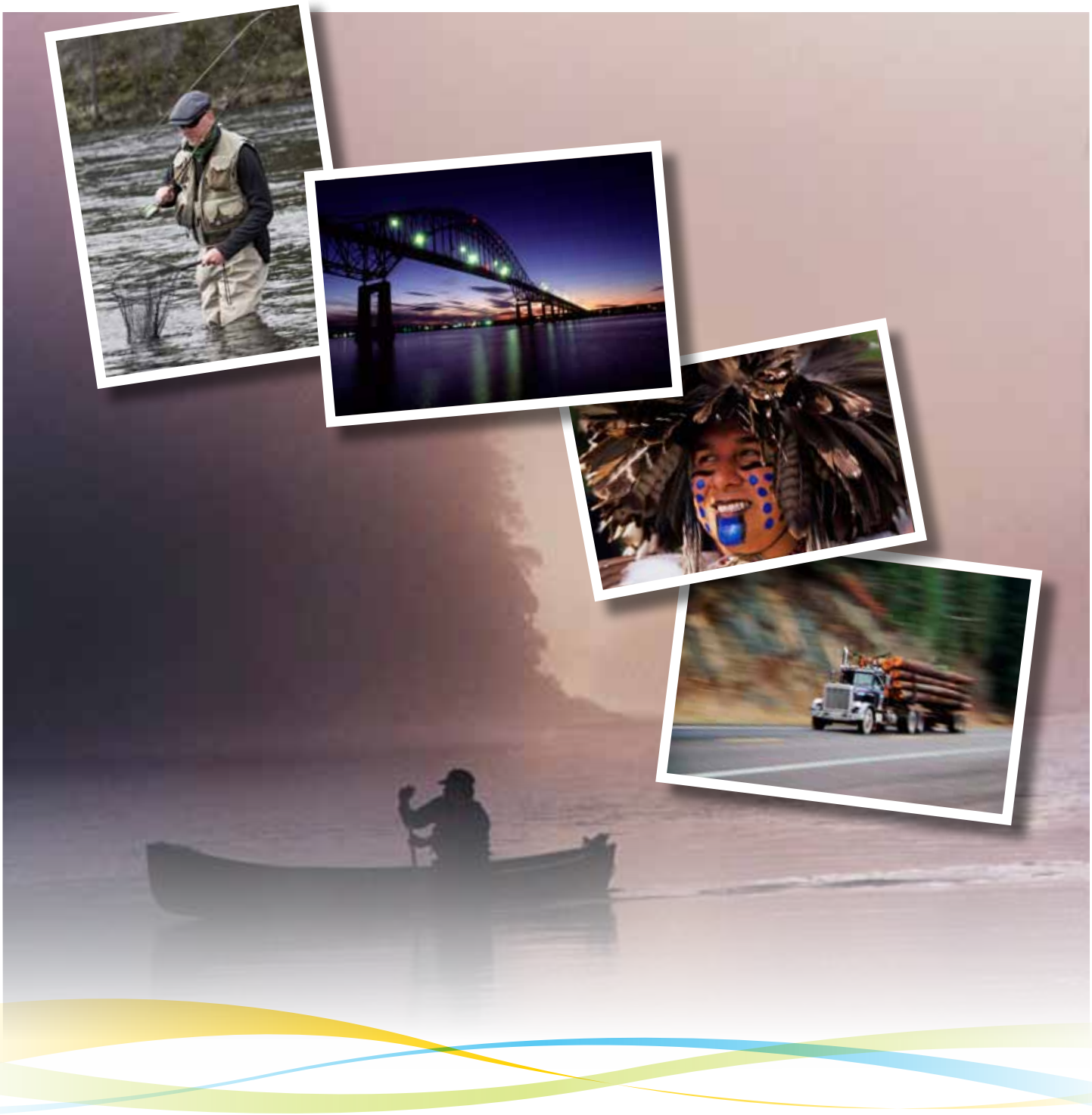
MIRAMICHI AREA

COMMUNITY HEALTH NEEDS ASSESSMENT



RÉSEAU DE SANTÉ Horizon HEALTH NETWORK

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Produced by

Horizon Health Network's

Community Health Assessment Team

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LIST OF ABREVIATIONS

CHA Team – Community Health Assessment Team

CHNA – Community Health Needs Assessment

NBHC – New Brunswick Health Council

CAC – Community Advisory Committee

ID – Interpretive Description

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1.0 EXECUTIVE SUMMARY

Introduction

In the early stages of the Miramichi Area Community Health Needs Assessment process, stakeholders in the community expressed a desire to be joined with their neighboring community of Neguac and to undergo the assessment process jointly under the umbrella of the Northumberland Area. Stakeholders expressed this desire because the two communities share a number of health and wellness resources and because they are comfortable working together as one community. Although the assessment process was jointly completed, two reports were developed for each of these communities; one for the Miramichi area and one for the Neguac Area. The focus of this report is the Miramichi Area.

The Miramichi Area covers a large geographic area in the northern half of New Brunswick and represents a very culturally diverse community. Although the city of Miramichi is considered mainly Anglophone, there are a number of communities surrounding the city which are primarily Francophone and are strongly connected to their Francophone culture and heritage. The area is also home to two First Nation communities. The population of the Miramichi Area is 36,032 and has seen a decrease of 3% from 2006-2011. This decrease is mainly due to an aging population in the community, with 19% of the population 65 years and over. Also contributing to this population decline is the fact that many younger families are leaving the community to seek employment elsewhere. The median household income in the Miramichi Area is $50,687 (2011) and 16% of people in the area live in low income. Data shows that the community has elevated rates of many chronic health conditions when compared to provincial averages such as high blood pressure, gastric reflux (GERD), arthritis, depression and chronic pain.

Background

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

Community Health Needs Assessment

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

While the CHNA process is designed to be flexible and accommodate unique differences in each community, Horizon's Community Health Assessment (CHA) Team uses a 12-step process to conduct CHNAs that takes into account these differences at each stage:

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

12. Share final report with CAC members and the larger community and begin work planning

CHNAs conducted within Horizon communities are guided by the population health approach, which endeavors to improve the health of the entire population and to reduce health inequities by examining and acting upon the broad range of factors and conditions that have a strong influence on our health, often referred to as the determinants of health. Horizon's CHA Team uses determinant of health categorizations from the Public Health Agency of Canada and the New Brunswick Health Council (NBHC).

Methodology

Quantitative data review and qualitative data collection, review and analysis were used by Horizon's CHA Team. Data compilations produced by the NBHC such as My Community at a Glance and The Primary Health Care Survey were used to review currently available quantitative data as many of the indicators are broken down to the community level. Based on limitations of the quantitative data review, a qualitative data collection plan was established by the CHA Team in partnership with the Northumberland Area Community Advisory Committee (CAC). Along with individual stakeholder interviews, key stakeholder groups were identified for consultation through the focus group interview method:

- Mental Health Professionals (Neguac)
- Mental Health Professionals (Miramichi)
- Patients Living with Chronic Disease
- Family Support Services
- Senior Issues
- Northumberland Alternative Level of Care Committee
- Spiritual Leaders
- Domestic Violence Support Services
- Eel Ground First Nation Health & Well Being
- Metepenagiag First Nation Health & Well Being
- Rogersville Health & Well Being

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

Results & Recommendations

The methodology used by the CHA Team resulted in the identification of 10 priority issues. Table 1 below outlines the 10 priority issues and provides recommendations for each.

Table 1: Miramichi Area CHNA Identified Priority Areas and Recommendations

	Priority → → → → → → →	Recommendation
1.	The need to improve supports in the community for families that are struggling and experiencing difficulties	Using a multi-sector approach that includes family support services, public health, and educators, revisit the current model of providing family support services and develop a more up-to-date approach to provision that better aligns with the challenges being faced by families in the community today.
2.	An increase in mental health issues among children & youth in the community	Further consult with educators, mental health professionals and parents in the community to determine what coping skills children and youth are missing and develop a proactive plan to further develop these skills. Also, determine what mental health services already exist for children & youth in the community and determine how best to align these resources to fill gaps.

3.	Food Insecurity in the Community	Working with key community partners, review the various elements of food insecurity affecting the community and develop a plan of action to address food insecurity in the community.
4.	An insufficient amount of affordable home care services in the community provided by well trained, adequately compensated staff	Assess what is currently available for home care services in the community, focusing on availability in outlying areas and determine what is needed to fill gaps in service. Also, work with local and provincial home care providers to advocate for better training opportunities and adequate compensation.
5.	The need for a community wellness center with affordable programs targeted at all age groups	Working with municipal, school district, and senior organization representatives, assess current wellness infrastructure in the community and determine how to build on and improve this infrastructure and its programs.
6.	Transportation issues in the community that impact health	Examine community health challenges due to limited transportation, review how other communities are addressing this challenge, and work with key community stakeholders to develop a strategy to improve transportation.
7.	Lack of awareness regarding programs and services already available in the community	Review current methods of communicating programs and services in the community and review uptake. Together with appropriate stakeholders, determine the most effective methods to use.
8.	The need for a mental health mobile crisis service in the community	Working with mental health leaders in the community, review how other communities have modeled their mental health mobile crisis service and develop a plan for how best to implement this service in the community.
9.	Limited recreational activities for children & youth in the community, particularly within outlying areas	Through stakeholder partnerships, review what recreational programs and services are currently available in the community and determine where additions can be made.
10.	The need to improve community safety for residents living in First Nation communities	Establish a working group with representation from law enforcement, leadership from First Nation communities and those working with children and youth in First Nation communities to develop a strategy to improve safety on First Nation communities in the area.

2.0 BACKGROUND

2.1 Primary Health Care Framework for New Brunswick

In 2012, the province of New Brunswick released the Primary Health Care Framework for New Brunswick with the vision of better health and better care with engaged individuals and communities.[1] The framework states that this vision will be achieved through an enhanced integration of existing services and infrastructure and the implementation of patient-centered primary health-care teams working collaboratively with regional health authorities to meet identified health needs of communities. The framework highlights "conducting community health needs assessments" as an important first step towards achieving these improvements and states that, "community health needs assessments have the potential to not only bring communities together around health care but to collectively identify community assets, strengths and gaps in the system[2]."

2.2 Horizon Health Network's Community Health Assessment Team

Although conducting CHNAs is a recommendation from the New Brunswick Department of Health, it is the responsibility of the two regional health authorities in the province, Horizon and Vitalité, to conduct the assessments in communities within their catchment areas. Prior to 2014, assessments conducted within Horizon communities were done with the services of external consultant companies. In 2014, Horizon decided to build internal capacity for conducting CHNAs in order to refine the process and make it more cost-effective. Horizon's CHA Team consists of one research lead and one project coordinator.

Responsibilities of the CHA Research Lead:

- formulate the research approach
- review available quantitative data sets
- collaborate with key community stakeholders
- qualitative data collection and analysis
- report writing

Responsibilities of the CHA Project Coordinator:

- coordinate with key community stakeholders
- establish and organize CACs
- coordinate data collection plans
- report writing and editing

2.3 Community Health Needs Assessment

CHNA is a dynamic, ongoing process that seeks to identify a defined community's strengths and needs to guide in the establishment of priorities that improve the health and wellness of the population[3].

The goals of a CHNA are:

to gather and assess information about the health and wellness status of the community

to gather and assess information about resources available in the community (community assets)

to determine the strengths and challenges of the community's current primary health-care service delivery structure in order to adapt it to the needs of the community

to establish health and wellness priority areas of action at the community level

to enhance community engagement in health and wellness priorities and build important community partnerships to address priority areas

2.4 The Population Health Approach

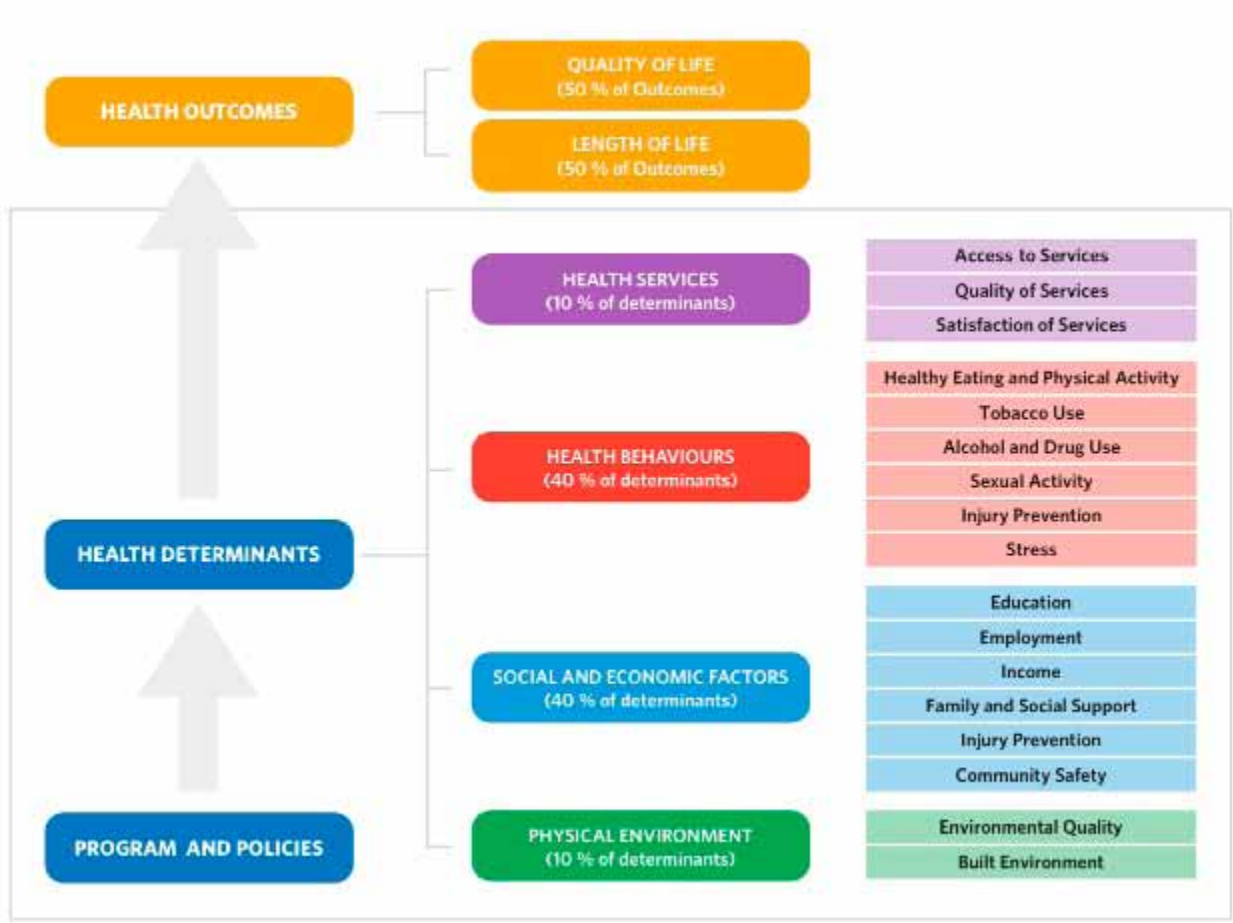
Health is a complex subject and assessing the health of a community goes far beyond looking at rates of disease and the availability of health-care services. Therefore, CHNAs conducted within Horizon communities are guided by the population health approach. This approach endeavors to improve the health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

(health disparities) among population groups by examining and acting upon the broad range of factors and conditions that have a strong influence on our health[4]. These factors and conditions are often referred to as the determinants of health and are categorized by the Public Health Agency of Canada as:

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

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

FIGURE 1: POPULATION HEALTH MODEL

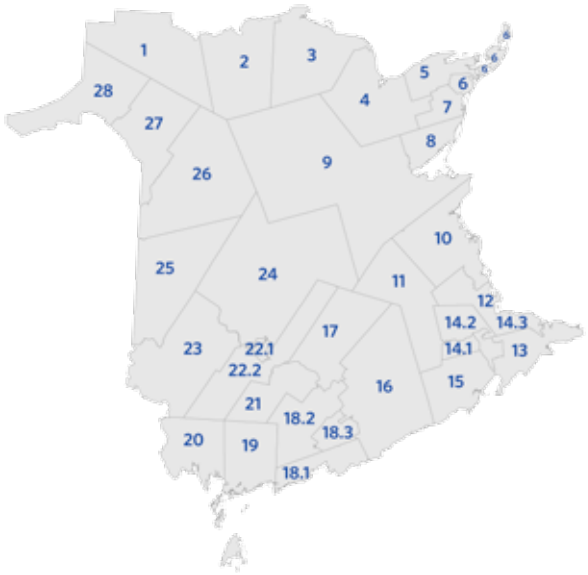


2.5 Defining Communities

For CHNAs, individual community boundaries are defined by the New Brunswick Health Council (NBHC). The NBHC works at arms length of the provincial government and has a dual mandate of engaging citizens and reporting on health system performance through areas of population health, quality of services, and sustainability.[6]

The NBHC has divided the province into 28 communities (with the three largest urban cores subdivided) to ensure a better perspective of regional and local differences. These community divisions can be seen on the map in figure 2 below. The actual catchment area of health-care centres, community health centres, and hospitals were used to determine the geographical areas to be included for each community. Census subdivisions were then merged together to match these catchment areas. The communities were further validated with various community members to ensure communities of interest were respected from all areas of New Brunswick. No communities were created with less than 5,000 people (as of Census 2011) to ensure data availability, stability, and anonymity for the various indicators. The NBHC uses these community boundaries as the basis for work and analysis done at the community level[7].

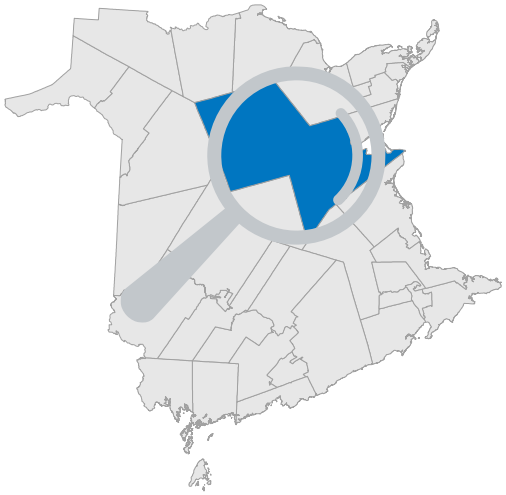
FIGURE 2: NBHC COMMUNITIES



2.6 The Miramichi Area

One of the NBHC communities selected by Horizon for assessment in 2015 is community 9, identified by the NBHC as the Miramichi Area. Figure 3 below shows the Miramichi Area and lists the smaller communities which fall within it.

FIGURE 3: Miramichi Area



Big Hole Tract
Baie-Sainte-Anne
Bay du Vin
Black River Bridge
Blackville
Chaplin Island Road
Collette
Eel Ground
Eel Ground First Nation
Hardwicke
Miramichi
Napan
Nelson
Metepenagiag
Northesk
Renous
Rogersville
Rosaireville
South Esk
Sunny Corner
Trout Brook
Upper Blackville
Wayerton

The Miramichi Area, as defined by the NBHC, covers a large geographic area in the northern half of New Brunswick and represents a very culturally diverse community. Although the city of Miramichi is considered mainly Anglophone, there are a number of communities surrounding the city that are primarily Francophone and are strongly connected to their Francophone culture and heritage such as the communities of Baie-Sainte-Anne, Bay du Vin, Black River Bridge, Collette, Hardwicke, Rogersville and Rosaireville. Also, the Miramichi area is home to two First

Nation communities; Metepenagiag First Nation and Eel Ground First Nation. Besides the city of Miramichi, much of the community is made up of smaller towns, villages and hamlets. The population of the Miramichi Area is 36,032 and has seen a decrease of 3% from 2006-2011. This decrease is mainly due to an aging population in the community with 19% of the population 65 years and over (compared to 17% NB). Also contributing to the population decline is the fact that many younger families are leaving the community to seek employment elsewhere. Historically, the Miramichi area was mainly reliant on the forestry industry, which has seen declines in recent decades. Also, given that a large part of the area follows the Miramichi River, salmon fishing has been a major part of the community's history and culture, as well as a source of employment. In some of the smaller communities that run along the coast of Miramichi Bay, fishing is a major industry and source of employment. The median household income in the Miramichi Area is $50,687 (2011) and 16% of people in the area live in low income. Data shows that the community has elevated rates of many chronic health conditions when compared to provincial averages such as high blood pressure, gastric reflux (GERD), arthritis, depression and chronic pain. As you can see in table 2 below, there has been an increase in the rate of many chronic health conditions between 2011 and 2014.

TABLE 2: CHRONIC HEALTH CONDITIONS IN THE MIRAMIHCI AREA[8]

Chronic Health Conditions[1]	2011 (%)	2014 (%)	2014[2] (#)	NB (%)
One or more chronic health conditions[3]	60.3 (57.0 – 63.6)	66.7 (62.3 – 71.0)	19,745	61.6 (60.8 – 62.4)
High blood pressure	27.5 (24.5 – 30.5)	30.0 (25.8 – 34.2)	8,874	27.0 (26.2 – 27.7)
Gastric Reflux (GERD)	18.3 (15.7 – 20.8)	21.8 (18.0 – 25.6)	6,464	16.4 (15.8 – 17.0)
Arthritis	16.4 (13.9 – 18.9)	20.6 (16.9 - 24.3)	6,097	17.4 (16.8 – 18.0)
Chronic pain	14.0 (11.7 – 16.4)	17.7 (14.2 – 21.2)	5,255	14.0 (13.5 – 14.6)
Depression	12.9 (10.6 – 15.1)	16.4 (13.0 – 19.8)	4,854	14.9 (14.3 – 15.5)
Asthma	9.7 (7.7 – 11.7)	12.5 (9.5 – 15.5)	3,704	11.8 (11.3 – 12.4)
Diabetes	10.1 (8.1 – 12.2)	11.3 (8.4 – 14.2)	3,357	10.7 (10.1 – 11.2)
Heart disease	8.3 (6.5 – 10.2)	8.9 (6.2 – 11.5)	2,622	8.3 (7.9 – 8.8)
Cancer	7.2 (5.4 – 8.9)	8.3 (5.8 – 10.8)	2,462	8.3 (7.8 – 8.7)
Stroke	2.7 (1.6 – 3.7)	5.8[E] (3.7 – 8.0)	1,725	2.5 (2.2 – 2.8)
Emphysema or COPD	2.8 (1.7 – 3.9)	4.2[E] (2.4 – 6.1)	1,253	3.0 (2.7 - 3.3)
Mood disorder other than depression	2.4 (1.4 – 3.5)	3.5[E] (1.8- 5.2)	1,036	3.0 (2.7 – 3.2)

Primary healthcare services in the Miramichi Area are provided through the Baie-St-Anne Health Centre, the Blackville Health Centre, the Miramichi Health Centre, the Rogersville Health Centre, the Miramichi Family Health Team, night clinics and other independent family physician offices. Based on data from the NBHC's Primary Health Care Survey of New Brunswick, 93.4% of respondents from the Miramichi Area have a personal family doctor. As shown in Table 3 below, primary healthcare services in the Miramichi Area are well rated in a number of indicator areas.

TABLE 3: PRIMARY HEALTH CARE SURVEY INDICATORS FOR THE MIRAMICHI AREA[9]

Primary Health Care Survey Indicator	2011	2014	NB
Family Doctor has after-hour arrangement when office is closed (%yes)	23.1	21.2	18.2
How quickly appointments can be made with family doctor (% on same day or next day)	34.7%	31.0%	30.1%
How quickly appointments can be made with family doctor (% within 5 days)	65.4%	61.8%	60.3%
Model of care used most often when sick or in need of care from a health professional (% hospital emergency department)	8.6%	8.4%	11.5%
How often a family doctor involves citizens in decisions about their health care (% always)	62.6%	69.9%	68.2%
Satisfaction with services from personal family doctor (% 8, 9, or 10 on a scale of zero to 10)	81.5%	85.4%	83.9%

3.0 STEPS IN THE CHNA PROCESS

CHNAs are a community driven process where community members' opinions are valued and taken into account for planning purposes. Therefore, the CHNA process needs to be flexible in order to meet the needs of individual communities. Each community is unique and therefore the same approach to conducting CHNAs is not always possible. When communities feel that they have a role in driving the CHNA process, they are more likely to feel ownership for the results and have a higher level of engagement. That being said, Horizon's CHA Team uses a 12-step process that tends to work well for most communities while staying flexible to accommodate the unique needs of the communities they work with. These 12 steps are:

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

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

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

Step Three: Establish CAC. Coordinated by Horizon's CHA Project Coordinator, the first CAC meeting is established. Both the project coordinator and the management committee play a role in inviting CAC members to participate. At the first meeting, the research team shares the goals and objectives of the CHNA with the CAC and discusses the particular role of the CAC (CAC terms of reference can be found in the technical document).

Step Four: Review currently available data on selected community. Because CHNAs conducted within Horizon are based on the geographic community breakdowns defined by the NBHC, the research team used many of their data compilations, which come from multiply surveys and administrative databases. The team reviews this data looking for any indicators that stand out in the selected community.

Step Five: Present highlights from data review to CAC members. Highlights from the data review are shared with CAC members and they are asked to reflect on these indicators. Often this leads to good discussion as members share their

experience of particular indicators. This usually takes place during the second meeting of the CAC and at the end of this meeting; members are asked to reflect on what is missing from the data reviewed for discussion at the next meeting.

Step Six: CAC members share insights about what is missing from currently available data and discuss how best to fill these information gaps. This often takes place during the third meeting of the CAC. Members share what they feel is missing from what has already been reviewed and sometimes members will have other, locally derived data to share with the research team. This leads to a discussion about who should be consulted in the community.

Step Seven: Development of a qualitative data collection plan. Using the suggestions shared by CAC members, the CHA Team develops a qualitative data collection plan outlining what methods will be used, who the sample will be and timelines for collection.

Step Eight: Qualitative data collection in the community. During this step, the CHA Team is in the community collecting qualitative data as outlined in the data collection plan from step seven.

Step Nine: Data analysis. All qualitative data collected is audio recorded and then transcribed by a professional transcriptionist. These data transcriptions are used in the data analysis process. This analysis is then cross referenced with the currently available quantitative data reviewed in step four.

Step Ten: Share emerging themes from data analysis with CAC members and identify priorities. Discussion summaries are developed for each of the themes that emerged from the analysis that are shared with CAC members, both in document form and also verbally shared through a presentation by the CHA Team. CAC members are then asked to prioritize these themes, which are taken into account when the CHA Team finalizes the themes and recommendations. This usually takes place at the fourth meeting of the CAC.

Step Eleven: Finalize themes, recommendations, and final report. Utilizing the CAC members' prioritization results, the CHA Team finalizes the themes to be reported and develops recommendations for each theme. These are built into the final CHNA report.

Step Twelve: Share final report with CAC members and the larger community and begin work planning. A final fifth meeting is held with the CAC to share the final report and begin work planning based on the recommendations. During this step, the CHNA results are also shared with the larger community. This process differs from community to community. Sometimes it is done through media releases, community forums or by presentations made by CAC members to councils or other interested groups.

4.0 NORTHUMBERLAND AREA COMMUNITY ADVISORY COMMITTEE

One of the first steps in the process when completing the CHNA is the establishment of a CAC. CACs play a significant role in the process as they are an important link between the community and Horizon's CHA Team. The mandate of the Northumberland Area CAC is:

To enhance community engagement throughout the Miramichi Area CHNA process and provide advice and guidance on health and wellness priorities in the community.

The specific functions of the Northumberland Area CAC are to:

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

As explained in step 2 of the CHNA 12-step process above, members for CACs are chosen in collaboration with key community leaders on the CHNA Management Committee. This is done with the use of the CAC membership selection guide which can be found in the technical document. To help ensure alignment with the population health approach and that a comprehensive representation of the community is selected, this guide uses the 12 determinants of health categories listed in section 2.4.

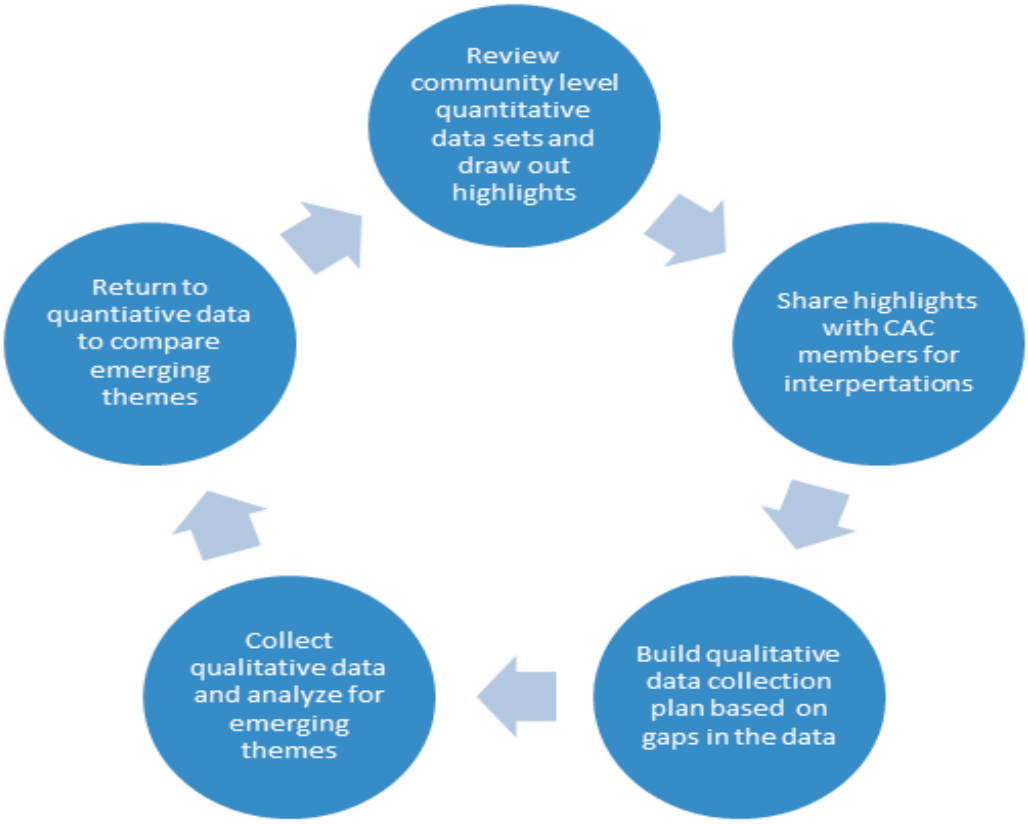
Membership for the Northumberland Area CAC consisted of representation from:

- Public Health
- Horizon's Extra-Mural Program
- Miramichi Regional Hospital
- Horizon Workplace Wellness
- Miramichi Family Health Team
- Horizon Mental Health & Addictions
- Miramichi Outpatient Clinics/Ambulatory care
- Anglophone North School District
- Metepenagiag First Nation Health Centre
- Eel Ground First Nation Health Centre
- City of Miramichi Recreation
- Mount Saint Joseph Nursing Home
- Dept. Healthy & Inclusive Communities
- Miramichi Business Community
- Village of Neguac
- Village of Blackville
- Village of Rogersville
- Northumberland County Sport Network
- Miramichi Family Resource Centre
- Community Mental Health Association
- Local Clergy
- Miramichi Regional Police Force
- MANGO Program
- Social Inclusion Network
- Live Well/Bien Vivre
- Miramichi Family Violence Prevention Network
- Education and Early Childhood Development
- Francophone Community Development

5.0 RESEARCH APPROACH

As outlined in section 3.0 above, one of the first steps in the CHNA process is a review of currently available quantitative data on the community by the CHA Team. Significant highlights are drawn out and shared with CAC members. The CAC members are asked to apply their own interpretation to these highlighted indicators and to indicate when further exploration is required to determine why a particular indicator stands out. These issues are further explored through the qualitative component of the CHNA. Once qualitative data is collected and analyzed for emerging themes, the CHA Team reviews the quantitative data once more to compare.

FIGURE 4: RESEARCH APPROACH



5.1 Quantitative Data Review

As outlined in section 3.0 above, one of the first steps in the CHNA process is for the CHA Team to review currently available quantitative data on the community. The bulk of the data reviewed comes from data compiled by the NBHC. As mentioned earlier, the NBHC has divided the province of New Brunswick into unique communities with their own data sets. The CHA Team uses two of these data sets extensively:

- **My Community at a Glance.** These are community profiles that give a comprehensive view about the people who live, learn, work, and take part in community life in that particular area. The information included in these profiles comes from a variety of provincial and federal sources, from either surveys or administrative databases.[10] In keeping with our guiding approach of population health, indicators within these profiles are divided based on the model shown in figure 1 above.
- **The Primary Health Care Survey.** First conducted in 2011, and then again 2014. Each time, over 13,500 citizens responded to the survey by telephone, in all areas of the province. Its aim is to understand and report on New Brunswickers' experiences with primary health services, more specifically at the community level.[11]

5.2 Qualitative Methodology: Interpretive Description

The qualitative component of CHNAs conducted by Horizon's CHA Team is guided by the Interpretive Description (ID) methodology. Borrowing strongly from aspects of grounded theory, naturalistic inquiry, ethnography and phenomenology, ID focuses on the smaller scale qualitative study with the purpose of capturing themes and patterns from subjective perceptions.[12] The products of ID studies have application potential in the sense that professionals, such as clinicians or decision makers could understand them, allowing them to provide a backdrop for assessment, planning and interventional strategies. Because it is a qualitative methodology and because it relies heavily on interpretation, ID does not create facts, but instead creates "constructed truths." Thorne and her colleagues argue that the degree to which these truths are viable for their intended purpose of offering an extended or alternative understanding depends on the researcher's ability to transform raw data into a structure that makes aspects of the phenomenon meaningful in some new and useful way.[13]

5.3 Qualitative Data Collection

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

- Mental Health Professionals (Neguac)
- Mental Health Professionals (Miramichi)
- Patients Living with Chronic Disease
- Family Support Services
- Seniors Issues
- Northumberland Alternative Level of Care Committee
- Spiritual Leaders
- Domestic Violence Support Services
- Eel Ground First Nation Health & Well Being
- Metepenagiag First Nation Health & Well Being
- Rogersville Health & Well Being

5.3.1 Focus Group Interviews

A focus group interview is an interview with a small group of people on a specific topic. Groups are typically six to 10 people with similar backgrounds who participate in the interview for one to two hours.[14] Focus groups are useful because you can obtain a variety of perspectives and increase confidence in whatever patterns emerge. It is first and foremost an interview, the twist is that, unlike a series of one-on-one interviews, in a focus group participants get to hear each other's responses and make additional comments beyond their own original responses as they hear what other people have to say. However, participants need not agree with

each other or reach any kind of consensus. The objective is to get high-quality data in a social context where people can consider their own views in the context of the views of others.

There are several advantages to using focus group interviews:

- Data collection is cost-effective. In one hour you can gather information from several people instead of one.
- Interactions among participants enhances data quality
- The extent to which there is a relatively consistent, shared view or great diversity of views can be quickly assessed
- Focus groups tend to be enjoyable to participants, drawing on human tendencies as social animals.

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

The CHA Research Lead acted as the moderator for the Northumberland Area focus groups with the main responsibility of guiding the discussion. The CHA Project Coordinator was also present to collect consent forms, take notes, manage the audio recording and deal with any other issues that emerged so that the moderator could stay focused and keep the discussion uninterrupted and flowing.

Focus group settings varied throughout the Northumberland Area CHNA. Attempts were always made to hold focus groups in a setting that was familiar, comfortable and accessible for participants. Upon arrival, participants were asked to wear a name tag (first name only) to help with the conversation flow. The CHA Team developed a script that was shared at the beginning of each session, which can be found in figure 5 below. Individual focus group interview guides can be found in the technical document.

FIGURE 5: FOCUS GROUP INTRODUCTION GUIDE

INTRODUCTION:

- CHA Team introduce themselves
- General discussion of CHNA goals
- General discussion of the community boundaries
- General discussion of the role of CAC and how it relates to FGs
  - reviewed currently available data
  - this review lead to further consultations (FGs)
- What is expected of FG Participants:
  - engage in guided discussion
  - no agenda
  - do not need to come to any censuses - may not agree, that is ok.
  - no work to be done, not a problem solving or decision making group.
  - just sharing insights.
  - please feel free to respond to one another
  - as the facilitator, my role is just to guide the discussion. Just a few questions so there are lots of room for discussion.
- Confirm that everyone has signed the consent/confidentiality form and remind everyone to remember that what is shared during the session is to remain confidential.
- ANY QUESTIONS BEFORE WE BEGIN?
- Explain that, as stated in the consent form, we will be recording the session
  - confirm that everyone is comfortable with being recorded.
- Turn on recorders
- Group Introductions

5.4 Content Analysis Framework

Content analysis done by Horizon's CHA Team is based on the Key Issues analytical framework approach.[15] The first step in this approach is to have all audio recordings that are produced as part of the qualitative data collection plan transcribed into text by a professional transcriptionist. Each transcript is then read in its entirety by the CHA Team while using a code book and an open coding process. During this process all possible 'issues based' content is coded and is divided into general categories that emerge through the review. At this stage it is about making a volume list of anything that could possibly be viewed as an issue and less about the frequency, significance and applicability of the issue. This process helps to eliminate text that is more 'conversation filler' and leads to the creation of a data reduction document where text is sorted into board category areas.

At this stage of the framework, a second review is done of the data reduction document to pinpoint more specific issues in the text, once again with the use of a code book and more detailed coding. During this round of coding, the CHA Team considers frequency, significance and applicability of the key issues. With the list complete, the CHA Team develops a summary of the discussion for each key issue. With the list of key issues and summaries developed the CHA Team returns to the quantitative data sets to see how certain indicators compare to what was shared through qualitative data collection. Sometimes the quantitative indicators support what is being said and sometimes they do not; either way the indicators related to the key issues are highlighted and incorporated into the key issue summaries.

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

6.0 RESULTS

Data analysis resulted in the identification of 10 priority issues:

1. The need to improve supports in the community for families that are struggling and experiencing difficulties
2. An increase in mental health issues among children & youth in the community
3. Food Insecurity in the Community
4. An insufficient amount of affordable home care services in the community provided by well trained, adequately compensated staff
5. The need for a community wellness center with affordable programs targeted at all age groups
6. Transportation issues in the community that impact health
7. Lack of awareness regarding programs and services already available in the community
8. The need for a mental health mobile crisis service in the community
9. Limited recreational activities for children & youth in the community, particularly within outlying areas
10. The need to improve community safety for residents living in First Nation communities

Table 4 below outlines the 10 priority issues and provides recommendations for each. Following the table, a profile for each of the priority issues is presented. These profiles include a summary of the qualitative consultation discussion, available community level quantitative indicators related to the priority issue, quotes from consultation participants and recommendations.

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

1. Income and Social Status
2. Social Support Networks
3. Education and Literacy
4. Employment and Working Conditions
5. Social Environment
6. Physical Environment
7. Personal Health Practices and coping skills
8. Healthy Child Development
9. Biology and Genetic Endowment
10. Health Services
11. Gender
12. Culture[16]

Table 4: Miramichi Area CHNA Identified Priority Areas and Recommendations

	Priority → → → → → → →	Recommendation
1.	The need to improve supports in the community for families who are struggling and experiencing difficulties	Using a multi-sector approach which includes family support services, public health, and educators, revisit the current model of providing family support services and develop a more up-to-date approach to provision that better aligns with the challenges facing families in the community today.
2.	An increase in mental health issues among children & youth in the community	Further consult with educators, mental health professionals and parents in the community to determine what coping skills children and youth are missing and develop a proactive plan to further develop these skills. Also, determine what mental health services already exist for children & youth in the community and determine how best to align these resources to fill gaps.
3.	Food Insecurity in the Community	Working with key community partners, review the various elements of food insecurity affecting the community identified during the CHNA and develop a plan of action to address food insecurity in the community.
4.	An insufficient amount of affordable home care services in the community provided by well trained, adequately compensated staff	Assess what home care services are currently available in the community, focusing on availability in outlying areas and determine what is needed to fill gaps in service in the community. Also, work with local and provincial home care providers to advocate for better training opportunities and adequate compensation for providers.
5.	The need for a community wellness center with affordable programs targeted at all age groups	Working with municipal, school district, and senior organization representatives, assess current wellness infrastructure in the community and determine how to build on and improve this infrastructure and its programs.
6.	Transportation issues in the community that impact health	Examine community health challenges due to limited transportation, review how other communities are addressing this challenge, and work with key community stakeholders to develop a strategy to improve transportation.
7.	Lack of awareness regarding programs and services already available in the community	Review current methods of communicating programs and services in the community and review uptake. Together with appropriate stakeholders, determine the most effective methods to use.
8.	The need for a mental health mobile crisis service in the community	Working with mental health leaders in the community, review how other communities have modeled their mental health mobile crisis service and develop a plan for how best to implement this service in the community.

9.	Limited recreational activities for children & youth in the community, particularly within outlying areas	Through stakeholder partnerships, review what recreational programs and services are currently available in the community and determine where additions can be made.
10.	The need to improve community safety for residents living in First Nation communities	Establish a working group with representation from law enforcement, leadership from First Nation communities and those working with children and youth in First Nation communities to develop a strategy for how to improve safety on First Nation communities in the area.

6.1 The need to improve supports in the community for families that are struggling and experiencing difficulties

Consultation Participants discussed the changing family dynamic that exists in the community. They explained how the changing economy has led to limited employment opportunities in the area and many families have one parent leaving the home for set periods of time for employment in Western Canada. They described how this led to the growing rate of the 'temporary single parent family.' A number of impacts were noted from these changes such as the stress it places on the parent left at home, the guilt felt by the parent who is leaving their family, the impacts on child rearing and discipline, burn-out experienced by the parent left at home, and mental health impacts on the whole family. Some participants discussed how many of the supports for families that already exist in the community are targeted at high risk families and are not universal. They explained a need to rethink this model given the changing family dynamics in the community, and the need to provide more universal programing to support families that are struggling as a result of these changes.

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

Satisfied with mental fitness needs related to my family, grades 6 to 12

- Miramichi **74%**
- NB **76%**

Adults who see their mental health as being very good or excellent

- Miramichi **70%**
- NB **71%**

"…mothers parenting on their own and are just really overwhelmed. They're the ones having to do discipline, homework, meals, keeping on top of the household and then they don't even have the time to take care of themselves… and they may not even have the support systems that might have been there in previous generations"

"So it becomes survival rather than enjoying this whole experience…Day-by-day, you know, how much are they enjoying parenthood, probably not."

"The gap is too that there's always those families that don't qualify …supports that we provide in-home are only to about 20% of the population so the 80% that don't qualify for our services for different reasons, some could benefit hugely as well. We see many many moms struggling that might not qualify"

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

6.2 An increase in mental health issues among children & youth in the community

Consultation Participants discussed a growth in mental health issues among children and youth in the community. They highlighted how mental health issues often occur among high school aged youth, but what is now concerning is a trend towards these issues at a younger and younger age. Some participants discussed the connection between mental health problems and changing technology and social media while others discussed the connection with changing family dynamics in the community. Participants also highlighted that they observe a lack of coping skills among today's children and youth to deal with basic life challenges. Because of this growing trend, it was also highlighted that there are not enough resources available in the community to manage the growth in mental health issues

This was a particular concern that came up during consultations with First Nation communities. They shared concerns surrounding the impacts waiting for service can have on the patient in need as well as the community as a whole.

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

Moderate to high level of mental fitness in children:

- Miramichi **84% NB 80%**

Moderate to high level of mental fitness in youth:

- Miramichi **75% NB 77%**

Have people I look up to (grades 6 to 12)

- Miramichi **41% NB 47%**

"…over the last year we've been overwhelmed with the amount of referrals coming in and younger and younger ages…it's like a lot, you know, a lot with really poor coping skills, a lot of anxiety."

"we've always had anxiety in kids but always seemed more high school level you know when anxiety may become more of an issue but these are you know, 8-9 year olds with anxiety you know. And pre-school kids that are poor coping skills that aren't even in the school yet, we never had that before."

"It's hard to say, there's been no data to really give evidence to that but I would say social media plays a big role, video games, lack of parents being busy, kids in many activities, the amount of expectations on kids are higher. You know."

RECOMMENDATION
Further consultation with educators, mental health professionals and parents in the community to determine what coping skills children and youth are missing, and develop a proactive plan to further develop these skills in children and youth. Also, determine existing mental health services for children and youth in the community and how best to align these resources to fill gaps.

6.3 Food Insecurity in the Community

Consultation Participants often discussed the problem of food insecurity in the community. They highlighted the fact that geography has a lot to do with the problem because the community is a large, spread out region with many rural pockets making it hard for some to access a fresh, whole foods diet. Participants also discussed food insecurity in relation to income and shared how many in the community cannot afford to eat or provide their families with a fresh, whole foods diet. This was a particular concern for participants from First Nation communities. Participants also described 'lack of skill' regarding the preparation of fresh whole foods as a barrier, which leads to over reliance on pre-packaged, processed foods.

DETERMINANTS OF HEATLH:
Income & Social Support, Education & Literacy, Physical Environment, Personal Health Practices & Coping Skills and Healthy Child Development

Food Insecurity in homes (moderate to severe)

- Children 0 to 5 **23% (NB 11%)**
- Children less than 18 **16% (NB 10%)**

Food insecurity in homes with or without children (moderate to severe)

- **11% (NB 9%)**

Eat Fruits & Vegetables, 5 or more daily

- Kindergarten to Grade 5 - **14 % (NB 14%)**
- Grade 4 to 5 – **46% (NB 51%)**
- Grade 6 to 12 – **32% (NB 40%)**
- Age 18 to 64 – **29% (NB 36%)**
- Age 65 and over – **37 % (NB 37%)**

Ate dinner with parent the day before the survey

- Miramichi 71% NB 77%

"And some people I know only get groceries every two weeks and they load up so they're not eating the fresh stuff, they're eating out of cans or frozen…That's a serious problem, the lack of fresh produce"

"Families struggle. Young mothers that don't have enough money to buy proper nutrition for their children or you know…the economic situation, people don't have basic needs. It's incredible how kids in school that don't have… they don't have breakfast, they don't have basic food."

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

6.4 An insufficient amount of affordable home care services in the community provided by well trained, adequately compensated staff

Consultation Participants discussed the issue from various perspectives, starting with the limited amount of affordable home care services in the community. They explained that in a community like this one, where the population is aging and everyone agrees the best option is to keep seniors in their homes longer, there needs to be an increase in the availability of home care services. They explained that this is a particular need in outlying areas of the community. Second, they discussed the difficulty in securing good, steady home care providers. They shared perspectives around the fact that because home care providers are often not adequately compensated, it can be challenging to retain good staff. Also, home care providers are sometimes not given the proper training to deal with the challenges they face making it a stressful and unpleasant work experience for the provider. The final perspective indicates there should be more financial support for seniors to receive home care; focusing on the idea that it is more affordable to pay for support in the home than for a hospital bed or an alternative level of care bed.

DETERMINANTS OF HEALTH:
Income & Social Status, Social Support Networks, Employment & Working Conditions and Health Services

Age 65+ in the community

- Miramichi: **22.8%**
- NB **20.3%**

NBHC Home Care Survey, unmet needs in the community:

- **13.1% (NB 11.4%)**

NBHC Home Care Survey, top 3 unmet needs in the community:

- more hours/access after-hours
- more home support services
- more funding

"I find that home care is not well organized in a community like ours where the population is aging and we'll need more and more of these types of services."

"…there needs to be more qualified caregivers and they need to be getting paid more money and have benefits and things in order to keep them."

"Home care for example is probably one of the best things that could ever happen but subsidize it. It would be a t least a portion of what you're paying for the hospital bed"

RECOMMENDATION
Assess current available home care services in the community, focusing on availability in outlying areas, and determine what is needed to fill gaps in service in the community. Also, work with local and provincial home care providers to advocate for better training opportunities and adequate compensation.

6.5 The need for a community wellness center with affordable programs targeted at all age groups

Consultation Participants often discussed the concept of wellness in the community and highlighted the need for improved wellness infrastructure. They described a community wellness center model that could provide accessible and affordable programming for all age groups in the community. When discussing senior's health, they described a need for a facility with an indoor walking track, which could be used during the winter months. Additional programming for children and youth was also highlighted as a necessity in the community to give children and youth more options in an effort to prevent engagement in risky behaviour and perhaps improve mental health. It was also discussed that programming should focus on athletics and activities such as drama, music and art.

DETERMINANTS OF HEATLH:
Income & Social Status, Social Environment, Physical Environment, Personal Health Practices & Coping Skills, Healthy Child Development and Culture

"…a center, like some place people can just go and walk, you know, I mean I'd love to see a place to keep our seniors moving, healthy long term….help with active aging, you know loneliness and depression and isolation…those are the key areas…"

"…like a Q-plex like they have in Quispamsis. People are walking you know in their 70s and 80s. It really shows how health can improve by having the facilites within the area that are free and people can get out to."

RECOMMENDATION
Working with municipal, school district, and senior organization representatives, assess current wellness infrastructure in the community and determine how to build on and improve this infrastructure and its programming.

6.6 Transportation issues in the community that impact health

Consultation Participants discussed transportation issues and how they impact health in the community. They highlighted how transportation can be a limitation for many community members given the widespread, rural nature of the community. Participants also shared concerns about the senior population in the community and how challenging transportation can be for them. It was shared how there are fewer and fewer social supports in the community for seniors to rely on as many younger families are moving away for employment. Participants discussed how transportation can often be a barrier to accessing primary health care services and the impact it can have on diet and nutrition due to limited access to fresh whole foods. They also discussed how transportation can be a barrier for many children and youth who wish to participate in recreational programing and the impact this has on their mental health and physical development.

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

Health Service Barrier:
Transportation Problems

- Miramichi Area **9.2 %**
- NB **7.1%**

Health service not available in your area when needed

- Miramichi **23.8%**
- NB **17.4%**

"Transportation is definitely an issue. The county is so large… so even though something is within our region, the region is so big and very rural region."

"…appointments in general But there's some services that people have to travel for, radiation or chemo and for the ones that need to travel outside of Miramichi to a specialist."

"I think poverty, you know, as much as we have children going to these after school programs, there's a whole selection of children that are not participating in those activities because, transportation isn't there"

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

6.7 Lack of awareness around programs and services already available in the community

Consultation Participants discussed that, although there are some additional programs and services they would like to see in the community, there are also many programs and services already in place that are not being used due to lack of awareness. Frustration around this issue was shared by a broad range of consultation participants - those who provide programs and services and those who use them. They highlighted how it can be particularly challenging to get information into the hands of seniors because so many of today's communication methods are online. Participants from the area's First Nation communities discussed how they sometimes need to do mail outs or go door-to-door to promote programs and services available, but this can be costly and very time consuming.

DETERMINANTS OF HEALTH:
Social Support Networks, Education & Literacy, Social Environment and Health Services

Know where to go in my community to get help grades 6 to 12

- Miramichi **20%**
- NB **26%**

"No matter what you have, you have tons of great stuff that works, but if people don't know how to access it or ask for it, you're not gonna get them...reaching out to everybody is hard. Awareness."

RECOMENDATIONS
Review current methods of communicating about programs and services in the community and review uptake. Determine the most effective methods to use with appropriate stakeholders.

6.8 The need for a mental health mobile crisis service in the community

Consultation Participants discussed the concept and benefits of a mental health mobile crisis service. They described a service similar to the ones found in other Horizon communities where a team of mental health professionals are mobile and able to get to the patient/client in crisis as opposed to the patient/client trying to get to them. They discussed how this could help cut down on the usage of other services such as the emergency room and 911. They also explained how this approach can be more beneficial for the patient/client as it would be a less traumatic alternative for both them and their families.

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

"If there is a gap at all for us, that to me is the most significant one…we are the only one in the province without mobile crisis under Horizon"

"it could literally be mobile in that they could go to where the person is, their family is calling, 'we can't get him to the hospital,' they don't want to call the police but if the staff are going to their home and able to offer some support there…. assessment. Eliminating a lot of possible trauma for family and for the patient"

RECOMMENDATIONS
Working with mental health leaders in the community, review how other communities have modeled their mental health mobile crisis service and develop a plan for how best to implement this service in the community.

6.9 Limited recreational activities for children & youth in the community, particularly within outlying areas

Consultation Participants discussed the impacts of limited recreational activities for children and youth in the community. They highlighted the importance of recreational programming to the physical and mental development of children and youth. They derived connections to the increase of mental health problems for this age group in the community to the increase in issues such as child and youth obesity. They also discussed how limited healthy activities could lead children and youth to engage in more risky behaviors like drug and alcohol consumption because of few alternatives. Participants also discussed how this is a particular concern in the rural outlying areas of the community. Participants shared how organized sports and athletic programs are important to the community, but that focus should also be given to a broader range of activities like music, art and drama for those not athletically inclined.

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

Physically active at least 30 minutes 3 or more times a week, grade 4 to 5

- Miramichi **83%**
- NB **80%**

Physical active at least 90 minutes daily (moderate to hard) grade 6 to 12

- Miramichi *4***4%**
- NB **40%**

Alcohol Use grade 9 to 12

- Miramichi **53%**
- NB **51%**

Marijuana use grade 9 to 12

- Miramichi **32%**
- NB **31%**

RECOMMENDATIONS
Through stakeholder partnerships, review what recreational programs and services are currently available in the community and determine where additions can be made.

6.10 The need to improve community safety for residents living in First Nation communities

Consultation Participants discussed the need to improve community safety for local First Nation communities. Participants highlighted concerns about a lack of police presence in First Nation communities and how this leads to an increase in crime. They also discussed the far reaching impacts crime has on First Nation communities because culturally they are so close knit and connected to one another. In one of the First Nation communities we met with, members gathered consultations from First Nation's children and youth as part of an organized brainstorming activity. They posed the question, "What does a healthy community look like to you?" Many of the emerging themes related to community safety:

- Greater police presence
- Control stray/loose animals
- Not feeling safe to walk unsupervised in community (unidentified vehicles)
- Being bullied when out in the community (less of a concern in school)
- The need for drug and alcohol free activities for parents and youth (together and separate)
- The need to be tougher on those selling and bringing drugs into community
- No drugs means that kids could feel safer in their own homes

DETERMINANTS OF HEALTH:
Social Support Networks, Social Environment, Physical Environment, Healthy Child Development and Culture

Feel safe at school Miramichi:

- Feel safe at school grades 4-5
  92% (NB 87%)
- Feel safe at school 6-12
  80% (NB 83%)

Bullied at school

- Neguac has been bullied (grades 6-12)
  60% (NB65%)
- Miramichi has been bullied (grades 6-12)
  63% (NB 65%)

RECOMMENDATION
Establish a working group of law enforcement representative(s) and First Nations leaders/ children and youth workers to develop a strategy to improve safety for First Nation communities in the area.

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