COMMUNITY HEALTH NEEDS ASSESSMENT GUIDELINES FOR NEW BRUNSWICK

Community and Institutional Services Division
13-05-13

Department of Health
13-05-13

Table of Contents

Background 3
What is a CHNA? 4
Population Health Perspective 4
CHNA Process 6
Community Engagement 6
Data Collection 7
Indicators and data sources 7
Gathering New Information 7
Analyze Information to Identify Need and Assets in Community 8
Develop Recommendations/priorities 8
Criteria to assess importance 8
Share and Facilitate the use if CHNA findings 8
Report back to the community 9
Invite Feedback from Community and Stakeholders 9
Conclusion: 9
Bibliography 10
Appendix B: Guidelines for Using Qualitative Methods as part of the CHNA 16

Background

The integration of primary health care services is a key direction cited in the Primary Health Care Framework for New Brunswick. The first recommendation of this key direction is to conduct community health needs assessments (CHNA). The CHNA is an on-going process that seeks to identify a defined community's strengths and needs to guide in the establishment of priorities that improve the health status of the population.

This is not a new process for New Brunswick as numbers of excellent CHNAs have been conducted over the last decade to respond to community level issues. However, 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. This evidence-based information must also serve to guide planning for health services that are rooted in evidence. Furthermore it must also impart the capacity to track changes over time.

This document sets out to describe the framework for conducting CHNAs and is intended to guide the Regional Health Authorities (RHA) and local committees in their endeavors to conduct these studies. The Department of Health, Horizon Health Network, Vitalité Health Network and the New Brunswick Health Council have joined forces to standardize the process for conducting CHNAs by agreeing on a common set of guidelines, indicators and data sources. Within this context, "Communities" are defined as 34 unique geographic communities as determined by the New Brunswick Health Council. Over time, each of these communities will undergo a CHNA. The CHNA process will assist in providing baseline information on 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 decision-making process within the health care system, serve to focus public discussions on health issues and expectations and lastly, increase understanding about the difficult choices linked to overall health resource allocation.

The first 10 of 34 communities to undergo a CHNA within the next 2 years were selected jointly with the Health Networks. In order to identify the priority of these communities, the following screens were considered:

- High levels of patients without a family doctor
- Higher than average levels of Chronic diseases
- Lower levels of access to primary health care services
- Previous platform commitments

These screens will also be considered in identifying priority for CHNA in the remaining communities.

What is a CHNA?

- A Community Health Needs Assessment Is a dynamic, on-going 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.
- While the primary goal of the CHNA is to determine a prioritized list of health and wellness issues that can inform decision-makers about the allocation of resources to the community, it is vital that this process enhance community participation and engagement.
- it 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 using the assets and resources within the community.
- Benefits
  - Provides baseline information about the overall health of the residents of the community
  - Encourages collaboration with community members, stakeholders and a wide variety of partners involved in decision-making processes within the health care system
  - Focuses public discussions on health issues and expectations of the health system, and increase understanding about appropriate use of resources.

Population Health Perspective

The CHNA process is best understood and executed from a population health perspective. The population health approach endeavors to improve the health of the entire population and to reduce health inequities (health disparities) among population groups by acting upon the broad range of factors and conditions that have a strong influence on our health commonly referred to as the social determinants of health. These social determinants of health influence the health of individuals, families and communities.

The determinants of health are described below. (Public Health Agency of Canada, 2003)

1- Income and social status

It is not the amount of wealth but its distribution that makes the difference to health. Social status also affects health by determining how much control people have over circumstances such as housing, nutrition and physical activity.

2- Social support networks
Support from families, friends and communities is vital to help people cope with difficult situations and maintain a sense of control over their lives.

3- Education and literacy
Education provides knowledge and skills for daily living and increases opportunities for employment.

4- Employment and working conditions
Meaningful work with economic stability and a healthy working environment are linked to good health.

5- Physical environment
Air and water quality, housing and community safety have a major impact on health.

6- Biology and genetic environment
Some people have a genetic predisposition to certain illnesses. Diabetes is one example.

7- Personal health practices and coping skills
Effective coping skills enable people to solve problems and make choices that enhance their health.

8- Healthy child development
Prenatal and early childhood experiences have a lifelong effect on health.

9- Health services
There is a relationship between availability of preventive and primary care services and improved health.

10- Gender
Gender-based social status or roles are linked to certain health issues

11- Social Environment
Social stability, recognition of diversity, safety, and cohesive communities provide a supportive society that reduces or avoids many potential risks to good health

12-Culture
Some persons or groups may face additional health risks due to
conditions such as marginalization, stigmatization, loss or devaluation of language and culture and lack of access to culturally appropriate health care and services.

CHNA Process

The CHNA process consists of five distinct 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 community**

Community Engagement

Community engagement is the overall term used to refer to the whole span of activities that support the involvement of residents, community groups, service users, health providers , and businesses, in decision-making processes and in shaping and in addressing issues that impact the health and well-being of the community. It is an essential element of a meaningful CHNA and requires careful planning in identifying formal and informal community leaders along with community groups. Moreover it is important that there is a clear understanding by all on the degree and form of participation in the process of conducting the CHNA and ensuring that expectations are realistic with regards to health resource allocation. In turn, the process must also effectively engage community partners, service providers, community groups and individuals, in the planning of primary health care services in the community

Overall, the process must provide an opportunity for diverse individuals to dialogue on health and wellness issues as well as involving the community in articulating a health and wellness vision. The process of organizing and conducting a CHNA becomes an impetus for assembling Collaborative Service Committees (CSC). The CSA ensures linkages between the community, the Regional Health Authorities and the professionals providing care. It serves to effectively engage community partners, service providers, community groups and individuals, in the planning of primary health care services in the community

and in the development community-wide inter-sectorial approaches to improve the health status of the population.

Data Collection

Indicators and data sources

The Vitalité and Horizon Health Networks, in collaboration with the Department of Health and the New Brunswick Health Council, have identified a list of core indicators from which to collect data on community health needs. This set of mandatory core indicators will ensure comparable and consistent application of CHNAs in all 34 of New Brunswick's geographic communities. Appendix A

It is recognized that a broad range of data may also available for use by the Health Networks and that the particular conditions in certain communities may require more data to supplement the data collected for the core indicators. The following criteria should be utilized in selecting additional (optional) indicators from which to collect data,

- The indicator reasonably reflects efforts to reduce health risks and improve health status and health systems.
- The indicator must be currently collectable at both the health authority and provincial level.
- The data for the indicator must be accurate and consistently reported/available.
- The indicator must be understandable, relevant and useful to decision-makers and program planners.
- The indicator must be sensitive and reflect changes in the phenomena it is intended to measure.
- Priority is given to indicators that are supported by evidence to support change (ex: health Improvement).

Gathering New Information

The previously existing data alone will not provide all the information about a community and will not reflect certain conditions that are known or suspected by front-line providers, local authorities or community members. Community consultation in the

form of focus groups, community meetings, key informant interviews and meetings with key stakeholders will help to identify issues and provide context with which to understand the data that has already been collected. This also serves to engage communities in working collaboratively in addressing community issues. Appendix B

Analyze Information to Identify Need and Assets in Community

- summarize findings of quantitative analysis
- analyze qualitative data
    - Major themes/concerns of the community aligned with health needs identified by health care providers and experts?
    - Opportunities to make substantial gains in health status?
    - Key areas for wellness and health promotion, disease and injury prevention?
    - Conclusions on needs and strengths of the community *Select Priorities from identified needs.*

Develop Recommendations/priorities

Criteria to assess importance

- Preventability
- Population potentially affected
- Population actually affected
- Prev. premature death or YPLL
- Severity
- Public Concern
- Economic Burden

Share and Facilitate the use if CHNA findings

- To inform Health Network strategic planning and operational planning

- To inform the Department of health on the provincial health plan, program and in policy development
- To change program direction or develop new programs/redirection of resources, consider use of community strengths to respond to identified priority needs
- Develop community-wide, inter sectorial approaches to improve health status of the population

Report back to the community

Invite Feedback from Community and Stakeholders

- Consider expectations of the community, especially actions that are not taken as a result of community advice. Provide rationale;
- Ensure priorities and actions are aligned with objectives of provincial health plan and the PHC Framework.

Conclusion:

The purpose of this guide is to provide a template with which to improve the process of conducting community health needs assessments. This template will serve to generate consistent and reliable evidence to communities, regional health authorities and the Department of Health so that they may plan more effectively in responding to the actual health and community needs of the population.

Bibliography

Ardel, S. B. (2006). *Assessing the Needs in "The Health Planner's Toolkit.* Ontario: System Intelligence Project, Ministry of Health and Long-Term Care.

Department of Health. (2012, August). *A Primary Health Care Framework for New Brunswick*. Fredericton, New Brunswick: Province of New Brunswick.

Health Council of Canada. (2010). *At the Tipping Point: Health leaders share ideas to spread primary health care reform.* Toronto: Health Council.

Retrieved March 2013, from: http://healthcouncilcanada.ca/rpt_det.php?id=163

Manitoba Health. (2009). *Community Health Assessment Guidelines 2009*. Manitoba. Retrieved October 2012, from http://www.chssn.org/en/pdf/networking/community%20health%20assessment.pdf

Onuzulike N.M. (2004), *Health Care Delivery Systems*, Owerri Achugo Publishers

New Brunswick Department of Health. (2003). The New Brunswick Community Health Needs Assessment. New Brunswick.

Public Health Agency of Canada. (n.d.). *What Makes Canadians Healthy or Unhealthy*. Ottawa, Ontario, Canada. Retrieved October 22, 2012, from http://www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php#socenviron

Appendix A

Community Health Needs Assessment Indicators

Population Breakdown for Community	Population Health Status and outcomes for Community
• Total Population • Population age 0-4 • Population age 5-9 • Population age 10-14 • Population age 15-19 • Population age 20-24 • Population age 25-29 • Population age 30-34 • Population age 35-39 • Population age 40-44 • Population age 45-49 • Population age 50-54 • Population age 55-59 • Population age 60-64 • Population age 65-69 • Population age 70-74 • Population age 75-79 • Population age 80-84 • Population age 85 and over • Median age of population • Total population 15 years and over • Male population • Female population • Population change • Aboriginal Identity • Total Visible Minority • Immigrants broken down by group (some communities need this) • Language spoken most often - French • Language spoken most often – English • Rate of single seniors • Rate of senior couples • Number of lone parent families, as a proportion of all families • Percentage of the aboriginal identity population who speak an aboriginal language most often at home	• Perceived health, very good or excellent • Youth perceived health, very good or excellent (12-19 years) • Overweight or obese (18 and over) • Overweight (18 and over) • Obese (18 and over) • Youth with unhealthy weight(overweight/obese) (12-19 years) • Child with unhealthy weight (grade K-5) • Youth Chlamydia rate (15-19) • Number of sexually transmitted infections (genital Chlamydia) • *Emphysema or COPD* • *Diabetes* • Prevalence of Diabetes among youth (12-19) • *Asthma* • Prevalence of asthma among youth (12 – 19) • Prevalence of asthma in aboriginal (6-14) • *High blood pressure or hypertension* • *Arthritis* • *Cancer* • *Chronic Pain* • *Depression* • *Gastric reflux (GERD)* • *Heart Disease* • *Mood disorder other than depression* • *Stroke* • *Premature deaths from heart and stroke, cancer, breathing diseases, injuries and suicides.* Mental Health Status • Adults – Mental health very good or excellent • Youth – mental health very good or excellent • Life satisfaction, very satisfied or satisfied • Youth satisfied or very satisfied with life • Perceived life stress (quite a bit and extreme) • Premature deaths due to suicides/self inflicted injuries (years of life lost)Adult • Youth premature deaths due to suicides/self inflicted injuries (years of life lost) • Youth who have a moderate to high level of mental fitness (grades 6 to 12) • Children who have a moderate to high level of mental

	fitness (grades 4 to 5)
Social and Economic status	
Income • Median Income (all census families) • Living in low-income family (under 17 years old) • Proportion of total households that spend 30% or more of household income on housing costs • *Household income less than $25,000* • *Household income $25,000 – $59,999* • *Household income $60,000 or more* • Family receiving social assistance or welfare benefits (% out of all families with children at home) • Food insecurity at home, moderate and severe (with or without children present) • Food insecurity in homes with children 0 to 5 present, moderate to severe • Food insecurity in homes with children 6 to 17 present, moderate and severe • Food insecurity in homes with children less than 18 years old, moderate and severe Education & Literacy • No certificate; diploma or degree • High school certificate or equivalent • College; technical trade diploma • University degree • Youth planning to begin studies at a college or university after high school graduation (grade 12) • School drop out by sector (grade 7-12) • Exam rates/provincial assessments Health Literacy • *Difficulty understanding written information about medical condition or prescription* • *When learning about a medical condition or a prescription, how often was it verbally explained to you in a way that you could understand* • *Agree with "I know how to try to prevent further problems with my health condition"* • *Agree with "I know what each of my prescribed medications do"*	Employment • Employment Rate • *Employed* • *Unemployed/seasonal* • *Retired* • *Other* • Unemployment Rate • Total experienced labour force 15 years and over • Agriculture and other resource-based industries • Construction • Manufacturing • Wholesale trade • Retail trade • Finance and real estate • Health care and social services • Educational services • Business services • Other services Social Factors • Sense of community belonging • Lived in a different province or territory 1 year ago • Lived in a different province or territory 5 years ago • Voter turn out • Teachers show a positive attitude towards healthy living (grade 12) • Child who ate dinner with parent day before survey (grade 4 and 5) • Youth who feel respected at school (grade 12) • Youth who have never been bullied • Child who feels safe at school • Youth who feel their school has provided them with opportunities to participate in exercise or physical activity other than physical education class • Youth who feel they had opportunities in high school to participate in cultural activities organized through school • • Mental fitness needs met by family • Mental fitness needs met by friends • Mental fitness needs met by schools • Youth who feel connected to their school (grade 6-12) • Child who feels connected to his/her school (grade 4-5) From NB Student Wellness Survey • I know where to go in my community to get help • I have people I look up to • My parent or caregiver know a lot about me • I have opportunities to develop skills that will be useful

	later in life (like job skills, and skills to care for others) • I feel I belong at my school • I enjoy my cultural and family traditions • *Care giver support for those receiving home care services*
Environment	
Physical Environment • Second hand smoke exposure at home • Second hand smoke exposure in vehicles • Second hand smoke exposure in public places • Proportion of total occupied dwellings requiring major repair • Greenhouse gas emissions per person • School promoted healthy eating by providing easy access to healthy food and snacks (grade 12) **Built environment** Location of food outlets/grocery stores Walkability score	

Personal Health Practices & Coping Skills
• Current smoker, daily or occasional • Current smoker, daily • Youth who have smoked in the last 30 days (grades 6 to 12) • Youth who have never tried smoking • Youth who have a family member who smokes (grades 6 to 12) • Heavy drinking (5 or more drinks at least once a month in past year) • Youth Heavy drinking (getting drunk) in the last 30 days (Grade 7,9,10 & 12) • Youth who have used Marijuana within the last year (Grade 7,9,10 & 12) • Leisure-time physical activity, moderately active or active • Youth who spend at least 90 minutes a day in a combination of moderate to hard physical activity (grades 6-12) • Child who is very physically active for at least 30 minutes 3 or more times per week(grade 4 – 5) • Fruit & Vegetable consumption, 5 or more per day • Youth who eat 5 or more fruits or vegetables a day (grade 6-12) • Child who eats 5 or more fruits or vegetables a day (grade 4-5) • Youth who eat breakfast daily (grades 6-12) • Child who eats breakfast daily (grades 4-5) • Youth who consume sweetened non-nutritious beverages (grades 6 to 12) • Child who consumes any sweetened non-nutritious beverages yesterday (grades 4 & 5) • Energy Drinks (grades 6-12) • Youth who sleep more than 8 hours a night (grades 6 to 12) • Youth who spend 2 hours or less per day in sedentary activities (screen time) (grade 6-12) • Child who spends 2 hours or less per day in sedentary activities (screen time) (grades 4-5) • Youth who have pro-social behaviors (grade 6-12) • Aboriginal youth who have pro-social behaviors (grades 6-12) • Child who has pro-social behaviors (grade 4-5) • I am able to solve problems without harming myself and others (for ex. using drugs and or being violent)

Early Childhood Development
• Low birth weight (DAD/HFUMS/AHIM) • Universal newborn and infant hearing screening (Hospital Services) • Breastfeeding initiation • Proportion of infants exclusively breastfed at 6 months • Proportion of children meeting immunization requirements (Public Health) • Proportion of children aged 6 and under living in low income families • Total approved available child spaces (count) • Early intervention services (Monthly Average) • Kindergarten school readiness by sectors (pre K-K)

Health Services

- Dental professional (CCHS)
- Youth who visited a dental professional within the last year (12-19 years)
- Eye specialist (CCHS)
- Youth who saw or talked to an eye professional within the last year
- Mental health professional (CCHS)
- Youth who saw or talked to a health professional about emotional or mental health within the last year (12-19 years)
- Seen someone for mental or emotional problem
- Influenza immunization
- Mammography
- Pap smear
- Receiving blood pressure measurement among those with either diabetes, heart disease, stroke, HBP
- Receiving cholesterol test among those with either Diabetes, heart disease, stroke, HBP
- Receiving body weight measurement among those with either diabetes, heart disease, stroke, HBP
- Receiving blood sugar test among those with either diabetes, heart disease, stroke, HBP
- Proportion of the population aged 12 and over who have a regular medical doctor (CCHS)
- Top 10 admissions to hospital by CMG from place of residence
- ACSC 3-year average rate of cases/10,000 population (DAD)
- Youth who had a medical doctor visit within the last year (12-19 years)

Primary Care Service Utilization

- PHC Team
- Visited a personal family doctor
- Visited hospital emergency department
- Visited a specialist
- Visited an after-hours clinic or walk-in clinic
- Visited a community health center
- Visited a nurse practitioner
- Visited an alternative practitioner
- Used Tele-care or other advice/info line
- Used ambulance services
- Insurance – drugs
- Insurance –dental
- Insurance – eye glasses
- Insurance – hospital charges
- % have insurance coverage
- *Hospital patient in last 12 months*
- *Trouble navigating/finding your way around the health care system*
- *Found cost of medications too high*
- *Had transportation problems in getting health care when needed*
- *Homecare*

Language of Service Preference:

Did you always receive service in the language of service preference

a) *Hospital Services*
b) *Community Services*
c) *Home Care Services*

Appendix B: Guidelines for Using Qualitative Methods as part of the CHNA

After reviewing existing data during the initial stages of the CHNA process, gaps and limitations in the data are often identified which need to be addressed through qualitative research methods. The resulting qualitative data obtained provide a context for which to understand the data previously considered (the story behind the numbers) and also provides rich information about the perceptions and priorities of the community. During the CHNA, qualitative information is most commonly obtained using focus group interviews, key informant interviews, community meetings and meetings with key stakeholders. These qualitative methods use open-end questions giving participants the opportunity to respond in their own words and have the ability to evoke responses that are meaningful and culturally salient; a necessary feature of CHNA.

There are often differences from community to community in the way the qualitative component of the CHNA is carried out. However, below is a set of guidelines to help provide direction.

- **Determine the purpose of the session(s).** You first need to consider what information you are looking for or what question are you looking to answer. This differs from the overall purpose of the CHNA as a whole and will be much more specific and focused. A clear purpose for each session will help ensure focus during qualitative data collection. If multiply sessions are required, some will have the same purpose and some will differ. What's important is that when going into each session the purpose is clear and focused.

- **Determine which methods are appropriate to use.** For CHNA these are often focus group interviews, key informant interviews, community meetings and meetings with key stakeholders.

- **Determine which individuals or groups can contribute to your information needs.** This form of sampling is considered purposeful sampling where individuals or groups are selected because they are information rich and illuminative. Here, sampling is aimed at insight about the phenomenon, not empirical generalization from a sample to a population. The advisory committee can assist in the selection of these individuals or groups.

- **Recruit participants.** Ideally, this will be done through the assistance of the advisory committee however things such as a generic invitation, letter or email will need to be developed to help initiate the process.

- **Informed consent.** For each session, whether a focus group or interview, the best process for obtaining informed consent will need to be determined. What is required/not required in terms of consent will be outlined through the Research Ethics Board (REB) approval process. Tools, such as consent forms may need to be developed.

- **Data collection tools.** Before sessions commence, data collection tools such as interview guides or focus group guides will need to be developed.

- **Administration.** All qualitative data collection needs to be audio recorded. When using qualitative methods, it is often hard to know when an adequate amount of data has been collected. A good goal is to aim for data saturation which is when you reach a point where no new data is being gathered and the data you are gathering is becoming redundant.

- **Transcription.** Audio recordings of sessions are to be transcribed into text files as soon as possible after each session.

- **Determine analysis method.** Either manual or with the use of a data analysis

- **Perform thematic analysis.** Categorize/code data and determine emerging themes.

- **Member check.** This is different from the "invite feedback on findings from the community and stakeholders" under core functions of the CHNA. With member checking, you take your findings from sessions back to the members of your original focus group/interview and ask if it reflects what was said.

- **Compare/correlate emerging themes with the previously reviewed quantitative indicators template.**

- **Engage readers.** Qualified individuals who will be considered "Readers" should be identified earlier on in the process. To avoid conflict of interest, these readers should not have a personal or professional interest in the results of the CHNA and should be qualitative to critique the methods and processes used for data collection. Once a draft report has been complied, it should be given to the readers with a time frame for return. When doing final reporting, the readers names and their qualifications to be readers, should be stated. At least 2 readers should be part of each CHNA.

- **Thick description.** Provide a rich and through description of the research context and data collection/analysis process used to the CHNA advisory committee and in the final reporting.

*Consultants may have additional processes or techniques that will benefit the CHNA process which may be used pending approval from the CHNA facilitator.