Community Health Needs Assessment

COMMUNITY OF BATHURST AND SURROUNDING AREAS

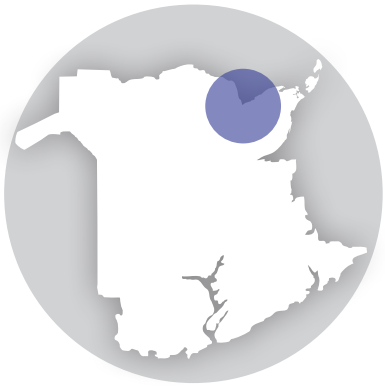
SUMMARY REPORT

JUNE 2017

RÉSEAU DE SANTÉ vitalité HEALTH NETWORK

INTRODUCTION

Primary healthcare is the cornerstone of any healthcare system, involving as it does local services that meet community health needs. This fact spurred New Brunswick's initiative to assess community health needs in order to identify each community's healthcare priorities in order to set healthcare priorities for each community and to identify individual community assets and challenges to adequately and fairly establish a plan for the development and ongoing strengthening of primary healthcare. This process uses a population-based approach focusing on the determinants of health and relies on close cooperation with local communities and engagement from their members.



The community of Bathurst and surrounding areas, as defined by the New Brunswick Health Council (NBHC), takes in the following localities: Allardville, Bathurst, Beresford, Big River, Dunlop, Laplante, Madran, Nicholas Denys, Nigadoo, Tétagouche North, Pabineau First Nation, Petit-Rocher, Pointe-Verte, Robertville, Sainte-Anne, Sainte-Thérèse South, Saint-Laurent, Saint-Sauveur, Salmon Beach, Tétagouche South and Tremblay.

ASSESSMENT PROCESS

The process used is based on an assessment method that is "a form of controlled investigation carried out to determine the value (merit) of a certain entity so as to improve or perfect it (formative assessment)" (Guba and Lincoln, 1986, quoted in Aubegny, 2006, unofficial translation). A participatory action research (PAR) methodology that combines quantitative and qualitative approaches was chosen for this assessment (Koch and Kralik 2009; McNiff 2013).

The process was carried out in compliance with the recommendations presented in ***Community Health Needs Assessment Guidelines for New Brunswick (GNB 2013)***.

The process consists of five key activities:

1. **Community engagement;**
2. **Data collection:**
   - 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 the community.**

The data used in this assessment comes from three sources:

1) quantitative data provided by the New Brunswick Health Council (NBHC);
2) discussion groups and interviews with key informants;
3) reports available in the community.

The data was analyzed to reveal:

1) needs (problems);
2) assets (existing strengths or programs and services);
3) possibilities (proposed by the participants).

Finally, the appropriateness of services was assessed in order to determine whether existing services can meet the needs identified and whether resource reallocation or new investments are needed. This step also served to establish a first directory of healthcare and social services by zone in Vitalité Health Network.

Experts' Opinions Process

COMMUNITY HEALTH NEEDS PROFILE

Quantitative Data

Sociodemographic profile

The median age of the population is 48 (43.7 in N.B.), 51% are women, 62% are Francophones and the rate of variation in the population between 2011 and 2012 was 2%. Also, 23% of those 65 and older live alone in private homes. On the economic front, the median family income is $48,760/year and the unemployment rate is 11%. Note that one adult in four (ages 25 to 65) does not hold a certificate, diploma or degree, one family in five has an income below $20,000, one youth in four under 18 lives in a low-income family and 7.5% of individuals experience conditions of moderate or serious food insecurity at home.

Profile of risky behaviours and population health status

A large proportion of the general population sees its mental health as excellent to good, is satisfied to very satisfied with its life and has a strong feeling of belonging. However, only one person in two sees his or her physical health as very good to excellent. The data shows that children, particularly the youngest, do not eat enough fruits and vegetables. Seniors, compared to those in the rest of the province, consume an excellent amount of fruits and vegetables, but access to food (including fruits) is poorer than in the rest of the province. As well, the vast majority of the population is not very active and there is a high rate of sedentariness. While the rate of smoking is lower than in the rest of the province, one adult in four smokes. Excessive alcohol consumption is very widespread among youth (half of youth in Grades 9 to 12). Youth health is of concern for several reasons: one in three states that they smoke marijuana regularly, youth state that they don't get enough sleep (less than 8 hours a night) and drink more sweet beverages with no nutritional value. However, they state that they have positive social behaviours (e.g., making themselves useful) and are less likely to resort to violence to solve their problems (compared to the provincial average). As a consequence of these behaviours, the population has a high rate of unhealthy weight in all age groups, especially among children: 50% of children in Kindergarten to Grade 5 are overweight or obese. The illnesses diagnosed the most often in the community (compared to the rest of the province) are asthma, gastroesophageal reflux, depression, high blood pressure (1/4) and disabling pain. Only 40% of patients with a chronic illness know how to control their disease or avoid complications and 1/5 knows the effect of their medications. Also, 1/3 of patients diagnosed with a chronic illness don't understand the written medical information, and of these 1/8 don't understand the oral information communicated by a healthcare professional.

Profile of healthcare services use

With respect to preventive practices, we noted (compared to the rest of the province) a lower rate of flu vaccination among seniors and a lower number of women who have mammograms (breast cancer screening) and Pap tests (cervical cancer screening). The five main reasons for hospital admission include chronic respiratory illnesses, heart attacks and angina or chest pain. Patients with chronic diseases state that their cholesterol level (84%) and blood pressure (94%) have been systematically monitored (in the past 12 months). However, only 77% state that their blood sugar has been systematically monitored, and 61% that their weight has. Although depression is among the illnesses most often diagnosed in the region, individuals state that there is low utilization of mental and emotional health services, especially among male youth. It is important to note that 50% of individuals in the region find that medication is expensive and 10% of the population say that they have problems navigating the system. The rate of hospitalization for problems that could be treated on an outpatient basis and for injuries in the region is above the provincial average. A very large proportion of the population uses the Emergency Department (two persons in five in the last twelve months) and walk-in clinics (one person in four). Moreover, 10% of the population used the services of the Extra-Mural Program or was hospitalized in the last twelve months. Some 80% of Anglophones and Francophones receive healthcare services in their language of choice. Note that the region has a low rate of access to dental services, to services in community health centres and to services provided by a nurse practitioner.

Qualitative Data

Analysis of discussion groups

A total of seven discussion groups were formed, involving 81 persons. As well, five key informants contributed to the discussion by giving their opinion to shed light on certain points or provide additional components to understanding the regional context. The seven discussion groups were divided as follows: seniors (18 participants), education sector (10 participants), youth services (10 participants), social and community services (13 participants), healthcare services and physicians (9 participants/physicians), healthcare services and healthcare professionals (12 participants), business sector (5 participants).

PRIORITY NEEDS

The Community Advisory Committee (CAC) participated in setting priorities and in an activity to organize, classify and set priorities for community health in the community of Bathurst and surrounding areas, and also voted on the final list of priorities. The following priorities were identified:

1 REDUCTION OF SOCIAL AND ECONOMIC INEQUALITIES

- Income and employment
- Transportation
- Literacy and health literacy

2 PREVENTION AND HEALTH PROMOTION (PHYSICAL AND MENTAL)

- Nutrition, physical activity
- Mental health, addictions, resilience, stress
- Sexual, reproductive and relationship health

3 ADJUSTMENT TO AN AGING POPULATION

- Seniors' health (continuum of care)
- Home-based care, caregivers

4 SUPPORT FOR FAMILIES, CHILDREN AND YOUTH (INCLUDING THOSE WITH SPECIAL NEEDS)

- In the community
- At school
- At home

5 STRENGTHENING PRIMARY CARE

- Timely access
- Integration of care and services
- Coordination with other service sectors

ASSESSMENT OF WHETHER HEALTHCARE SERVICES MATCH NEEDS

I. REDUCTION OF SOCIAL AND ECONOMIC INEQUALITIES

A low income is a determinant of health responsible for 20% of health-related costs in Canada (Federal-Provincial-Territorial Advisory Committee on Public Health and Health Security, 2004). Social inequalities in health that are linked to poverty are strongly associated with other determinants of health, like risky behaviours (drug use, alcoholism, smoking, unhealthy diet, sedentariness, etc.), early childhood development (violence against children, food insecurity, etc.), and health status, such as the occurrence of chronic diseases or reduced life expectancy (Mikkonen and Raphael, 2010; Hodgetts et al., 2014). The CAC chose priorities that reveal the need for major actions to first examine the social determinants of health in the community of Bathurst and surrounding areas. Social and economic inequalities are at the centre of community concerns, in particular for access to employment and an adequate income, for availability of a community transportation network and the reduction of geographical inaccessibility (of healthcare and services, but also of structures for social support and socialization), and for support for individuals with a low level of literacy and needs for health literacy. An analysis of the services available in the region shows that many programs exist for income support and literacy, but health literacy still needs to be developed. As well, accessible community transportation within the region and for travel outside the region, in particular to access healthcare services, is still very limited.

Recommendations

- Create a single point of service or provide a direct telephone number for information and guidance on assistance and support services (interaction with a professional).
- Develop an organized, secure, insured volunteer transportation network.
- Use computer technologies to improve access to services (telemedicine and telecare).
- Training and information programs for healthcare professionals about communication in health as part of shared clinical decision-making.
- Develop contents adapted to different levels of literacy and health literacy for health promotion and education.

2. PREVENTION AND HEALTH PROMOTION (PHYSICAL AND MENTAL)

The concern for increasing prevention services and health promotion actions is basically justified by the high prevalence of the following problems:

1) obesity, heart and lung diseases;
2) abuse of cannabis (marijuana), tobacco and alcohol, especially among youth;
3) teen pregnancies and STBBIs among youth in general;
4) self-mutilation among youth.

Also, the community has a strong perception of a mismatch between the services available and the needs of the population, in particular for mental health services and addiction treatment, so the members of the CAC opted for preventive actions. An analysis of the services available in Zone 6 shows that numerous services are available. However, the lack of access to these services, their inadequate use by individuals and families, the lack of integration of these services and the difficulty of navigating them visibly explain the community perception of a need. Establishing health promotion programs requires community engagement and the development of multifaceted programs (Kahn, Ramsey et al., 2010; Cluss, Ewing et al., 2013; Barry, Clark et al., 2013; Free et al., 2013; Khanlou and Wray 2014; Alvarez-Jimenez et al., 2014; Whithaker et al., 2014). Studies show that diversifying and harmonizing interventions produce better results at a better cost (Klickpatrick 2009). Integrating a technological component allows 24/7 access from anywhere to pertinent information and increases participation by youth.

Recommendations

- Develop a territorial approach to refurbishing physical environments and organizing them to support an active lifestyle and facilitate access to fresh food.
- Establish an intersectoral approach to fight addictions (cannabis, tobacco and alcoholism) and risky behaviours (hypersexualization and self-mutilation) among youth.
- Develop education and information programs on healthy sexuality and balanced intimate relationships.
- Develop integrated health promotion programs targeting a number of positive aspects and including several interventions: informational, recreational, educational, behavioural, electronic and inclusive (integrating persons from various backgrounds with diverse problems) delivered in several places (e.g., community, schools, workplace and medical clinics).

3. ADJUSTMENT TO AN AGING POPULATION

Many services for seniors living in the community (remaining at home) or losing their autonomy are available in Zone 6. From the community's point of view, available resources are still insufficient and do not cover the needs of the aging community. The major points have to do with integration of services (continuum of care), home-based care and support for caregivers.

Recommendations

- Create a single point of service to help seniors and their caregivers to navigate the system.
- Establish a systematic screening program to efficiently assess changes in the cognitive capacities and physical autonomy of seniors living in the community, maintain a social network around them; expanded role for pharmacists.
- Structure programs for help in the home and standardize the skills of the professionals involved.
- Create a multidisciplinary (interprofessional and intersectoral) primary care team linked to geriatric services and providing coordinated person- and family-centred services (nurse or other navigator for case management).
- Decentralize management of services for seniors to better match services to local needs.
- Integrate health technologies (telecare at home).
- Create respite centres for caregivers, along with psychological and financial assistance programs.

4. SUPPORT FOR FAMILIES, CHILDREN AND YOUTH (INCLUDING THOSE WITH SPECIAL NEEDS)

The community brought up major challenges in dealing with children, youth, vulnerable families and children with special needs. There is a huge lack of services to support these vulnerable population groups. Conditions that make a family more likely to be vulnerable include: divorce or separation, poverty (or job loss), substance abuse, physical or mental illness, exposure to abuse (physical or psychological) and homelessness (Mikkonen and Raphael, 2010). Although many services are available in Zone 6, they don't seem to adequately meet the needs raised by the community. Clearly, what is needed is to offer a continuum of services covering the main environments for children, youth and their family: community, school and family. Various sectors are involved: healthcare, education, social development and public safety. Municipalities and the business sector are also seen as important partners. An intersectoral approach is fundamental, as is the creation of a working group around the theme of "healthy environments for a healthy future generation." Information is needed on available services and better case assessment to meet needs equitably and effectively (better assessment tools and admission criteria for certain social programs).

Recommendations

- In the community:
  a. Strengthen health education and health promotion programs (social marketing);
  b. Surtax on unhealthy food, energy drinks and sweet beverages;
  c. Program of community operation of sports and recreational infrastructure in the schools.

- At school:
  a. Kindergarten: establish a program to screen young children for abuse and malnutrition;
  b. School: education program on healthy lifestyles and resilience;
  c. High school: screening and intervention program in the school, encourage peer interventions and engagement of underprivileged youth in developing interventions, valuing volunteerism and social involvement;
  d. Eliminate unhealthy food from the schools.
- In the family:
  a. Integrated support program for young mothers (taking control of their lives, developing social skills and personal abilities).

5. STRENGTHENING PRIMARY CARE

Strengthening primary healthcare did not appear as a first priority, but participants continually related the various needs to primary care. Thus timely access rests on the necessity of a system that is adapted to the realities of life in our communities (e.g., extended hours of service to accommodate workers or patients living in more distant regions). Integration of care and services and intersectoral coordination cover basically the necessity to adjust to the needs of patients facing complex health problems, seniors, or those with specific needs (Davies et al., 2006; Armitage et al., 2009).

Recommendations

- Timely access:
  a. Develop telemedicine, virtual visits and remote in-home monitoring of elderly patients;
  b. Plan to extend hours of operation.
- Integration of services:
  a. Create a primary care network;
  b. Create an electronic health record;
  c. Establish a basic basket of services for the community.
- Intersectoral coordination:
  a. Create intersectoral working groups on primary healthcare;
  b. Draft an assessment policy for the health repercussions of existing policies in other sectors that influence the determinants of health;
  c. Implement an accountability and assessment system for the quality and performance of primary care.

CONCLUSION

Community Health Needs Assessments are an excellent opportunity to spur dialogue among the various partners and the communities. They shed light on the priorities for which it is important to find and implement solutions based on the fields of activity and expertise of each player.

Vitalité Health Network uses the results of these assessments to guide its decisions and planning. They help it to provide sustainable, accessible, fair, effective and safe high-quality care and services to the various communities in its service area.

It goes without saying that improving public health and wellness is everyone's business. Many other partners have their own contributions to make, just like Vitalité Health Network. We must get everyone involved in order to achieve positive overall results.

Research, analysis and consultation provided by:

UNIVERSITÉ DE MONCTON
CAMPUS DE MONCTON

RÉSEAU DE SANTÉ vitalité HEALTH NETWORK

Jalila Jbilou, M.D., MPH, Ph.D.