada. Chlamydia, the most commonly reported sexually transmitted infection in Canada, has been rising in New Brunswick since 2007 going from 1,240 cases to 1,923 in 2012.<sup>44</sup> The bulletin also discusses that there is some evidence to show disparities in sexual health, and that economically disadvantaged and marginalized population groups may be more vulnerable to negative sexual health outcomes than others.

During CHNAs, discussion around sexual abuse often focused on the long-term health effects

associated with childhood experiences of sexual abuse. Sexual abuse is considered an adverse childhood experience (ACE) and extensive research has been done demonstrating the impact of ACEs on future health status.<sup>45</sup> Key points about sexual abuse from the CHNA data were:

- the need for more training for health care providers dealing with cases of sexual abuse
- the need for more mental health services for sexual abuse victims
- the need for more sexual abuse education for youth



### **ACCESS TO PRIMARY HEALTH CARE SERVICES**

Primary health care is usually the first place people go when they have health concerns, often a general practitioner or family physician. It typically includes routine care, care for urgent but minor/common health problems, mental health care, maternity and child care, psychosocial services, liaison with home care, health promotion and disease prevention, nutrition counseling and end-of-life care. It is also an important source of chronic disease prevention and management and may include other health professionals such as nurses, nurse practitioners, dietitians, physiotherapists, and social workers.<sup>46</sup> Primary health care is a vital part of our health care system because it reduces costs and pressures on hospitals by supporting people to manage their health issues in the community. Key points about access to primary health care from the CHNA data were:

- the need to address hours of operation for primary health care services (more after-hours access)
- the need to increase the use of nurse practitioners in communities to improve access
- the need to address long wait times experienced by many to access primary health care services
- the need to make primary health care services more mobile in order to improve access in rural communities

## **BROADENING OUR FOCUS:**

Identifying regional priorities from the needs of our communities.

According to results from the 2014 NBHC Primary Health Care Survey, 16.2% of respondents stated that their family doctor has extended office hours (after 5 p.m. or on weekends), 60.3% stated that an appointment can be made with their family doctor within 5 days, 92.1% have a personal family doctor, and 17.4% stated that a health service was not available in their area when needed.<sup>47</sup>



### **A SHIFT TO MORE COMPREHENSIVE, TEAM-BASED PRIMARY HEALTH CARE**

Closely related to the issue discussed above, is the need for more comprehensive, team-based primary health care. Although research on the effectiveness of team-based care across Canada has shown both positive and negative outcomes, the New Brunswick Department of Health has reviewed this approach for some time. In 2002, the introduction of the Community Health Centre (CHC) model of care was a step towards more team-based care and currently there are six CHCs operating in Horizon. In 2010, the Department released, *Improving Access and Delivery of Primary Health Care Services in New Brunswick* which states that, "New Brunswick must develop networks of primary health care teams, creating innovative service delivery models that will ensure that all New Brunswickers are able to access a family physician supported by an interdisciplinary primary health care team."<sup>48</sup> In 2012, the department released *A Primary Health Care Framework for New Brunswick* which stated that, "...the citizens of New Brunswick need a team-based approach to primary health care. Team-based care is one way to improve the quality of care, since teams can focus on prevention of chronic disease, offer better access to services, shorter wait times, and achieve better coordination of care to help ensure that patients receive the right care, by the right provider, in the right place and at the right time."<sup>49</sup> During CHNAs, communities shared the same opinion and expressed a desire for more team-based care. Key points about comprehensive team-based primary health care from the CHNA data were:

- the need for more collaborative,

multidisciplinary team-based models of primary health care which focus on prevention in communities

- the need to better support Horizon's currently operating CHCs so they can achieve the full CHC model they were originally designed for
- the need to establish new CHCs in communities that could benefit from this model

According to results from the 2014 NBHC Primary Health Care Survey, 6.9% of respondents visited a CHC in the 12 months before the survey and 76.2% were satisfied with the services they received at the CHC. Also, 28.5% of respondents have access to a primary health care team.<sup>50</sup>



### **MORE FOCUS ON CHRONIC DISEASE PREVENTION**

Chronic Diseases are any condition requiring a complex ongoing response and coordinated interventions over an extended period of time from a wide range of health professionals and the prevention of chronic disease emphasizes helping patients stay as healthy as possible through prevention and early detection. In New Brunswick, rates for many chronic diseases such as chronic obstructive pulmonary disease, diabetes, obesity, asthma, high blood pressure/hypertension and depression have been on the rise. Key points about prevention of chronic disease from CHNA data were:

- the need to invest in prevention/wellness education type programming
- the need to put more emphasis on prevention in primary health care delivery and to create the right conditions/environments for providers to be able to focus on prevention
- the need for more time in the patient-care provider interaction to determine root cause of health concerns
- the need for a shift in focus, more towards prevention and less on treatment
- the need for staff (both health care and education) to have capacity and time to do preventative programming

According to data from the NBHC 2014 Primary Health Care Survey, responses to 'how often family doctor gives citizens enough time to discuss feelings, fears, and concerns about their health (% *always*), was 71.9% and 'Discuss regularly with a health professional on improving health or preventing illness (% *always or usually*), was 25.4%.<sup>52</sup>



## HEALTHY EATING & PHYSICAL ACTIVITY

It is well understood that our personal health behaviours greatly impact our health (making up 40% of the NBHC model) and two of these main behaviours are what we eat and the level of physical activity we engage in. Tied to this priority, during CHNA consultation, a lot of concern was expressed around the growing rate of overweight and obesity in our population, as well as other chronic health conditions such as diabetes. However, the conversations were less about individual behaviours and more about the challenges facing us on a larger scale within our environmental contexts. Key points about healthy eating and physical activity from the CHNA data were:

- the need to be proactive and address poor eating habits among children and youth
- the need to improve the quality of food offered in public schools, hospitals, and other public facilities
- the need to further develop policies that encourage healthier eating
- the need to address the sedentary lifestyle trend
- the need to promote all forms of activity (not just competitive sports) for children and youth
- the need to provide more activity options during and after school hours
- the need to encourage play

According to grades 4&5 students' responses to the New Brunswick Student Wellness Survey: 51% eat 5 or more fruits or vegetables a day, 45% spend 2 hours or less on screen time and 35% get the recommended amount of daily physical activity for their age group. In their *Make Menus*

*Matter* campaign the New Brunswick Medical Society identified that, of the 41% of New Brunswick schools analysed, 54% did not meet the provincial nutrition guidelines.<sup>54</sup>



## AWARENESS OF SERVICES & SYSTEM NAVIGATION

A key discussion point during CHNAs was the fact that improving service provision in one area or another was not the only need but how we make the population aware of services available is equally important. New Brunswick's population is aging and has a high rate of illiteracy. Given these demographics, it can be challenging to get the right information into the right hands. Also challenging for many is navigating health and social service systems to find the right care and service require at the right time. Key points about awareness of services and system navigation from CHNA data were:

- the need to create a more centralized index or directory of health and community services
- the need to expand public communication on programs and services currently available presented in a fashion that is user friendly given our high rates of illiteracy
- the need to build awareness amongst health care providers of the wide range of services available throughout the region for their patients, including those in CHCs
- the need to utilize communication methods that will effectively reach the senior population
- the need to provide support to improve system navigation and care coordination

In 2016, seniors made up 19.5% of New Brunswick's population (16.5% for Canada) and with the current trend, by 2038, it is expected to be 31.3%<sup>55</sup>. One in five New Brunswickers (18.5%) have literacy levels below the average for New Brunswick and Canada.<sup>56</sup> According to the NBHC's 2014 Primary Health Care Survey, 9.3% of respondents stated that they have trouble finding their way around the health care system.<sup>57</sup>



## SOCIAL SUPPORTS TO HELP INDIVIDUALS MOVE OUT OF POVERTY

Income is often referred to as the most important social determinant of health. According to Juha Mikkonen and Dennis Raphael in their work, *Social Determinants of Health: The Canadian Facts*, "Level of income shapes overall living conditions, affects psychological functioning and influences health related behaviors such as quality of diet, extent of physical activity, tobacco use, and excessive alcohol use."<sup>58</sup> Income can also determine the quality of other determinants of health such as food security and housing. Thus it is not surprising to see that low income also correlates with a shorter life expectancy.<sup>59</sup> In her book, *Better Now: Six Big Ideas to Improve the Health Care System for all Canadians*, Dr. Danielle Martin states that "...acting on it (poverty) would do more to improve health than any single other policy our governments could embrace...the biggest disease that needs to be cured in Canada is the disease of poverty."<sup>60</sup> One of the strongest predictors of low income is unemployment and job insecurity. Although unemployment leads to material and social deprivation, it is also associated with physical and mental health problems.<sup>61</sup> Key points about social supports to help individuals move out of poverty from CHNA data were:

- the need to provide economic/employment counselling support in our communities as part of health service delivery,
- the need to adequately train health care providers to identify poverty as a root cause of illness and help patients navigate towards the right resources
- the need to build closer relationships between Horizon and those working on poverty reduction both at the community and provincial levels
- the need to identify indicators at the regional and provincial level that help us better understand health inequities
- the need to advocate for poverty reduction strategies in our province

In 2016, the unemployment rate in New Brunswick was 10.3%; the 3rd highest rate in Canada when compared with other provinces<sup>62</sup> and in 2011, 17% of New Brunswickers were living in low income households.<sup>63</sup> According to the NBHCs 2014 Primary Health Care Survey, 61.6% of respondents have one or more chronic health conditions in the province but for those in low-income households (household income \$25,000 or less) the rate is 73.9%<sup>64</sup> which demonstrates a clear health inequity in New Brunswick. The estimated cost of poverty to health care budgets alone in Canada has been assessed at \$7.6 billion per year.<sup>65</sup>



## HOUSING

Many studies show that poor quality housing and homelessness are clear threats to health as living in unsafe, unaffordable or insecure housing increases the risk of many health problems. Recent studies on housing interventions have demonstrated that investment in housing greatly reduces health problems and health care utilization rates.<sup>66</sup> Directly related to the priority discussed above, lack of economic resources is the prime reason many experience housing challenges.<sup>67</sup> Key points about housing from CHNA data were:

- the need to provide more safe, affordable housing options in communities
- the need to provide more housing for vulnerable populations at risk (youth homes, transitional/emergency housing, shelters etc.)
- the need for more safe affordable housing for seniors
- the need to provide more support for seniors living in older homes that need repair
- the need to advocate for safe affordable housing and work with partners such as Housing NB to improve housing options for New Brunswickers

According to the 2011 National Health Survey, 10% of New Brunswickers occupy dwellings that require major repairs<sup>68</sup> and New Brunswick has 29,400 households in core housing need (meaning that they live in housing that require major repairs, is overcrowded or too costly in comparison to their annual incomes),<sup>69</sup> and according to the 2011 census, 24% of seniors live alone.<sup>70</sup>



## COLLABORATION WITH FIRST NATIONS

Nine First Nations communities fall within community boundaries for Horizon's CHNAs:

- St. Mary's Maliseet First Nation
- Oromocto Maliseet First Nation
- Kingsclear Maliseet First Nation
- Fort Folly Mi'kmaq First Nation
- Metepenagiag Mi'kmaq First Nation
- Eel Ground Mi'kmaq First Nation
- Esgenoôpetitj Mi'kmaq First Nation
- Woodstock Maliseet First Nation
- Tobique Maliseet First Nation

Although the First Nation Communities of Elsipogtog Mi'kmaq First Nation, Bouctouche Mi'kmaq First Nation, and Indian Island Mi'kmaq First Nation fall within Horizon's catchment area, as explained in section 3.1, these areas are having their CHNAs conducted by Vitalité Health Network. For various reasons, there were challenges engaging First Nation communities as part of the CHNA process and First Nations were often underrepresented on Community Advisory Committees. That is why, as seen in section 4.1, we often went into these communities directly to get input for individual CHNAs. As well, First Nation issues came up in a number of other consultation areas such as social supports, primary health care, seniors' issues, child and youth issues, and addictions and mental health. Key points about First Nations from CHNA data were:

- the need to improve cultural safety in the delivery of services
- the need to improve partnerships and collaboration between Horizon and First Nation health centres
- the need to work towards overcoming jurisdictional issues as a barrier to service
- the need to provide more mental health services/supports tailored to the needs of First Nation Communities

According to the NBHCs 2014 Primary Health Care Survey, 61.6% of respondents have one or more chronic health conditions in the province,

but for those who identify as Aboriginal, the rate is 70.8%. Also, 14.9% of respondents have depression but for those who identify as Aboriginal, the rate is 23%. The same trend can be seen for mood disorders other than depression which is 3% for New Brunswick and 9.8% for those who identify as Aboriginal.<sup>71</sup> These correlations demonstrate a health inequity between New Brunswick's Aboriginal and Non-Aboriginal populations and highlight culture as a determinant of health.



## SUPPORTING THE NEW FAMILY REALITY

Horizon's Strategic Priority #1 states that, "above all, we will work with our patients and families to create and sustain an exceptional patient and family centred care environment."<sup>72</sup> The structure of families has changed but how we deliver programs and services has not kept up with this changing reality. Communities shared how changing circumstances means there are fewer social supports to lean on, which is a major determinant of health. Key points about supporting the new family reality from CHNA data were:

- the need to provide more support for families providing elderly care
- the need to better plan services and provide more support for single-parent families
- the need to better plan services and provide more support for the temporary single parent family (one member employed in another region)
- the need for further inclusion of the family in health and social service provision (including family in consultation)

According to the 2011 census, 16% of households in New Brunswick are single parent families.<sup>73</sup> The NBHC 2015 Home Care Survey shows that 61.5% of those receiving home care have a friend, family member or volunteer help them with their care.<sup>74</sup>

## BROADENING OUR FOCUS:

Identifying regional priorities from the needs of our communities.



## SENIOR ISOLATION AND LACK OF COMMUNITY/SOCIAL SUPPORTS FOR SENIORS

Having social supports is a major determinant of health, particularly for the senior population. Seniors who have limited social supports in their community may experience isolation and loneliness. In New Brunswick, many seniors, particularly in rural areas, lack informal or family supports for several reasons; loss of spouse, smaller family sizes or younger family members relocating to other provinces or to move urban areas to seek employment. Studies have shown that seniors experiencing social isolation are at higher risk for health issues, including poor mental health and many have a harder time managing the health care/social service system and their health conditions. Key points about senior isolation and lack of community/social supports for seniors from CHNA data were:

- the need to provide more services and programs that get seniors engaged, connected and mobile
- the need to make the health care, and social service systems more user-friendly for seniors.

And according to the 2011 census, 24% of seniors are living alone<sup>75</sup> and according to the NBHC 2014 Primary Health Care Survey, 9.3% of respondents have trouble finding their way around the health care system.<sup>76</sup>



## SENIOR HOME CARE AND OUTREACH SERVICES

Home care is a range of health and support services received at home that help citizens achieve and maintain optimal health, well-being and functional ability through a process of assessment, case coordination and/or the provision of services. In New Brunswick this usually refers to the Extra-Mural Program or home support services.<sup>77</sup> Outreach services refer to services that are offered to seniors by such groups as community organizations, long-term care facilities and churches. These services fulfill a need that adds to the quality of life for seniors still living in their own homes and include programs such as Meal-on-Wheels, transportation programs, Lifeline, and adult day programs at long term care

facilities. Horizon's current Strategic Plan states that "Increasingly urgent is the need to provide appropriate care options that enable elderly residents to remain in their homes or, at least, near their home communities."<sup>78</sup> Key points about senior home care and outreach services from CHNA data were:

- the need to further expand senior outreach programs in order to help seniors stay in their own homes
- the need to increase the amount of home care services available (particularly in rural communities)
- the need to ensure home care providers are well trained and adequately compensated

Currently, Horizon continues to experience an increased burden on its acute care system managing alternative levels of care (ALC) patients; patients who occupy a hospital bed yet do not require that intensity of service and are waiting placement in other facilities such as special care or nursing homes. In 2015-16 24% of Horizon's beds were occupied by ALC patients.<sup>79</sup> According to the results from the NBHC's *New Brunswickers Experiences with Home Care survey*, 14.5% of citizens receiving home care services said that more could have been done to help them stay at home. When responding to the question, 'How often home support workers seemed informed about all care received at home, 55.9% said always.



## RECREATION

Closely related to the concerns raised about physical activity and the challenges facing us on a larger scale within our environmental context, the area of recreation was also widely discussed. Key points about recreation that came from CHNA data were:

- the need for more affordable recreation activities for children and youth in rural communities
- the need for activities beyond organized sports
- the need to enhance recreational infrastructure
- the need to remove the barrier of transportation to participating in recreation (build it into planning)

- the need to provide more recreation for seniors that is accessible, particularly in rural communities.

According to respondents, 36% of seniors are physically active during their free time.



## **ENHANCED COLLABORATION, COMMUNICATION & CONNECTEDNESS**

When collaboration and communication are weak, it is often patients/clients who end up being affected. Also, when we do not create the conditions and environments where collaboration and communication can happen effectively, we miss opportunities to build important relationships and trust. You can read more about this issue in section 5.4 below. Key points about collaboration, communication and connectedness from CHNA data were:

- the need to improve communication and collaboration between health care providers
- the need to improve communication and collaboration between hospitals and CHCs
- the need for improved communication for transitions in care (moving from one part of the system to another)
- the need to build better relationships between Horizon and community organizations
- the need to remove barriers to information and resource sharing with community partners
- the need for Horizon to be more open and transparent with community partners and the general public in order to enhance trust and improve relationships
- the need to foster stronger community connectedness and inclusion

Horizon's current Strategic Plan states that, "We will have significantly increased the number of partnerships with community-based organizations, First Nations communities and the government departments of Education, Community Services and Health and Inclusive Communities (now Social development). This may include formal agreements to serve collaboratively,

or accomplished through amalgamated mandates as determined by Horizon and other organizations."<sup>80</sup>



## **CONTINUAL COMMUNITY ENGAGEMENT**

Community engagement is the process by which citizens are engaged to work and learn together on behalf of their communities to create and realize bold visions for the future. It can involve informing citizens, inviting their input, collaborating with communities to generate solutions and partnering to create a desired outcome together.<sup>81</sup> Key points about continual community engagement from CHNA data were:

- the need to further include community input and engagement in health system planning and decision-making beyond the CHNA process
- the need to actively promote community engagement and encourage participation
- the need to have open and transparent communication with communities to build trust and relationships

This priority is connected to Horizon's current strategic plan through strategic priority #1 which states that "Horizon will shift its focus from primarily meeting the needs of the system, care providers, or financial constraints to meeting the needs of patients, their families and the community through engagement processes."<sup>82</sup> Beyond the engagement achieved through CHNAs, Horizon is also striving to improve community engagement through the establishment of local Community Engagement Advisory Committees whose purpose is to provide the opportunity for two-way communication for richer understanding of issues from a local community point of view. Not to be confused with the CHNA CACs discussed above, these committees are still operating at a high level with the goal of achieving a deeper reach into the community. This endeavor could offer great potential for us to further enhance Horizon's relationship with the communities it services. Community engagement will be further discussed in section 5.2 below.

# 5. Moving Forward

Given the amount of time, energy and resources (and emotional toll) the CHNAs project has taken over the last few years, it feels strange to say this, but that was the easy part. The real challenge lies ahead. This section of the report looks at the various elements of moving forward such as the importance of Horizon's core value, *we act with integrity and are accountable*, the need to maintain community engagement, the Collective Impact model of collaboration, the need to invest in relationships, and the need to build solid action and financial plans that bring work on these priorities to life.

## 5.1 HORIZON'S CORE VALUE: WE ACT WITH INTEGRITY AND ARE ACCOUNTABLE

The first hurdle comes with owning these results; not just on paper or in published reports, but actually owning them. We will know we have achieved this when, as individuals working in Horizon and as an organization, we are able to wholeheartedly say, "these priorities are our priorities." To do this, we can lean on our value of *integrity* to help get us there. In terms of accountability, Horizon's commitment to the CHNA results was established long before this stage in the process. In fact, by stepping into this work in 2012 and highlighting it in our strategic plan, Horizon instantly established accountability. It is easy to slip into the mindset that some of these priorities lie outside the work of an RHA because they are not where we have traditionally invested, but our past way of thinking about these priorities cannot be our guide now, or excuse us from accountability. We cannot divide these priorities into those belonging to Horizon and those belonging to "others" because they all have a strong impact on the health status of our population and therefore, Horizon has an active role to play in each of them. Shifting to this mindset may not happen overnight; the organization has so many pressing priorities facing us already on a day-to-day basis. However, our organizational values are there to guide us;

***we act with integrity and are accountable*** can help us move forward and knowing that these priorities are built from the words and stories of the individuals and communities we serve, will provide a reassurance that we are on the right track.

## 5.2 MAINTAINING COMMUNITY ENGAGEMENT

The *Community Health Needs Assessment Guidelines for New Brunswick* highlight enhancement of community engagement as a key element to the CHNA process. When the structure of health care delivery changed in our province in 2008 from eight health service regions to two, our ability to succeed at community engagement became more challenging, understandably. However, as an organization, a large opportunity lies before us at this point in time. Reflecting on section 4.1 above and the community reach achieved through the CHNA project and the relationships built, we now, perhaps more than ever, have a significant level of community engagement. What do we do with that? How do we maintain it? How do we make it stronger?

During the CHNA journey, while engaging with community members, relationships between the community and the organization were not always viewed in a positive light. The assessment team would sometimes hear disgruntled sentiments such as, "What's the point?," "Who is really listening to us anyway?,"

The cover photo for this report is a visual representation of the importance of the community/organization relationship. The bind between Horizon (blue rope) and communities (smaller ropes) is what keeps the system together. If you look closely, you'll notice that the smaller ropes are beginning to fray, representing the current challenges faced by our communities. If we ignore the frays, thinking they are not Horizon's frays, and a smaller rope lets go (a community falls behind) we all become weaker for it. Together we are stronger

“We’ve been here before, and nothing changed from that,” and “What difference will it really make?,”. The team could often see a very obvious level of discouragement and disengagement. If these sentiments were to end up holding truth, we run a high risk of causing irreversible damage to the relationship between Horizon and the communities we service; trust would be lost, and we would add another layer of detachment and discouragement. However, if we view these sentiments as a source of motivation instead, and see the importance of keeping this work moving forward, keeping the words of our communities at the forefront of our decision making, and keeping the channels of communication open, the benefit would be remarkable; because we are stronger together.

### 5.3 INVESTMENT IN RELATIONSHIP

Health care is all about relationship; its value is something most frontline staff know all too well; particularly those working in community settings. When discussing an issue as central as someone’s health one-on-one, a good patient-provider relationship can make all the difference. However, in order for our system to thrive and be able to address the priorities identified in this report, we need to examine the importance of relationship in other areas of our system as well. As we have learned from the CHNA process and can see from the section above, one major area of investment is in relationship between Horizon and the communities we serve. Other areas include investment in relationship between staff members,

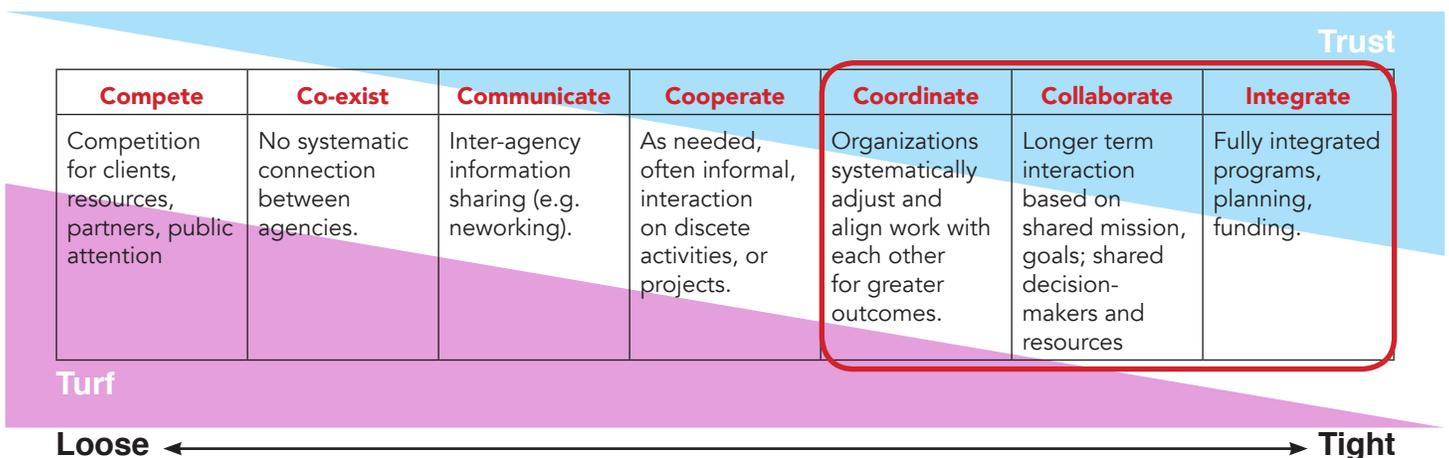
between staff and management, between Horizon and provincial departments and between Horizon and community organizations.

Good relationship building is an art form and one that takes time. As an organization, we must prioritize the building of a culture and environment where relationship matters. However, with the speed at which we work, not just within our organization but within modern society in general, we often jump in without taking the time to build authentic, interpersonal relationships. In bypassing this important step, we may save ourselves time and get the job done, but productivity is much higher when relationship building is our first step.<sup>83 84</sup>

The priorities presented in this report require a high degree of collaboration. Therefore, one reason relationship is so important to the process is because it manifests trust, which is the most important element of collaboration. Our population needs to trust Horizon as an organization, Horizon needs to trust and be trusted by the external organizations we partner with. Within our system, we need to trust each other and staff need to trust Horizon’s leadership.

Figure 4 below, shows a spectrum of collaboration, from competition to integration. The visual shows that the need for trust increases the further up the collaboration spectrum we go. The spectrum highlights how important it is that we invest in relationship and trust building if we are to achieve a successful level of collaboration and address these regional priorities.

**FIGURE 4: The Collaboration Spectrum<sup>85</sup>**



## 5.4 COLLECTIVE IMPACT: A STRUCTURED APPROACH TO COLLABORATION

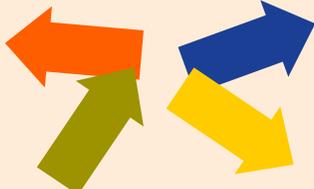
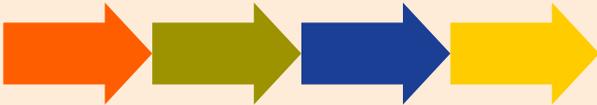
During CHNAs, many Community Advisory Committees were introduced to the Collective Impact model as a way to structure themselves around addressing the complex priorities identified through the CHNA process for their individual communities. Many found it valuable at the community level, and there is also value in incorporating it here as we take a more regional perspective. Collective Impact is a structured form of collaboration that brings together a committed group of stakeholders from different sectors for a common agenda to solve complex social problems.<sup>86</sup>

“No single organization is responsible for any major social problem, nor can any single organization cure it.”

*John Kania  
& Mark Karmar*

Many past attempts to address complex social problems in our province and in our Horizon region have been done using an isolated impact model, which is an approach oriented toward finding and funding a solution embodied within a single segment or organization.<sup>87</sup> With isolated impact, every attempt is made to isolate the individual influence from all other variables, and it often causes organizations to work at odds with each other. Lingering in isolated impact has often led to an “us” and “them” mentality; dividing up responsibility and then blaming and finger pointing when goals are not met, when, in reality, the responsibility for many of these complex social problems facing our population cannot be addressed in isolation.

**TABLE 5: Isolated vs. Collective Impact**

ISOLATED IMPACT	COLLECTIVE IMPACT
<p>An approach oriented toward finding and funding a solution embodied within a single segment or organization that often causes organizations to work at odds with each other</p> 	<p>A structured form of collaboration that brings together a committed group of stakeholders from different sectors for a common agenda to solve complex social problems</p> 

The Collective Impact model is built upon five interconnected components<sup>88</sup> that help create a structured form of collaboration:

**Common Agenda:** All participants have a shared vision for change that includes a common understanding of the problem and a joint approach to solving the problem through agreed-upon actions.

**Shared Measurement:** Agreement on the ways success will be measured and reported, with a short list of common indicators identified and used across all participating organizations for learning and improvement.

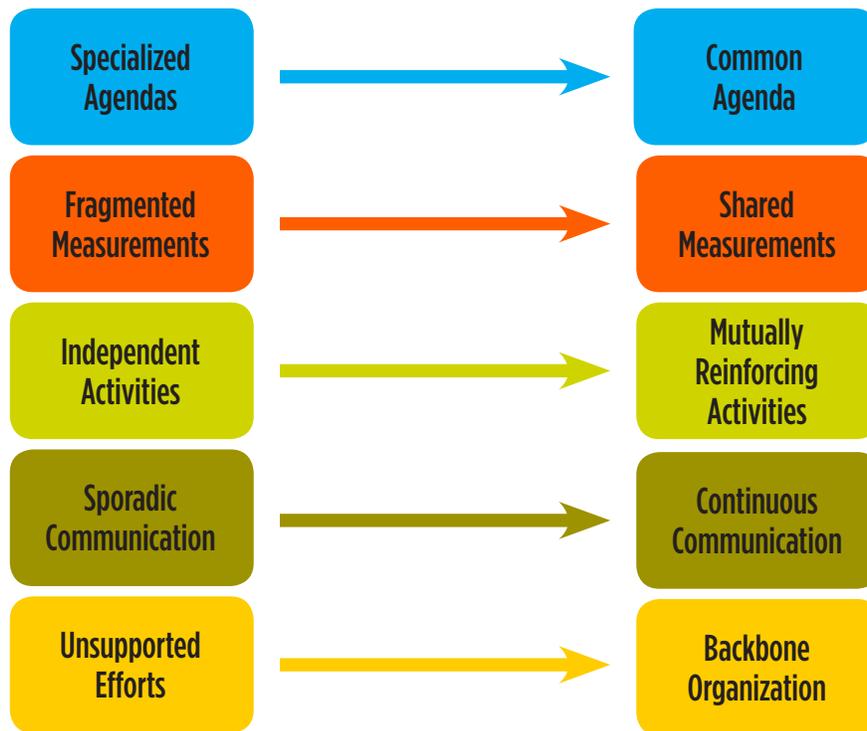
**Mutually Reinforcing Activities:** Engagement of a diverse set of stakeholders, typically across

sectors, coordinating a set of differentiated activities through a mutually reinforcing plan of action.

**Continuous Communication:** Frequent and structured open communication across the many players to build trust, assure mutual objectives, and create common motivation.

**Backbone Support:** Ongoing support by independent, funded staff dedicated to the initiative, including guiding the initiative’s vision and strategy, supporting aligned activities, establishing shared measurement practices, building public will, advancing policy, and mobilizing funding. Backbone staff can all sit within a single organization, or they can have different roles housed in multiple organizations.

**FIGURE 5: The Shift: 5 Conditions of Collective Impact**



There are two opportunities for the Collective Impact approach to assist us in addressing these regional priorities. First, given the breadth of Horizon as an organization, it can be used to bring together key stakeholders internally to help us work in a more structured form of collaboration to tackle some of our regional level priorities. Secondly, given that many of the regional priorities highlight complex social problems, the Collective Impact model can provide a framework for working with other external partners in a structured form of collaboration.

### **5.5 WHAT NEXT? THE NEED FOR SOLID ACTION AND FINANCIAL PLANS**

Throughout the CHNA journey, the assessment team witnessed promising work on the priorities presented in this report in various communities. The challenge lies in the fact that, at a regional level, we have not aligned with these priorities and therefore, individual community examples are in isolation and operating without proper support, funding and direction. Once we overcome the

first hurdle of realizing our ownership for these priorities, the time for regional level strategizing and action planning can begin. We can draw on our local examples to help us find our way, but we must also examine best-practices and investigate ways in which other RHAs tackle priorities such as ours from a regional level.

Part of Horizon's action planning around these priorities will need to be the development of key performance indicators (KPI) which are measurable values that demonstrate how effectively we are achieving objectives. For some of the priorities presented here, this task will come easily; for others it will be a challenge. The data sources we require to measure the types of priorities presented here are not always available, and where health inequity is a theme that runs throughout these priorities, data correlations will also be needed. We will need to be creative and innovative in order to find the right KPIs and in some cases, will need to go a step further and advocate for the collection of data that helps us focus and see our impact.

### **BROADENING OUR FOCUS:**

Identifying regional priorities from the needs of our communities.

There is much evidence to support that we have not seen a return on investment with our substantial growth in health care spending; we have not seen the health of the population improve, in fact many trends are heading in the wrong direction. As stated in Horizon's Strategic Plan, "New Brunswick has continued to spend more of its resources on areas that have done little to improve the health of the general population....better strategic decisions about spending are necessary."<sup>89</sup> Horizon is already on the right track with strategic priority #3 which states that, "Working with our community partners and clinicians, we will significantly increase the relative share of resources to improve community-based primary care, and support expensive tertiary services that our aging population will require." Formal systems will need to be in place to monitor the impact work on these priorities has on health care utilization and expenditure. Beyond the improvement of population health status, one of the main reasons for taking on these priorities and this upstream approach is to keep our population healthier and less reliant on the system; protecting it and relieving some of the strain it is currently experiencing. Although

monitoring success will be dynamic, having the capability to monitor it in this fashion will help us clearly see our return on investment from a systems scale.

As mentioned in the introduction, this report is not a "how-to" guide. Much work lies ahead of us to strategize action and financial plans in order to address these priorities on a regional scale. As an organization, we have the advantage of housing the PHP-CDM department whose mandate and core functions align with the population health approach and these priorities. PHP-CDM can provide a centralized place from which to lead, manage and monitor these priorities that impact the health of our population. However, to succeed, they cannot do it alone. Their work on these priorities needs to be supported by the larger organization; there needs to be investment, there needs to be clear commitments from Horizon's leadership, and the creation of an opened and innovative work culture in order to get these action plans off the ground and achieve results.

# 6. Conclusion

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If you let your wheels start turning, you may be jumping to questions such as: “Where are we at with these priorities?” “Where do we look for solutions and best practice?” “Who are the stakeholders?” “How do we fund this work?” and “Where do we begin?” But in concluding, let’s pause a minute. We have one more topic to address before we start rolling, the topic of courage. We see acts of courage often within this organization. The courage of a family doctor broaching the topic of marital breakdown, when she knows it is the root cause of her patient’s health concerns, the courage of a mental health professional holding space for a patient after their first suicide attempt, the courage of ER staff, silently awaiting the arrival of multiple ambulances on route from a fatal car crash, the courage of an oncologist walking into a room to tell their patient and family members that the treatment he recommended is not working and the cancer has spread. If you look closely, you see acts of courage on our frontline every...single...day. What we need now is to channel this courage to the decision-making level so that we can create the systems change required to tackle the priorities presented in this report.

In her book, *Better Now: Six Big Ideas to Improve Health Care for all Canadians*, Dr. Danielle Martin says that, “We can’t change the way we address the social determinants of health, the organization of primary care, the delivery of services, and their coverage without brave people in governments and health authorities who are willing to help us push for those changes.” Dr. Martin is right, it does require brave people, but it also requires the creation of conditions and work environments where this can happen; where people can show up fully and be innovative and courageous. As well, it requires that this practice be reinforced and modeled by our leadership on a daily basis.

Within this type of environment, mistakes are for learning, not shaming. In his ground-breaking work *The Fifth Discipline*, Peter Senge describes learning organizations as “...organizations where people continually expand their capacity to create the results they truly desire, where new and expansive patterns of thinking are nurtured, where collective aspiration is set free, and where people are continually learning to see the whole together.”<sup>90</sup> Many organizations are shifting to this approach and creating these conditions with remarkable results. If we wait for the perfect action plan to address these priorities, the one with the guarantee, we will wait forever. We need an environment that offers us the freedom to try, make mistakes, learn and try again; and to have the courage to own that this is part of our process.

We need the courage to be honest and to truly investigate what limits us from acting on these priorities; we need to determine if these limitations are real or not, and if they are, we need to find the courage to overcome them. Then, we stand, put one foot in front of the other, and we move. How exciting is this?

# Appendix A:

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## Horizon's CHNA 12-Step Process

**Step One:** Develop a management committee for the selected community. An important first step was to meet with key individuals who had a strong understanding of the community. These individuals were 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 were often able to share insights on pre-existing issues in the community with potential to impact the CHNA.

**Step Two:** Select CAC members with the assistance of the management committee. Using a CAC membership selection guide, the research team and management committee brainstormed 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 reflective of the community and a manageable size.

**Step Three:** Establish CAC. Both the research team and management committee played a role in inviting CAC members to participate. At the first meeting, the research team shared the goals and objectives of the CHNA and discussed the particular role of the CAC.

**Step Four:** Review currently available quantitative data on selected community. As CHNAs conducted within Horizon are based on NBHC geographic community breakdowns, the research team used many of their data compilations, which come from multiple surveys and administrative databases. The team reviewed this data looking for any indicators that stood out in the selected community.

**Step Five:** Present highlights from data review to CAC members. Highlights from the data review were shared with CAC members and they were asked to reflect on the indicators. Often this led to rich discussion as members shared their experience of particular indicators, usually during the second meeting of the CAC. At the end of this meeting, members were asked to reflect on what was 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 the gaps. This often took place

during the third meeting of the CAC. Members shared what they felt was missing and sometimes members would have other locally derived data to share with the research team. This led 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 research team developed a qualitative data collection plan outlining what methods would be used, who the sample would be, and timelines for collection.

**Step Eight:** Qualitative data collection in the community. During this step, the research team was in the community collecting qualitative data as outlined in the data collection plan.

**Step Nine:** Data analysis. All qualitative data collected was audio recorded and then transcribed by a professional transcriptionist. The data transcriptions were used in the data analysis process. The analysis was 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 jointly identify priorities. Discussion summaries were developed for each of the emerging themes from the analysis which were then shared with CAC members. CAC members were asked to prioritize the themes, which were taken into account when the research team finalized the themes and recommendations. This usually took place at the fourth meeting of the CAC.

**Step Eleven:** Finalize themes, recommendations, and final report. Utilizing CAC members' prioritization results, the research team finalized the themes to be reported and developed recommendations for each. These were 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 was held with the CAC to share the final report and begin work planning based on the recommendations. During this step, the CHNA results were also shared with the larger community. This process differed from community to community.

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**BROADENING OUR FOCUS:**

Identifying regional priorities from the needs of our communities.



