Western Health Community Health Needs and Resources Assessment Summary Report

2013

Summary Prepared by:

Darlene Welsh, Regional Manager Research and Evaluation

Primary Health Care Area Community Health Needs and Resources Assessments Prepared by:

Erica Parsons, Primary Health Care Manager, Bonne Bay and Port Saunders Area

Alison Dower, Primary Health Care Manager, Deer Lake and White Bay South Area

Danielle Shea, Primary Health Care Manager, Bay St. George Area

Danielle Shea, Acting Primary Health Care Manager, Port Aux Basques and Burgeo Area

Doreen Burry, Primary Health Care Manager, Corner Brook Area

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Acknowledgements

The success of the Community Health Needs and Resources Assessment Summary Report and Primary Health Care Community Health Needs and Resources Assessments was dependent upon a number of individuals and groups. A special thank you is extended to the following individuals and groups for their time and commitment to the project:

Residents of the Western Region;

Community Advisory Committees;

Staff and leadership throughout Western Health;

Ms. Rebecca Nippard, Western Regional School of Nursing;

Ms. Heidi Ryan, Community Accounts Manager, Government of Newfoundland and Labrador.

Introduction

A Summary Report on the Community Health Needs and Resources Assessment Study of the Western Region was completed in 2009 through a partnership between Western Health, the Western Regional Advisory Committee, and the Community Health Assessment Team of Memorial University of Newfoundland, School of Nursing (MacDonald, Bennett, Best, & Blakeley, 2009). The Community Health Needs and Resources assessment study of the Western region (MacDonald, Bennett, Best, & Blakeley, 2009) provided valuable information in the identification of organizational priorities and planning. Western Health decided that a similar process would continue as a means to obtain community feedback and assist in planning.

Following a review of the process used from 2007 to 2009, Western Health revised the process for completing the Community Health Needs and Resources Assessment (CHNRA) of the Western region. In the revised process, assessments for each primary health care (PHC) area throughout Western Health were conducted. The Regional Director Health Promotion and Primary Health Care, Primary Health Care Managers, Regional Director Planning and Research and Regional Manager Research and Evaluation partnered over a three year period in the development and implementation of the revised CHNRA process. A policy was developed to guide the process and support utilization of the information from the assessment (see Appendix A).

Data obtained from the CHNRA for each PHC area and this summary report will serve a dual purpose: PHC area planning and organizational planning. To support the PHC area planning, the information from the CHN&R Assessments will be shared with Community Advisory Committees and PHC area teams. Community Advisory Committees are committees consisting of community representatives who work with PHC teams to assist in the planning, implementing and evaluating

of initiatives to improve the health and wellbeing of people living within each PHC team region. Key priorities for each PHC area were identified and recommendations were made based on CHNRA findings. These will be incorporated into the individual PHC area work plans. To support organizational planning, the information from this Community Health Needs and Resources Assessment Summary Report will be incorporated into the Western Health Environmental Scan. The Environmental Scan helps Western Health to understand the external and internal environment, including health determinants and population health, and informs organizational planning and decision making. Significant consideration is given to Western Health stakeholders in the Environmental Scan and this CHNRA Summary Report is one means of obtaining community feedback.

Western Health PHC Area Profile

Western Health offers a broad range of health and community services to the 77,983 residents of the Western region (Government of Newfoundland and Labrador, 2013). The geographic boundaries of Western Health extend from Port aux Basques southeast to Francois, northwest to Bartlett's Harbour, and on the eastern boundary, north to Jackson's Arm. Western Health provides community based programs, primary health care, secondary acute care, adult rehabilitation and long term care services. Community based programs include health promotion, health protection, mental health and addictions, community support programs, intervention services, and community health nursing. Programs and services are provided through 26 community based offices, 26 medical clinics including travelling clinic sites, and eight health facilities.

Within the Western Health region, there are seven PHC areas: Port Aux Basques, Burgeo, Bay St. George, Corner Brook, Deer Lake and White Bay South, Bonne Bay, and Port Saunders areas (see Figure 1). Five PHC Managers lead primary

health care for these areas and two of these managers oversee two PHC areas; one manager is responsible for Bonne Bay and Port Saunders areas and another is responsible for Port Aux Basques and Burgeo areas. During the time that the CHNRA for each PHC area were being completed, the PHC Manager for Bay St. George was also acting PHC Manager for Port Aux Basques and Burgeo areas.

Figure 1. Primary Health Care Areas in the Western Region

The Population Health Promotion Approach

The population health promotion approach guided the methodology utilized in the CHNRA process. This approach helps health care systems understand the health of a population and how many factors influence wellness and health. The population health promotion approach consists of eight key elements:

1. focus on the health of populations;
2. address the determinants of health and their interactions;
3. base decisions on evidence;
4. increase investments;
5. apply multiple strategies;
6. collaborate intersectorally;
7. engage the public and
8. demonstrate accountability for health outcomes (Public Health Agency of Canada, 2001).

A population health promotion approach measures and analyzes many factors that are known to influence and contribute to health and their interactions. These factors are typically referred to as the determinants of health and include: social, economic and physical environments, early childhood development, personal health practices, individual capacity and coping skills, human biology and health services.

The population health promotion approach uses evidence-informed decision making. Evidence on health status and the determinants of health are utilized to assess health, identify strengths and gaps in programs and services and thereby develop priorities based on this evidence. Evidence-informed decision making outlines the need to support findings and recommendations with systematic, empirical evidence. In the population health promotion approach, planning is based on data generated from a number of sources through a combination of

qualitative and quantitative methods.

The population health promotion approach was utilized in the development of the CHNRA process in that the assessment process utilized multiple methods to provide evidence to decision makers. In addition, the assessment promoted public participation in the decision making process to help leaders better understand communities. Involvement of the public in the CHNRA was critical to gain a full understanding of the issues confronting the communities and the strengths of the communities. This knowledge provided leaders with insight into strategies to promote health.

Community Health Needs and Resources Assessment Objectives

The objectives of the CHNRA were to:

1. identify health and community strengths and needs in each PHC area;
2. identify whether there are any differences in the PHC areas throughout the Western region in terms of health and community strengths and needs;
3. determine whether there are any differences in any of the PHC areas compared to the overall Western region.

Recommendations are presented based on data collected.

Data Collection Methods and Instruments

This assessment used a mixed methods approach in the compilation of the data on the community health needs and resources in the PHC areas of the Western region. Quantitative and qualitative data were obtained from a review of other surveys and/or reports, telephone surveys with a random selection of households

and focus groups with key community informants (see Appendix B for survey instrument and Appendix C for focus group interview guide). Using these methods of data collection allowed triangulation which ensured validity of the data and facilitated the identification of recommendations and priority issues and concerns about community health needs and resources. Data was collected related to:

1. health needs;
2. public feedback;
3. health status and
4. community assets.

Health Needs

Health needs were assessed by Western Health staff through a standardized survey that was administered to a random sample of residents in each PHC area. The CHNRA survey (Appendix B) was used to collect quantitative and qualitative data about awareness of, and satisfaction with, available health and community services, barriers to accessing these services, awareness and identification of community groups that contribute to improving the health of the community, identification of health related community concerns, where and how individuals obtain health information, and strengths of communities.

The survey tool was a modified version of the instrument used by Western Health in a previous study by MacDonald, Twomey, Bennett, Best, and Blakeley (2009). Western Health revised the survey based on the needs of the stakeholders and the method of survey administration. The list of health and community services, community groups, and community concerns that were used in the 2009 survey was also revised. The previous survey was administered using a mail out methodology, whereas the current CHNRA survey was administered by the PHC Managers on the telephone and therefore, the survey tool was shortened to

enhance participation. The response scale was also revised; rather than using a 5 point satisfaction Likert scale (“1" being not satisfied to “5" being satisfied or “1" being no problem to “5" being major problem), the response options were yes, no, don’t know and not available. Comments from participants were documented.

Public Feedback

Public feedback was obtained through focus groups and/or key informant interviews based on priorities identified through the CHNRA surveys. Each PHC Manager facilitated focus groups in their own areas with community members or groups who could speak to issues related to identified priorities. PHC Managers coordinated the focus groups and invited key stakeholders based on their involvement in the focus group topics.

A focus group interview guide (Appendix C) was developed by the Regional Manager Research and Evaluation and the PHC Managers modified the script to meet the needs of their individual focus group topics. The focus group interview guide was designed to gather more specific information based on the group’s perception of community health needs and resources related to a specific topic. In the development of the focus group guide for the aboriginal population, a representative from the Qalipu Band, Department of Health and Community Services-Aboriginal Health Division was consulted. Focus group participants were asked open-ended questions to explore community strengths and to determine how specific concerns or problems might be addressed.

Key informant interviews were conducted in two of the PHC areas. The PHC Manager for those two areas felt that key stakeholders were unable to attend the focus groups and therefore, conducted key informant interviews to ensure a comprehensive and thorough assessment of the identified priority issues. The focus group interview guide was revised to meet the needs for the key informant interviews.

Health Status

Health status of the community residents was assessed through data from the Community Accounts website, Statistics Canada, Newfoundland and Labrador Centre for Health Information, the Canadian Community Health Survey, the Canadian Tobacco Use Monitoring Survey, the Canadian Institute for Health Information Health Indicators Report, Western Health internal data, and the Comprehensive School Health Assessment Summary Report (Pye, 2013). Statistics validated the survey and focus group results.

Community Assets

A list of community resources and organizations was compiled in consultation with Community Advisory Committees, Western Health staff, key stakeholders and members of the communities. The community asset listing included, but was not limited to, churches, daycares, health facilities, recreational facilities, community and volunteer organizations, libraries, schools, businesses, fire halls, police and so on. In addition to using the community assets listing for the purpose of the CHNRA and validating survey and focus group findings, it provided PHC Managers with a comprehensive overview of available resources within their areas.

Support and Education

The PHC Managers were responsible for the collection of all data and therefore education was provided to ensure that data was collected in a standardized method from valid and reliable sources. Education sessions were delivered by the Regional Manager Research and Evaluation on telephone survey administration and conducting focus groups. A webinar was organized with the Manager of Community Accounts to facilitate the data collection process from the Community Accounts Website. Ongoing communication through teleconferences, face to face meetings, and individual meetings was initiated between the Regional Manager Research and Evaluation and the PHC Managers to support this process.

In the completion of the CHN&R Assessment process, PHC Managers prepared PHC area specific CHN&R Assessment reports (see Appendix D, E, F, G, and H).

Data Analysis

CHNR Assessment Surveys

The quantitative data from the CHNR Assessment surveys were analyzed using the *Statistical Package for Social Sciences (SPSSx).* The Regional Manager Research and Evaluation managed the employment of a student to complete the data entry. Statistics were calculated for each PHC Manager area. The survey responses were analyzed by simply calculating descriptive statistics (frequencies and percentages). Descriptive statistics were calculated for each response category, "yes", "no", "don't know", and "not available". When identifying the top three and lowest three community services and health related community services, community groups, and community concerns, the "don't know", "not available", and "no response" categories were excluded. However, these

responses were considered when recommendations were identified. Qualitative data from the survey were transcribed by a student.

Focus Groups and Key Informant Interviews

The focus group discussions and key informant interviews provided more in-depth, rich information about the key issues identified in the CHNRA surveys. The focus group discussions and key informant interviews were transcribed and summarized by each PHC Manager for their areas.

Health Status and Community Assets

The health status statistics and community assets listings obtained in this CHNRA were presented as summary discussions in each PHC area report. PHC managers used the information to validate survey and focus group findings and incorporated the findings into the discussion.

Participant Selection

Survey Participants

The sample for the survey was compiled based on the approximate population in the PHC areas for each of the five PHC Managers throughout the Western region (see Table 1). A 95 percent confidence level and 10 percent confidence interval were chosen. A 10 percent confidence interval was selected based on the fact that several data sources were being utilized in the identification of community health needs and resources and also based on feasibility in terms of resources and time. A random sample was obtained from the phone book for each area.

Table1. Random Sample for each PHC Manager Area

PHC Manager Area	Population	Sample
Corner Brook	27,880	95
Bonne Bay/Port Saunders	9060	95
Port Aux Basques/Burgeo	9,120	95
Deer Lake/White Bay South	13,090	95
Bay St. George	21,830	96
Western Region	**80,980**	**476**

Households were contacted by telephone and asked to participate in the CHNRA survey. There were few refusals and all PHC Managers obtained the agreed upon sample for their areas.

Focus Group Participants

Focus group participants were identified and selected by the PHC Managers based on their involvement in the focus group topic. Table 2 outlines the focus group topic and number of participants for each area. As previously noted, key informant interviews were conducted by one of the PHC Managers in her two areas. The key informant interviews were conducted as a result of those individuals not being able to attend the focus groups.

Focus groups were conducted with representatives from the Aboriginal population in both the Bay St. George and Corner Brook PHC areas. A focus group was held with the Francophone population in the Bay St. George PHC area. Although the data from the CHNRA surveys did not indicate key issues specific to these populations, a large proportion of the population in both of these PHC areas is Aboriginal. Also, a large percentage of the population in the Bay St. George area is Francophone. Western Health agreed that conducting focus groups with these

groups were necessary to ensure a thorough and comprehensive assessment of the areas.

Table 2. Focus Group Topic and Participation in each PHC Manager Area

PHC Manager Area	Focus Group Topic	Number of Participants
Corner Brook	Diabetes Aboriginal Health	15 4
Bonne Bay/Port Saunders	Chronic Disease Management Diabetes Cancer Care	10 6 4
Port Aux Basques/Burgeo	Port Aux Basques: Cancer Care Burgeo: Healthy Eating	11 15
Deer Lake/White Bay South	Cancer Care Healthy Eating	7 8
Bay St. George	Access Aboriginal Health Francophone Health	5 5 5
Total Focus Groups	**12 focus groups**	**95**

Results

CHN&R Assessment Survey

Demographics. A total of 476 surveys were conducted throughout the Western region. Of the 476 surveys administered, 75.6% of the respondents were female, 23.7% were male, and 2.1% did not have the gender included on the survey response sheet. The average age of the respondents was 53.51; ranging from 19 years of age to 96. The average years living in that community was 36.32 and this ranged from 1 to 88 years.

Community Services. Survey respondents were asked to report on whether they were satisfied with a list of community services (see Table 3). Of those community services that respondents knew about or used (excluding the "don't know", "not available", and "no response" responses), respondents reported being more satisfied with: fire protection, libraries and postal services. When all of the responses were considered, the three community services with the higher percentages of satisfaction included fire protection, postal services and garbage collection and disposal. Across the PHC areas respondents reported being more satisfied with: fire protection, postal services, libraries, university/college, banking, schools, garbage collection and/or telephone (see Appendices D, E, F, G, and H).

Of those community services that respondents knew about or used (excluding the "don't know", "not available", and "no response" responses) respondents reported being less satisfied with: child care/day care, shopping and after school programs. When all of the responses were considered, the three community services with the lower percentages of satisfaction included shopping, recycling and recreation programs. Across the PHC areas respondents reported being less satisfied with: child care/day care, shopping, recycling, recreation programs/facilities and/or after school/children and youth programs. Lower percentages of satisfaction with the community services of career development, food bank, hazardous waste disposal and literacy support was identified in only one PHC area.

When probed for further comments regarding the community services with which respondents reported being less satisfied, many indicated that there was a lack of child care/day care and programs for youth. Comments about shopping were typically related to the lack or expense of fresh fruits and vegetables. Other PHC area specific comments indicated inadequacy of services related to; recycling programs, cell phone service, public transportation, accessibility for disabled individuals, hazardous waste and shelters for abused women.

Table 3. Percent Satisfied with Community Services

Community Services	Yes	No	Don't know	Not available	No response
1. Preschool programs	39.7% (189)	7.8% (37)	47.5% (226)	4.6% (22)	0.4% (2)
2. University / College	38.4% (183)	2.3% (11)	26.5% (126)	32.4% (154)	0.4% (2)
3. Schools	60.9% (290)	8.6% (41)	27.1% (129)	2.9% (14)	0.4% (2)
4. Child Care/day care	16.2% (77)	22.3% (106)	44.5% (212)	16.6% (79)	0.4% (2)
5. After school programs	24.8% (118)	13.0% (62)	52.5% (250)	9.2% (44)	0.4% (2)
6. Children/Youth programs	29.4% (140)	14.3% (68)	48.7% (232)	7.4% (35)	0.2% (1)
7. Seniors programs (55+)	39.3% (187)	18.7% (89)	35.5% (169)	6.1% (1)	0.4% (2)
8. Recycling	58.2% (277)	28.6% (136)	3.2% (15)	9.9% (47)	0.2% (1)
9. Water and sewage	78.4% (373)	15.1% (72)	3.4% (16)	2.9% (14)	0.2% (1)
10. Garbage collection And disposal	89.1% (424)	8.2% (39)	1.5% (7)	0.8% (4)	0.4% (2)
11. Hazardous waste disposal	38.0% (181)	15.5% (74)	22.7% (108)	23.3% (111)	0.4% (2)
12. Community planning (Town Council)	61.6% (293)	20.4% (97)	13.7% (65)	4.0% (19)	0.4% (2)
13. Telephone	87.6% (417)	11.8% (56)	.4% (2)		0.2% (1)
14. Fire protection	93.9% (447)	3.4% (16)	1.9% (9)	0.6% (3)	0.2% (1)
15. Police	83.8% (399)	11.1% (53)	2.7% (13)	2.1% (10)	0.2% (1)
16. Libraries	77.3% (368)	3.4% (16)	10.7% (51)	8.2% (39)	0.4% (2)
17. Postal services	93.5%	4.8%	.2%	1.1%	0.4%

Community Services	Yes	No	Don't know	Not available	No response
	(445)	(23)	(1)	(5)	(2)
18. Banking	78.4% (373)	6.3% (30)	.2% (1)	14.9% (71)	0.2% (1)
19. Grocery stores	73.9% (352)	20.0% (95)		5.9% (28)	0.2% (1)
20. Shopping	37.6% (179)	39.3% (187)	1.5% (7)	21.2% (101)	0.4% (2)
21. Public transportation (Ex. buses, taxis)	45.2% (215)	14.7% (70)	14.5% (69)	25.4% (121)	0.2% (1)
22. Recreation programs	53.6% (255)	23.1% (110)	14.7% (70)	8.4% (40)	0.2% (1)
23. Recreation facilities	62.4% (297)	17.2% (82)	9.5% (45)	10.7% (51)	0.2% (1)
24. Career development services	38.2% (182)	9.9% (47)	35.1% (167)	16.6% (79)	0.2% (1)
25. Literacy support	30.7% (146)	8.4% (40)	41.6% (198)	18.9% (90)	0.4% (2)
26. Food bank	39.5% (188)	9.9% (47)	22.1% (105)	28.2% (134)	0.4% (2)

Health Related Community Services. Respondents were asked to report whether they were satisfied with a number of health related community services (See Table 4). Of those health related community services that respondents knew about or used (excluding the "don't know", "not available", and "no response" responses), respondents reported being more satisfied with: immunization services, telehealth and pharmacy services. When all of the responses were considered, the three health related community services with the higher percentages of satisfaction included pharmacy services, immunization services and ambulance services. Across the PHC areas, respondents reported being more satisfied with: immunization services, pharmacy services, telehealth and/or services for pregnant women/new mothers/babies. Higher percentages of

satisfaction with the health related community services of healthline, respiratory services and diabetes services was identified in only one PHC area.

There was variation across the PHC areas with respect to satisfaction with ambulance services, physician services and emergency health services.

Of those health related community services that respondents knew about or used (excluding the “don’t know”, “not available”, and “no response” responses), respondents reported being less satisfied with: addiction treatment centres, gambling addiction services and services for victims of sexual and physical abuse. When all of the responses were considered, the three health related community services with the lower percentages of satisfaction included physician services, emergency health services and services for people with disabilities. There was variation throughout the region (see Appendices D, E, F, G, and H). Comments indicated that dissatisfaction was related to the specific program or service not being available in that community, the lack of awareness about the availability of the program or service, or the long wait time for the program or service.

PHC area specific comments indicated that there were opportunities for improvement in the following areas: mental health and addiction programs, physician services, home and respite programs, and programs for disabled and seniors. Other PHC area specific comments included positive reports about nurse practitioners and programs such as Family Resource Centres.

Respondents were asked if there were barriers to accessing health related community services. Generally, comments indicated that lack of awareness, travel and transportation, weather, cost of travel, wait times for physicians, and lack of available programs and services were barriers to access.

Table 4. Percent Satisfied with Health Related Community Services

Health related Community Services	Yes	No	Don't know	Not available	No response
1. Mental health services	28.8% (137)	18.5% (88)	38.0% (181)	14.5% (69)	.2% (1)
2. Addiction services	25.2% (120)	16.8% (80)	42.6% (203)	15.1% (72)	.2% (1)
3. Drug addiction services	22.3% (106)	16.2% (77)	45.2% (215)	16.0% (76)	.4% (2)
4. Alcohol addiction services	22.9% (109)	16.4% (78)	45.0% (214)	15.3% (73)	.4% (2)
5. Gambling addiction services	20.2% (96)	15.3% (73)	47.9% (228)	16.4% (78)	.2% (1)
6. Addiction treatment centres	13.7% (65)	14.3% (68)	32.1% (153)	39.7% (189)	.2% (1)
7. Counselling services	25.6% (122)	15.3% (73)	39.7% (189)	19.1% (91)	.2% (1)
8. Family planning	27.3% (130)	7.4% (35)	50.8% (242)	14.1% (67)	.4% (2)
9. Sex education	25.4% (121)	8.4% (40)	56.3% (268)	9.2% (44)	.6% (3)
10. Ambulance services	77.7% (370)	10.7% (51)	7.6% (36)	3.6% (17)	.4% (2)
11. Emergency health services	63.7% (303)	25.4% (121)	7.8% (37)	2.9% (14)	.2% (1)
12. Income support services	45.8% (218)	13.0% (62)	36.1% (172)	4.8% (23)	.2% (1)
13. Home support services	55.0% (262)	16.2% (77)	26.3% (125)	2.1% (10)	.4% (2)
14. Respite care services	35.7% (170)	12.0% (57)	39.7% (189)	12.2% (58)	.4% (2)
15. Supportive housing (e.g. personal care home, alternate family care)	40.1% (191)	15.5% (74)	33.4% (159)	10.5% (50)	.4% (2)
16. Long term care	41.4% (197)	9.9% (47)	26.5% (126)	21.6% (103)	.6% (3)
17. Services for pregnant women	34.7% (165)	6.7% (32)	50.4% (240)	7.6% (36)	.6% (3)

Health related Community Services	Yes	No	Don't know	Not available	No response
18. Services for new mothers/ babies	39.1% (186)	4.2% (20)	48.5% (231)	7.4% (35)	.8% (4)
19. Services for seniors (e.g. foot care)	38.2% (182)	13.4% (64)	37.8% (180)	10.1% (48)	.4% (2)
20. Services for people with chronic diseases (disease longer than 3 months for example, asthma, diabetes, cancer)	25.8% (123)	18.1% (86)	42.0% (200)	13.4% (64)	.6% (3)
21. Wellness/Illness prevention	26.7% (127)	19.1% (91)	42.2% (201)	11.3% (54)	.6% (3)
22. Services for people with Disabilities	29.0% (138)	20.0% (95)	35.9% (171)	14.7% (70)	.4% (2)
23. Rehabilitation services	20.2% (96)	9.9% (47)	46.0% (219)	23.3% (111)	.6% (3)
24. Physiotherapy services	40.5% (193)	15.3% (73)	27.1% (129)	16.6% (79)	.4% (2)
25. Services for victims of physical or sexual abuse	14.7% (70)	11.1% (53)	54.2% (258)	19.5% (93)	.4% (2)
26. Adult day programs	19.7% (94)	8.6% (41)	35.3% (168)	35.9% (171)	.4% (2)
27. Meals on wheels type services	14.9% (71)	4.8% (23)	28.4% (135)	51.5% (245)	.4% (2)
28. Dental health services	54.8% (261)	16.0% (76)	8.0% (38)	20.6% (98)	.6% (3)
29. Health inspection services	25.8% (123)	7.1% (34)	46.0% (219)	20.6% (98)	.4% (2)
30. Pharmacy services	83.6% (398)	5.3% (25)	1.7% (8)	9.2% (44)	.2% (1)
31. Immunization services	80.7% (384)	2.5% (12)	12.6% (60)	3.6% (17)	.6% (3)
32. Health education services	39.3% (187)	6.5% (31)	47.3% (225)	6.5% (31)	.4% (2)
33. School health services	41.4% (197)	3.4% (16)	49.2% (234)	5.5% (26)	.6% (3)
34. Occupational therapy	26.1% (124)	7.1% (34)	46.4% (221)	19.7% (94)	.6% (3)

Health related Community Services	Yes	No	Don't know	Not available	No response
35. Physician services	63.9% (304)	29.8% (142)	2.5% (12)	3.4% (16)	.4% (2)
36. Nurse practitioner services	54.6% (260)	9.2% (44)	25.8% (123)	9.5% (45)	.8% (4)
37. Diabetes programs	30.0% (143)	7.6% (36)	48.3% (230)	13.2% (63)	.8% (4)
38. Chronic disease self-management program	14.7% (70)	4.8% (23)	64.5% (307)	15.1% (72)	.8% (4)
39. Primary Health Care Teams	22.5% (107)	3.2% (15)	65.1% (310)	8.2% (39)	1.1% (5)
40. Services for Young Offenders	18.5% (88)	11.8% (56)	54.8% (261)	13.7% (65)	1.3% (6)
41. Diagnostic Services	59.2% (282)	9.7% (46)	16.2% (77)	13.9% (66)	1.1% (5)
42. Child Protection Services	34.9% (166)	7.4% (35)	44.3% (211)	12.4% (59)	1.1% (5)
43. Adoption Services	19.1% (91)	5.3% (25)	58.4% (278)	16.2% (77)	1.1% (5)
44. Health Line	61.3% (292)	4.6% (22)	31.3% (149)	2.1% (10)	.6% (3)
45. Telehealth Services	33.4% (159)	1.7% (8)	54.6% (260)	9.5% (45)	.8% (4)
46. Cervical Screening	58.2% (277)	5.5% (26)	30.5% (145)	5.0% (24)	.8% (4)
47. Nutrition Services	46.6% (222)	7.4% (35)	33.8% (161)	11.1% (53)	1.1% (5)
48. Dietitian Services	49.8% (237)	5.9% (28)	31.7% (151)	12.0% (57)	.6% (3)
49. Respiratory Services	20.6% (98)	3.8% (18)	43.9% (209)	31.1% (148)	.6% (3)
50. Emergency Preparedness	33.8% (161)	4.2% (20)	54.6% (260)	6.5% (31)	.8% (4)
51. Speech and Hearing Services	31.9% (152)	12.8% (61)	35.1% (167)	18.9% (90)	1.3% (6)
52. Vision Services	50.2% (239)	18.7% (89)	12.6% (60)	17.4% (83)	1.1% (5)
53. Foot Care	29.6%	8.6%	41.2%	18.9%	1.7%

Health related Community Services	Yes	No	Don't know	Not available	No response
	(141)	(41)	(196)	(90)	(8)

Community Groups. Respondents were asked to report on whether they were satisfied with a number of community groups (See Table 5). Across the PHC areas, respondents recognized the work of community groups and the events in their communities. Respondents reported on many community groups and activities that influence their efforts to be healthy including;

- Community Advisory Committee Initiatives (e.g., community kitchens, community café, and community gardens, and lunch time nutrition programs)
- Volunteer groups (e.g., TOPS, seniors groups, Search and Rescue, church groups, Sea Cadets, snowmobile groups, Children's Wish Foundation, Ski Patrol, and volunteer fire departments/brigade)
- Community events and activities (e.g., darts, bingo, dances, quilting, Winterfest, Santa Claus parade, Kids Marathon group, Strawberry Festival, fall and spring fairs, and memorial tournaments)
- Organized sports (swimming, skating, and hockey)
- Walking Trails and use of school gyms to promote physical activity and socialization
- Recreation facilities

Table 5. Percent Satisfied with Community Groups

Community Groups	Yes	No	Don't know	Not available	No response
1. Self Help/Support Groups	51.5% (245)	4.6% (22)	20.6% (98)	19.1% (91)	4.2% (20)
2. Town Councils	55.9% (266)	21.4% (102)	13.2% (63)	5.5% (26)	4.0% (19)
3. Service Organizations (e.g. Kinsmen, Knights of Columbus,	64.9% (309)	5.0% (24)	12.0% (57)	13.9% (66)	4.2% (20)

Lion's Club)					
4. Churches	76.1% (362)	7.6% (36)	10.9% (52)	1.3% (6)	4.2% (19)
5. Sports Clubs (e.g. minor hockey, softball)	63.7% (303)	4.2% (20)	12.4% (59)	15.3% (73)	4.4% (21)
6. Recreation Clubs (e.g. Girl Guides, Cadets)	64.1% (305)	3.4% (16)	13.7% (65)	14.3% (68)	4.6% (22)
7. School Council	48.9% (233)	4.8% (23)	35.9% (171)	5.9% (28)	4.4% (21)
8. Health Related Groups (e.g. Cancer Society, Lung Association, Seniors Wellness)	51.9% (247)	8.2% (39)	19.5% (93)	15.8% (75)	4.6% (22)
9. Advocacy Groups (e.g. Status Of Women, Tobacco Free Network)	42.9% (204)	3.2% (15)	27.9% (133)	21.2% (101)	4.8% (23)
10. Family Resource Center (e.g. Healthy Baby Clubs)	59.7% (284)	1.3% (6)	22.9% (109)	11.6% (55)	4.6% (22)
11. Hospital Foundations and Auxiliary Groups	57.1% (272)	2.7% (13)	22.5% (107)	13.0% (62)	4.6% (22)
12. Western Health Community Advisory Committee	43.9% (209)	.8% (4)	41.6% (198)	8.6% (41)	5.0% (24)

Community Concerns. Survey respondents were asked to indicate whether a list of potential community concerns were actual concerns for their community. Of those community concerns that respondents knew about (excluding the "don't know", "not available", and "no response" categories), respondents reported being more concerned with: cancer, diabetes and high blood pressure (see Table 6). When all of the responses were considered, the three community concerns with the higher percentages included cancer, diabetes and outmigration. Across the PHC areas, respondents reported being concerned with: cancer, diabetes, distracted driving, outmigration, unhealthy eating habits and/or high blood pressure. The community concern of physical activity was among the top concerns in only one PHC area.

Other community concerns that were noted by the respondents and not on the survey list included:

- Loitering
- Cat population
- Disrepair of sidewalks
- Lack of discipline and respect in youth.

Table 6. Community Concerns

Community Concerns	Yes	No	Don't know	Not available	No response
1. Drinking and driving	68.5% (326)	24.6% (117)	5.7% (27)	.4% (2)	.8% (4)
2. Distracted driving	75.2% (358)	20.6% (98)	3.2% (15)	.4% (2)	.6% (3)
3. Alcohol abuse	63.0% (300)	26.5% (126)	9.9% (47)	.2% (1)	.4% (2)
4. Loneliness	63.7% (303)	17.6% (84)	17.6% (84)	.4% (2)	.6% (3)
5. Suicide	13.2% (63)	27.7% (132)	10.3% (49)		48.7% (232)
6. Age Friendly/Senior Friendly	27.5% (131)	60.7% (289)	10.9% (52)	.2% (1)	.6% (3)
7. Care of the older person	34.5% (164)	51.9% (247)	12.8% (61)	.4% (2)	.4% (2)
8. Care of People with disabilities	31.1% (148)	47.9% (228)	19.5% (93)	.6% (3)	.8% (4)
9. Mental health problems	43.7% (208)	35.9% (171)	19.5% (93)	.2% (1)	.6% (3)
10. Unhealthy eating habits	69.3% (330)	18.9% (90)	10.9% (52)	.2% (1)	.6% (3)
11. Elder Abuse	27.5% (131)	46.2% (220)	25.4% (121)	.2% (1)	.6% (3)
12. Illegal drug use	70.6% (336)	13.0% (62)	15.5% (74)	.2% (1)	.6 (3)
13. Abuse of prescription drugs	50.4% (240)	24.2% (115)	24.6% (117)	.2% (1)	.6% (3)
14. Abuse of over the counter drugs	43.5% (207)	25.8% (123)	29.6% (141)	.2% (1)	.8% (4)
15. Unemployment	60.9% (290)	30.5% (145)	7.1% (34)	.2% (1)	1.3% (6)
16. Smoking	67.4% (321)	22.3% (106)	9.2% (44)	.2% (1)	.8% (4)
17. Physical inactivity	67.9% (323)	23.3% (111)	7.4% (35)	.2% (1)	1.2% (6)
18. Poverty	37.8%	48.5%	12.6%	.2%	.8%

Community Concerns	Yes	No	Don't know	Not available	No response
	(180)	(231)	(60)	(1)	(4)
19. Gambling	52.3% (249)	27.5% (131)	18.9% (90)	.4% (2)	.8% (4)
20. Illiteracy	34.5% (164)	40.5% (193)	23.5% (112)	.4% (2)	1.0% (5)
21. Garbage disposal	20.4% (97)	65.5% (312)	12.8% (61)	.2% (1)	1.1% (5)
22. Water pollution	21.0% (100)	64.5% (307)	13.0% (62)	.2% (1)	1.3% (6)
23. Noise pollution	13.0% (62)	75.8% (361)	9.7% (46)	.6% (3)	.8% (4)
24. Road accidents	19.5% (93)	67.0% (319)	11.3% (54)	1.1% (5)	1.0% (5)
25. Housing conditions	23.7% (113)	61.3% (292)	13.2% (63)	.4% (2)1	.3% (5%)
26. Homelessness (e.g. couch surfing)	13.7% (65)	69.3% (330)	16.0% (76)	.2% (1)	.8% (4)
27. Crime	32.4% (154)	59.5% (283)	7.1% (34)	.2% (1)	.8% (4)
28. Vandalism	41.0% (195)	50.8% (242)	7.1% (34)	.2% (1)	.8% (4)
29. Bullying	47.5% (226)	31.1% (148)	20.6% (98)	.2% (1)	.8% (4)
30. Violence in the home	26.9% (128)	35.5% (169)	36.6% (174)	.2% (1)	.8% (4)
31. Violence in the community	23.3% (111)	56.5% (269)	19.1% (91)	.2% (1)	.8% (4)
32. Child abuse/Neglect	27.9% (133)	42.6% (203)	27.9% (133)	.2% (1)	1.3% (6)
33. Sexual abuse	22.5% (107)	41.4% (197)	34.9% (166)	.2% (1)	1.1% (5)
34. Personal safety	15.3% (73)	69.3% (330)	13.9% (66)	.2% (1)	1.3% (6)
35. On the job risks for injury	21.6% (103)	52.5% (250)	24.4% (116)	.2% (1)	1.3% (6)
36. Parenting difficulties	38.4% (183)	31.5% (150)	28.6% (136)	.2% (1)	1.3% (6)
37. Teenage pregnancy	32.8% (156)	38.2% (182)	27.3% (130)	.2% (1)	1.5% (7)
38. Young people in trouble with the law	38.7% (184)	35.3% (168)	24.4% (116)	.2% (1)	1.5% (7)
39. Unplanned pregnancy	25.6% (122)	37.6% (179)	34.9% (166)	.4% (2)	1.5% (7)

Community Concerns	Yes	No	Don't know	Not available	No response
40. Abortion counselling	12.8% (61)	32.6% (155)	49.6% (236)	3.2% (15)	1.9% (9)
41. Education system concerns	22.7% (108)	40.1% (191)	34.9% (166)	.8% (4)	1.5% (7)
42. Day care problems for children	30.3% (144)	25.0% (119)	33.0% (157)	10.3% (49)	1.5% (7)
43. Dental health	26.9% (128)	47.3% (225)	23.1% (110)	1.9% (9)	.8% (4)
44. High blood pressure	73.3% (349)	11.8% (56)	13.9% (66)	.4% (2)	.6% (3)
45. Stoke	50.4% (240)	29.8% (142)	18.9% (90)	.2% (1)	.6% (3)
46. Heart disease	68.3% (325)	16.8% (80)	14.1% (67)	.2% (1)	.6% (3)
47. Circulatory problems	47.1% (224)	24.2% (115)	27.9% (133)	.2% (1%)	.6% (3)
48. Cancer	88.4% (421)	5.7% (27)	4.8% (23)	.2% (1)	.8% (4)
49. Diabetes	80.9% (385)	9.7% (46)	8.4% (40)	.2% (1)	.6% (3)
50. Eating disorders	33.0% (157)	34.2% (163)	31.7% (151)	.2% (1)	.8% (4)
51. Hepatitis (or other liver disease)	13.9% (66)	38.2% (182)	46.6% (222)	.4% (2)	.8% (4)
52. Sexually transmitted infections	20.2% (96)	33.2% (158)	45.4% (216)	.4% (2)	.8% (4)
53. HIV/AIDS	14.3% (68)	41.0% (195)	43.3% (206)	.4% (2)	1.1% (5)
54. Lung disease	38.0% (181)	31.9% (152)	28.6% (136)	.2% (1)	1.3% (6)
55. Kidney disease	32.6% (155)	35.1% (167)	30.7% (146)	.2% (1)	1.5% (7)
56. Out migration	79.2% (377)	14.5% (69)	5.5% (26)	.2% (1)	.6% (3)
57. Access to health services	55.0% (262)	39.7% (189)	4.2% (20)	.4% (2)	.6% (3)
58. Littering	53.8% (256)	39.3% (187)	5.5% (26)	.2% (1)	1.3% (6)
59. Access for people with disabilities	35.9% (171)	50.8% (242)	10.9% (52)	.8% (4)	1.5% (7)

Other. In all PHC areas, the majority of respondents indicated that they get their health information from the doctor, followed closely by the internet. Respondents in some PHC areas also indicated that they get health information from the pharmacist, health line or family. When respondents were asked about the strengths of living in their respective communities, community pride and spirit were evident. Generally, respondents reported that their communities are safe, beautiful, clean, and friendly and community support is highly valued.

Survey Highlights. Based on survey results, the highlights included:

- of those community services about which respondents knew or used, respondents reported being more satisfied with fire protection, postal services, libraries, university/college, banking, schools and/or garbage collection. There was little variation throughout the region;
- of those community services about which respondents knew or used, respondents reported being less satisfied with child care/day care, shopping, recycling, recreation programs/facilities and/or after school/children and youth programs. There was little variation throughout the region;
- of those health related community services about which respondents knew or used, respondents reported being more satisfied with immunization services, pharmacy services, telehealth and/or services for pregnant women/new mothers/babies. There was variation across the PHC areas with respect to satisfaction with ambulance services, physician services and emergency health services;
- of those health related community services about which respondents knew or used, respondents reported being less satisfied with addiction treatment centres, gambling addiction services, services for victims of sexual and physical abuse, physician services, emergency health services and/or services for people with disabilities. There was variation across the PHC

areas. Based on respondent comments, satisfaction varied throughout the region as a result of availability, awareness, and wait times;

- barriers to accessing health related community services included lack of awareness, travel and transportation, cost of travel, wait times for doctors and mental health services, lack of available programs and services, and weather;
- community groups influenced the health of the community through activities and events;
- of those community concerns about which respondents knew, respondents reported being concerned with: cancer, diabetes, outmigration, distracted driving, unhealthy eating habits and/or high blood pressure. There was little variation throughout the region;
- health information was typically accessed through doctors and the internet;
- all PHC area reports identified community strengths as being safety, cleanliness, beauty and sense of community support. Other strengths identified were technology and community services and support;
- opportunities for improvement included cancer, diabetes and high blood pressure (chronic disease) prevention and management, health eating, and reducing concerns with outmigration and distracted driving.

Focus Group and Key Informant Interviews

Focus group and key informant interview results are described in PHC area reports in Appendices D, E, F, G, and H.

Health Status and Community Assets

Health status statistics and community assets listings are outlined in PHC area reports in Appendices D, E, F, G, and H.

Discussion

The CHNRA process was a thorough and comprehensive method to collect information about community health needs and resources throughout the Western region. There were many strengths in the development and implementation of this process. Most crucial to this process was that the individuals involved in the development and implementation of the CHN&R Assessment process were engaged and dedicated to learning more about the PHC areas throughout the Western region. Despite some challenges encountered in this new process, individuals continued to move forward in the successful completion of the CHNRA. These challenges will be further explored in the evaluation of the CHNRA process.

The CHNRA utilized a methodology in keeping with the best practice literature. Data was collected using multiple methods from multiple sources. The data was validated through this methodology. In addition, the community members had an opportunity to express their perspectives through participation in the surveys, focus groups, and/or key informant interviews. Ensuring that all segments of the population were engaged was critical. Two of the PHC areas had high numbers of Francophone and Aboriginal community members. Through focus group participation, these groups were given an opportunity to participate in the CHNRA process thereby strengthening the study findings.

The CHNRA had three primary purposes. These were to 1. identify health and community strengths and needs in each PHC area; 2. identify whether there are any differences in the PHC areas throughout the Western region in terms of health and community strengths and needs; 3. determine whether there are any differences in any of the PHC areas compared to the overall Western region. These objectives were achieved. Although there were some differences in the PHC areas throughout the Western region, the strengths and priority concerns in the individual PHC areas were not unlike those experienced by the overall region.

The Appendices D, E, F, G and H provide detailed descriptions of findings by PHC area(s). In general, findings indicate many strengths related to the use of technology, specifically telehealth, and community services and support. Overall, access to health care programs and services and community services, chronic disease prevention and management, and health promotion and wellness were cited as key challenges confronting community members in the PHC areas. The following sections provide a discussion of the findings, assess similarities and differences and provide recommendations for the Western region.

Strengths

Community Services and Support. Members of communities throughout all PHC areas in the Western region discussed the strengths of their communities as they reflected on all of the available services and their satisfaction with each service. In addition, the sense of community belonging, support and safety was shared. In fact, regionally, survey respondents reported personal safety to be one of the lowest three community concerns. Survey respondents indicated that they have beautiful communities, their communities are safe, and people in the community support one another.

The Canadian Community Health Survey (2010) supports these findings as residents of the Western region tend to have a greater sense of community belonging than the province and Canada; 82% in the Western region, 80.1% in the province and 65.4% in Canada.

Although the community assets listings indicated that many structured programs and services, self-help groups, and nonprofit organizations were not available throughout all PHC areas, the strengths shared by community members suggested that informal community networking underlies and defines the Newfoundland culture. The satisfaction with community groups information from the survey

suggested that informal community networking was supported by churches, service organizations and recreation clubs.

Rural Access. The survey respondents who knew about or used telehealth services also rated their satisfaction with the service highly. Western Health's provision of programs and services through technology such as telehealth has enhanced access for clients throughout the Western region. Telehealth initiatives include tele-diabetes, tele-psychiatry and many others. Efforts to expand telehealth continue.

Partnerships and collaboration have also enhanced services to clients in rural and isolated areas of the Western region. Examples of partnerships and collaboration include outreach and/or travelling clinics/team services and Emergency First Responders. Western Health continues to work to enhance access to programs and services throughout the region through partnerships, communication, collaboration, and technology.

Opportunities for Improvement

Access. Access to health care programs and services in the Western region was reported to be hampered by availability, lack of awareness, public transportation, weather, and wait times. These issues were particularly problematic in the more rural and isolated communities throughout the Western region. In specific PHC areas, development of information in the French language, cultural sensitivity related to the aboriginal population. Comments from respondents suggested that access to child care, recreation, specific mental health or addictions services and specific community support services contributed to lower satisfaction with the services. Although specific issues related to access were identified, access in general was reported to be a significant barrier throughout the Western region in both the CHNRA surveys and focus groups.

Further analysis of community assets and regional demographics provided evidence of the challenges related to access. It is evident from community assets listings that the lack of programs and services was problematic in some of the more rural and isolated areas. Population statistics also indicated that the regional population was geographically diverse and provision of programs and services in those rural and isolated areas was challenging. However, partnerships, collaboration, communication and technology can help reduce the impact of access issues throughout the Western region. Some of the examples of service and/or service delivery options that can help reduce access issues, from the PHC area reports, include travelling clinics, Emergency First Responders and telehealth. Western Health has also used wait list management approaches to improve access to services, including identifying priorities for service and managing service provider work to support timely access, in keeping with the priority.

Chronic Disease Prevention and Management. Chronic disease was commonly cited by residents of the PHC areas as being a community concern. In some areas, diabetes was considered to be most problematic while in other areas, cancer was considered to be the top concern. Issues related to chronic disease prevention and management were reported in the CHNRA surveys and also discussed at length in focus groups.

Statistics Canada provided extensive statistics related to chronic disease which supported these concerns. According to the Canadian Community Health Survey (2010), chronic diseases such as diabetes, high blood pressure, and colon cancer are higher in the Western region than in the province and nation (See Table 7). The incidence of chronic diseases, in general, is of concern for the residents in all PHC areas throughout the Western region and is evident in the statistics.

Table 7. Diabetes, High Blood Pressure, and Colon Cancer in the Western region, NL, and Canada

Disease	Western Health	NL	Canada
Diabetes (%)	9.3%	8.2%	6.2%
High Blood Pressure (%)	24.5%	22.9%	17.0%
Colon Cancer (rate per 100,000)	69.2	68.7	49.9

Programs and services for individuals across the region to support them in preventing chronic diseases or managing their diseases varied. As was evident in the community assets, some areas had self-help groups, volunteer groups, programs and services, and appropriate health care professionals to help support individuals diagnosed with chronic diseases or prevent disease occurrence, however, this availability was not standard in all PHC areas across the region. Overall, chronic disease prevention and management, through enhanced knowledge related to healthy eating and physical activity, was a theme from the discussions. Partnerships, collaboration, communication and technology can be utilized in chronic disease prevention and management throughout the Western region.

One of the goals in Western Health's Strategic Plan for 2011-2014, is to enhance programs and services in diabetes management to respond to the identified concerns of residents in the Western region. To achieve this goal, Western Health has initiated work with partners, including community advisory committees in the PHC areas. This work is addressing improving access to services (through awareness and telehealth), improving self-management support and evaluating the quality of services. This approach to working with community partners to improve diabetes management may guide ongoing efforts to address community concerns with chronic disease prevention and management.

Health Promotion and Wellness. Directly linked to chronic disease prevention and management were issues related to healthy behaviors, practices, and overall lifestyles. Across all PHC areas, challenges related to health promotion and wellness were discussed. The surveys indicated that many PHC area participants believe that healthy eating is a significant challenge for their areas and this concern was discussed at the Burgeo and Deer Lake and White Bay South focus groups. Some PHC areas also discussed challenges related to obesity, lack of physical activity, and the lack of fresh fruits and vegetables. In two of the PHC areas, but not regionally, distracted driving was in the top three areas of community concern.

The community assets listings provided data to determine whether these challenges were factual for the area or whether there was a lack of awareness related to the availability of programs and services in the community. A review of the community assets information indicated inconsistencies across the region in terms of available programs and services to support residents' efforts to maintain a healthy lifestyle. In some areas, programs and services such as recreation programs or facilities were not available to residents. Also, self-help groups, nonprofit groups, or appropriate professionals to support individuals in their efforts to be healthy were not available in many communities. Information and statistics obtained through the Canadian Community Health Survey supported these concerns about health related behaviours. Although rates of healthy behaviors are improving, tobacco use, physical inactivity, lack of consumption of fruits and vegetables, and obesity rates continue to be issues for the Western region (See Table 8).

Table 8. Health Behaviors

Health Behavior	Western Health	NL	Canada
Current Smoker (%)	24.7%	23.1%	20.4%

Physically active (%)	53.5%	47.4%	52.3%
Consumption of Fruits/Vegetables at least 5 times per day (%)	37.5%	29.0%	44.2%
Overweight or obese (%)	63.7%	63.9%	52.0%

In addition to the Canadian Community Health Survey statistics, information was obtained from the Comprehensive School Health Assessment (2013). Results from the Comprehensive School Health Assessment indicated that as children grow older, eating breakfast everyday decreased. In fact, in grade 12, only 38% of those who participated in the Comprehensive School Health Assessment ate breakfast everyday compared to 84 percent in Kindergarten. Further to this, the Comprehensive School Health Assessment reported that children's activity levels also decreased with age and the number of hours spent being sedentary increased. Nearly 85% of the Comprehensive School Health Assessment participants in grade 7 reported being active for more than 30 minutes a day for at least 4 days per week compared to 65% in grade 12. Nearly 43% of grade 7 students participating in the assessment spent more than 3 hours per day sitting down and by grade 12, this percent increased to 71.

Enhancement of partnerships, collaboration, and communication and technology to support healthy behaviors throughout the Western region may reduce some of the challenges related to wellness. One of the goals in Western Health's Strategic Plan for 2011-2014, is to enhance health promotion through the implementation of priority initiatives to support improving population health. Western Health has commenced many initiatives to achieve this goal. Since 2011, Western Health has added information on healthy eating and physical activity to its website and worked with schools to promote healthy eating and physical activity. The Community Advisory Committees have dedicated significant efforts to health promotion activities. In 2012-13, Western Health facilitated a community forum in each of the PHC areas to identify opportunities to promote physical activity and

healthy eating for the promotion of healthy weights and the prevention of obesity. Working with community partners, the implementation of actions from the forums was initiated.

Outmigration. Outmigration was among the top community concerns in all but one PHC area report. Opportunities to explore this concern, at a PHC area level, and identify the partnerships and collaboration that may reduce the concern with outmigration exist.

Distracted Driving. Distracted driving was among the top community concerns in all but one PHC area report. Opportunities to explore this concern, at a PHC area level, and identify the actions that may reduce distracted driving and/or the injuries/harm from distracted driving, exist.

Limitations

Although there were many strengths in this CHNRA process, limitations were identified. As previously mentioned, the average age of survey respondents was 53.51. In fact, only 19.5% of the respondents were under the age of 40. The community health needs and resources outcomes are based more on the perspectives of the middle aged to elderly population. However, it must be noted that youth input was incorporated in this report through the findings outlined in the Comprehensive School Health Assessment Summary Report (Pye, 2013).

Analysis of CHNRA survey data indicated that there were high percentages of "don't know" and "not available" responses on many questions related to awareness of, or satisfaction with, health and community programs and services. It can be speculated that a high number of "don't know" responses could have been a result of either the survey respondents needing specific programs and services but not being aware of them or not needing the specific programs or services and therefore not being aware of them. These responses were considered

when identifying recommendations.

Recommendations

These recommendations are based on the findings from all components of the CHNRA from all PHC areas throughout the Western region.

Western Health should:

1. continue to enhance communication regarding available programs and services at Western Health to increase awareness of Western Health programs and services and support access. Two strategies may increase awareness throughout the region:
    a. since many of the residents of the Western region obtain health related information from the internet, Western Health should continue to promote, maintain and update its website;
    b. many residents throughout the Western region also obtain information from their physicians so Western Health should continue to work with physicians throughout the region to provide up to date information related to Western Health's programs and services;

2. continue to enhance access to programs and services through the use of telehealth, outreach and/or traveling clinic/team services, as appropriate to rural and isolated areas;

3. continue to use wait list management approaches to enhance access to programs and services, in particular mental health and addictions;

4. continue to enhance service delivery, in keeping with the chronic disease

prevention and management model, to families living with chronic diseases, in particular, diabetes and cancer;

5. continue to work with communities and partners to enhance access to information on healthy behaviours, support personal skill development and/or strengthen community action, for healthy eating and physical activity;

6. consider opportunities to improve collaboration with the Aboriginal and Francophone communities, to enhance assessment, planning and/or service provision;

7. share the information from the PHC area CHNRA with stakeholders and use the information to inform PHC planning, including PHC area specific priorities and opportunities, and Western Health strategic planning.

8. evaluate the CHNRA process and outcomes involving all partners.

References

Government of Newfoundland and Labrador. (2013). Statistics Canada 2010 Census Data.

MacDonald, S., Twomey, C., Bennett, L., Best, D., & Blakeley, J. (2009). *A Summary Report on the Community Health Needs and Resources Assessment of the Western Region*. Memorial University of Newfoundland, School of Nursing.

Public Health Agency of Canada. (2001). Retrieved May 2013 from http://www.phac-aspc.gc.ca/ph-sp/pdf/discussion-eng.pdf

Pye, U. (2013). Comprehensive School Health Assessment Summary Report. *Unpublished Manuscript.*

Statistics Canada. (2013). Canadian Community Health Survey. Retrieved May 2013 from http://www12.statcan.gc.ca/health-sante/82-228/details/page.cfm?Lang=E&Tab=1&Geo1=HR&Code1=1013&Geo2=PR&Code2=01&Data=Rate&SearchText=Canada&SearchType=Contains&SearchPR=01&B1=All&Custom=

Western Health. (2011). Western Health's 2011-2014 Strategic Plan. *Unpublished Manuscript.*

Appendix A

Community Health Needs and Resources Assessment Policy

CATEGORY:	**ORGANIZATONAL - CLIENT/COMMUNITY RELATIONS**
SUB-CATEGORY:	**COMMUNITY RELATIONS WITH WESTERN HEALTH**
GROUP:	
DISTRIBUTION:	**ALL STAFF**
TITLE:	**COMMUNITY HEALTH NEEDS AND RESOURCES ASSESSMENT**

PURPOSE

To identify the processes used in assessing community health needs and resources to support planning within Western Health.

POLICY

The Community Health Needs and Resources Assessment (CHNRA) must be completed every three years. The CHNRA will be used for organizational strategic planning and primary health care team planning

Primary Health Care Managers must:
1. Utilize the Community Health Needs and Resources Assessment Template (Appendix A) to complete the team area report.
2. Consult with the Regional Manager of Research and Evaluation.
3. Forward the Community Health Needs and Resources Assessment team area reports to the Regional Director of Health Promotion and Primary Health Care.

The Regional Director of Health Promotion and Primary Health Care (PHC) must:
1. Forward Community Health Needs and Resources Assessment team area reports to the Regional PHC Management Team for feedback.
2. Once feedback is received, forward team area reports to VP Population Health and VP Quality Management and Research for approval.
3. Once approved, forward approved team area reports to Regional Manager of Research and Evaluation.

The Regional Manager of Research and Evaluation must:
1. Provide expertise on data collection and analysis.

2. In the third year, complete the Community Health Needs and Resources Assessment, which includes a synthesis of the team area reports and the annual Western Health Environmental Scan.
3. Place the Community Health Needs and Resources Assessment on the Planning and Research Intranet site.

REFERENCES

Western Health (2009). A Summary Report on the Community Health Needs and Resources Assessment Study of the Western Region.

The New Brunswick Health and Wellness (2002). The New Brunswick Community Health Needs Assessment. Author.

KEYWORDS

Community Health Needs and Resources Assessment, CHNRA, Primary Health Care, Primary Health Care Managers, Needs Assessment, Needs Assessments

Approved By: Chief Executive Officer	Maintained By: Regional Director of Health Promotion and Primary Health Care
Effective Date: 06/August/2010	☐ Reviewed: ☐ Revised: *(Date of most recent changes to the policy)*
Review Date: 06/August/2013	☐ Replaces: *(Indicates name and number of policy being replaced) OR* ☑ New

APPENDIX A

Community Health Needs and Resources Assessment Template

Four categories of information in a Community Health Needs and Resources Assessment:

1. Health Status (statistics)
2. Community Assets (profile)
3. Health needs identified by community (survey)
4. Public feedback (key informants, focus groups, consultation with community advisory committee)

	Data to be Collected	Source	Timeframe
1. Collect data for health status (statistics)			Every 3 years commencing January 2012
	Population	Community accounts	
	Age groupings	Community accounts	
	Communities in area	Organizational Data	
	Migration	Community accounts	
	Birth rates	Newfoundland and Labrador Centre for Health Information	
	Mortality rates	Newfoundland and Labrador Centre for Health Information	
	Overall school enrolment	Community accounts	
	Income	Community accounts	
	Employment	Community accounts	
	Education	Community accounts	
	Well being	Canadian Community Health Survey	
	Self assessment of health	Canadian Community Health Survey	
	Tobacco use	Canadian Tobacco Use Monitoring Survey	
	Alcohol use	Canadian Community Health Survey	

	Data to be Collected	Source	Timeframe
	Obesity	Canadian Community Health Survey	
	Physical activity	Canadian Community Health Survey	
	Cervical Screening	CSI Coordinator	
	Breast Screening rates	Canadian Community Health Survey	
	Consumption of fruits and veggies	Canadian Community Health Survey	
	Breastfeeding		
	Flu vaccine uptake	Canadian Community Health Survey Organizational Data	
	HPV	Organizational Data	
	Child immunization	Organizational Data	
	Circulatory diseases	Health Indicators Report	
	Respiratory diseases	Health Indicators Report	
	Cardiovascular disease	Health Indicators Report	
	Cancer	Health Indicators Report	
	Other (unintentional injury data)	Health Indicators Report	
2. Community assets		Community Advisory Committee, staff of Western Health, community key stakeholders/members	January to December every three years commencing January 2012
	Churches		
	Daycares		
	Public facilities		
	Health facilities		
	Recreational facilities		
	Community agencies and Volunteer organizations		

	Data to be Collected	Source	Timeframe
	Business and private sector		
	Environment		
	Libraries		
	Schools		
	Fire halls		
	Police		
3. Health needs identified by survey		Standardized Survey	Develop survey between September 2011 and December 2011
			Conduct survey every three years commencing January 2012
	School Assessments	Public Health Nurses	
4. Public feedback		Key informants, focus groups based on survey findings	Conduct focus groups or key informant interviews every three years commencing September 2012. Prepare final report by April every three years commencing April 2013

Final Community Health Needs and Resources Assessment team area reports to be forwarded to the Regional Manager Research and Evaluation every three years commencing April 2013.

The Community Health Needs and Resources Assessment will be completed every three years commencing August 2013.

Appendix B

Community Health Needs and Resources Assessment Survey

Demographics:

Questionnaire completed by: male __________ or female ___________

Age: __________

Years living in the community: __________

Are you satisfied with the following community services?

Community Services	Yes	No	Don't know	Not Available
1. Preschool programs	1	2	3	4
2. Schools	1	2	3	4
3. University / College	1	2	3	4
4. Child Care/day care	1	2	3	4
5. After school programs	1	2	3	4
6. Children/Youth programs	1	2	3	4
7. Seniors programs (55+)	1	2	3	4
8. Recycling	1	2	3	4
9. Water and sewage	1	2	3	4
10. Garbage collection and disposal	1	2	3	4
11. Hazardous waste disposal	1	2	3	4
12. Community planning (Town Council)	1	2	3	4
13. Telephone	1	2	3	4
14. Fire protection	1	2	3	4
15. Police	1	2	3	4
16. Libraries	1	2	3	4
17. Postal services	1	2	3	4
18. Banking	1	2	3	4
19. Grocery stores	1	2	3	4
20. Shopping	1	2	3	4
21. Public transportation (Ex. buses, taxis)	1	2	3	4
22. Recreation programs	1	2	3	4
23. Recreation facilities	1	2	3	4
24. Career development services	1	2	3	4

25. Literacy support	1	2	3	4
27. Food bank	1	2	3	4
Are there other community services that were not in this list that you would like to add?				

Are you satisfied with the following health related community services?

Health Related Community Services	Yes	No	Don't know	Not Available
28. Mental health services	1	2	3	4
29. Addiction services	1	2	3	4
30. Drug addiction services	1	2	3	4
31. Alcohol addiction services	1	2	3	4
32. Gambling addiction services	1	2	3	4
33. Addiction treatment centres	1	2	3	4
34. Counselling services	1	2	3	4
35. Family planning	1	2	3	4
36. Sex education	1	2	3	4
37. Ambulance services	1	2	3	4
38. Emergency health services	1	2	3	4
39. Income support services	1	2	3	4
40. Home support services				
41. Respite care services	1	2	3	4
42. Supportive housing (e.g. personal	1	2	3	4
care home, alternate family care)	1	2	3	4
43. Long term care	1	2	3	4
44. Services for pregnant women	1	2	3	4
45. Services for new mothers/babies	1	2	3	4
46. Services for seniors (e.g. foot care)	1	2	3	4
47. Services for people with chronic	1	2	3	4
diseases (disease longer than 3 months	1	2	3	4
for example, asthma, diabetes, cancer)	1	2	3	4

48. Wellness/Illness prevention	1	2	3	4
49. Services for people with	1	2	3	4
disabilities	1	2	3	4
50. Rehabilitation services	1	2	3	4
51. Physiotherapy services	1	2	3	4
52. Services for victims of physical or	1	2	3	4
sexual abuse	1	2	3	4
53. Adult day programs	1	2	3	4
54. Meals on wheels type services	1	2	3	4
55. Dental health services	1	2	3	4
56. Health inspection services	1	2	3	4
57. Pharmacy services	1	2	3	4
58. Immunization services	1	2	3	4
59. Health education services	1	2	3	4
60. School health services	1	2	3	4
61. Occupational therapy	1	2	3	4
62. Physician services	1	2	3	4
63. Nurse practitioner services	1	2	3	4
64. Diabetes programs	1	2	3	4
65. Chronic disease self-management program	1	2	3	4
66. Primary Health Care Teams	1	2	3	4
67. Services for Young Offenders	1	2	3	4
68. Diagnostic Services	1	2	3	4
69. Child Protection Services	1	2	3	4
70. Adoption Services	1	2	3	4
71. Health Line	1	2	3	4
72. Telehealth Services	1	2	3	4
73. Cervical Screening	1	2	3	4
74. Nutrition Services	1	2	3	4

75. Dietitian Services	1	2	3	4
76. Respiratory Services	1	2	3	4
77. Emergency Preparedness	1	2	3	4
78. Speech and Hearing Services	1	2	3	4
79. Vision Services	1	2	3	4
80. Foot Care				

Are there other health related community services that were not in this list that you would like to comment on? (Please explain reasons if you are not satisfied with these services)

Are there barriers to accessing any of these services?

Do you think that any of the following community groups improve the health of your community?

Community Groups	Yes	No	Don't Know	Not Available
81. Self Help/Support Groups	1	2	3	4
82. Town Councils	1	2	3	4
83. Service Organizations (e.g. Kinsmen,	1	2	3	4
Knights of Columbus, Lion's Club)	1	2	3	4
84. Churches	1	2	3	4
85. Sports Clubs (e.g. minor hockey,	1	2	3	4
softball)	1	2	3	4
86. Recreation Clubs (e.g. Girl Guides,	1	2	3	4
Cadets)	1	2	3	4
87. School Council	1	2	3	4
88. Health Related Groups (e.g. Cancer	1	2	3	4
Society, Lung Association, Seniors	1	2	3	4
Wellness)				
89. Advocacy Groups (e.g. Status of	1	2	3	4
Women, Tobacco Free Network)	1	2	3	4

90. Family Resource Center (e.g. Healthy Baby Clubs)	1	2	3	4
91. Hospital Foundations and Auxiliary	1	2	3	4
Groups	1	2	3	4
91. Western Health Community Advisory Committee	1	2	3	4
Are there other community groups that are not in this list that you would like to comment on who influence the health of your community?				
Please provide examples of how your community supports your efforts to be healthy.				

Do you feel any of the following are problems in your community?

Please include age group of those you are concerned about?

Community Concerns	Yes	No	Don't Know	Not Available
92. Drinking and driving	1	2	3	4
93. Distracted driving	1	2	3	4
94. Alcohol abuse	1	2	3	4
95. Loneliness	1	2	3	4
96. Suicide	1	2	3	4
97. Age Friendly/Senior Friendly	1	2	3	4
98. Care of the older person	1	2	3	4
99. Care of People with disabilities	1	2	3	4
100. Mental health problems	1	2	3	4
101. Unhealthy eating habits	1	2	3	4
102. Elder abuse	1	2	3	4
103. Illegal drug use	1	2	3	4
104. Abuse of prescription drugs	1	2	3	4
105. Abuse of over the counter drugs	1	2	3	4

106. Unemployment	1	2	3	4
107. Smoking	1	2	3	4
108. Physical inactivity	1	2	3	4
109. Poverty	1	2	3	4
110. Gambling	1	2	3	4
111. Illiteracy	1	2	3	4
112. Garbage disposal	1	2	3	4
113. Water pollution	1	2	3	4
114. Noise pollution	1	2	3	4
115. Road accidents	1	2	3	4
116. Housing conditions	1	2	3	4
117. Homelessness (e.g. couch surfing)	1	2	3	4
118. Crime	1	2	3	4
119. Vandalism	1	2	3	4
120. Bullying	1	2	3	4
121. Violence in the home	1	2	3	4
122. Violence in the community	1	2	3	4
123. Child abuse/Neglect	1	2	3	4
124. Sexual abuse	1	2	3	4
125. Personal safety	1	2	3	4
126. On the job risks for injury	1	2	3	4
127. Parenting difficulties	1	2	3	4
128. Teenage pregnancy	1	2	3	4
129. Young people in trouble with the law	1	2	3	4
130. Unplanned pregnancy	1	2	3	4
131. Abortion counselling	1	2	3	4
132. Education system concerns	1	2	3	4
133. Day care problems for children	1	2	3	4
134. Dental health	1	2	3	4
	1	2	3	4
	1	2	3	4

135. High blood pressure	1	2	3	4
136. Stoke	1	2	3	4
137. Heart disease	1	2	3	4
138. Circulatory problems	1	2	3	4
139. Cancer	1	2	3	4
140. Diabetes	1	2	3	4
141. Eating disorders	1	2	3	4
142. Hepatitis (or other liver disease)	1	2	3	4
143. Sexually transmitted infections	1	2	3	4
144. HIV/AIDS	1	2	3	4
145. Lung disease	1	2	3	4
146. Kidney disease	1	2	3	4
147. Out migration	1	2	3	4
148. Access to health services	1	2	3	4
149. Littering	1	2	3	4
150. Access for people with Disabilities				
Please list other concerns in your community:				
Are there other community concerns not listed that you would like to comment on?				

Where or how do you get your health information?

What are some of the strengths of your community?

Thank you for your time.

Based on the responses of the survey, we will be hosting small group discussions about some of the main issues, would you be interested in participating?

If you have any questions or concerns about this survey, please contact……

Appendix C

General Focus Group Guide

General Focus Group Questions

1. What is it like to live in your community? What does being healthy mean to you?

2. What does being healthy mean to you?

3. What kinds of things need to happen at the community level to help you and your family stay healthy?

4. What are the issues facing you that you would like to see addressed by Western Health? What are the priorities?

5. What do you feel needs to be done to improve the health of your community? Or what needs to happen at the community level to make the health of your family better?

6. What role do you see for yourself in addressing what needs to be done to improve the health of your community?

Appendix D

Corner Brook Area

Community Health Needs and Resources Assessment

Appendix E

Port Aux Basques/Burgeo

Community Health Needs and Resources Assessment

Appendix F

Bonne Bay/Port Saunders Area

Community Health Needs and Resources Assessment

Appendix G

Bay St. George Area

Community Health Needs and Resources Assessment

Appendix H

Deer Lake/White Bay South

Community Health Needs and Resources Assessment