2018

Experiences with Community Health Needs Assessment

New Brunswick
Nouveau Brunswick

New Brunswick Health Council | Conseil de la santé du Nouveau-Brunswick

Who we are

New Brunswickers have a right to be aware of the decisions being made, to be part of the decision-making process, and to be aware of the outcomes delivered by the health system and its cost. The New Brunswick Health Council will foster this transparency, engagement, and accountability by engaging citizens in a meaningful dialogue, measuring, monitoring, and evaluating population health and health service quality, informing citizens on health system performance and recommending improvements to the Minister of Health.

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Executive summary

The New Brunswick Health Council (NBHC), in its work on population health and health service quality, has demonstrated that information at the local level can have the greatest potential for change. Within the New Brunswick health system, this reality has been acknowledged through the legislated requirement for Regional Health Authorities (RHAs) to perform Community Health Needs Assessments (CHNAs).

These assessments bring together system planners, community health service providers and other stakeholders to identify community needs and resources in a format that supports the overall business planning efforts of the RHAs.

In spite of the legislated mandate being in force since 2002, there was no consistent work done provincially on CHNAs until a Ministerial Directive in 2012. With this directive, 10 communities were identified and the two RHAs were tasked with creating CHNAs for their communities. They were also asked to use the results as part of an overall initiative related to improving primary health services in the province.

The NBHC has evaluated the CHNA work of the RHAs from 2012 to 2017 using the criteria outlined in the initial directive, the guidelines that were developed, key informant interviews, consultation of CHNA documents and related literature, and the evaluation questions in the table below. The key findings were made available for review by the RHAs senior management groups.

Responses from the RHAs indicated a commitment to future CHNAs and to use the results as part of their planning efforts. The NBHC will continue to monitor and report on these efforts as part of its overall mandate.

Evaluation questions	Key findings
1. Did the CHNAs establish priorities that would lead to the improvement of the health status of the population?	In spite of a number of challenges, the CHNAs were able to produce priorities that could have an impact on population health.
2. Does the information from the CHNAs serve as a guide for planning for health services?	While the challenges limited the degree to which the CHNAs' information was used in RHA planning processes, it appears that with experience and process improvements that are currently being completed, the RHAs will make greater use of this information from 2017 onward.
3. Does the CHNA work focus on strengthening primary health care?	While the 2012 directive mandated doing CHNAs to "strengthen primary health care" the evaluation did not find evidence of a common understanding of that outcome nor of any specific results that could be considered examples of such "strengthening."
4. Does the information from the CHNAs create the capacity to track changes over time?	The health system has had ongoing difficulties in tracking change over time, and the same difficulty impacts CHNAs. This difficulty will limit the potential benefits of CHNAs for performance improvement within communities and the system overall.

About CHNAs and the NBHC's evaluation

Within the provincial health system, there is growing recognition of the importance of understanding the health needs of those being served when planning health services. This includes the use of scarce resources efficiently and effectively given the changing demographics, demands for care and the province's current economic situation.

The health system conducts Community Health Needs Assessments (CHNAs) to learn about local health needs. CHNAs are defined as "a dynamic, 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."[1]

In this report, the NBHC evaluates how well the recently conducted CHNAs identify a list of priorities and properly contribute to health services planning.

Moving forward ,this evaluation can support improvements to the CHNA process or guidelines.

This type of evaluation work is in accordance with the *New Brunswick Health Council Act*[2]:

- to measure, monitor and assess population health and health service quality in the Province
- to identify effective practices for the improvement of health service quality in the Province
- to evaluate strategies designed to improve health service quality in the Province

Background

Since 2002, each RHA has had the legal mandate to:

- determine the health needs of the population that it serves
- determine the priorities in the provision of health services for the population it serves, and
- allocate resources according to the regional health and business plan [3]

Until 2012, few CHNAs had been conducted. Those that were conducted were typically in response to an emerging community level issue or an announcement such as "changing hospital status of a facility to a community health centre."

In August 2012, the Primary Health Care Steering Committee released *A Primary Health Care Framework for New Brunswick* [4]. Although not all activities have been guided by the framework since its release in 2012, it outlined a long-term strategic plan for improving primary health care in New Brunswick. It presented several recommendations, one of which was to "conduct community health needs assessments".

At the same time as the release of this framework, the Minister of Health directed the two RHAs, Horizon Health Network and Vitalité Health Network, to conduct a first set of assessments covering 10 communities. Additional CHNAs were also performed.

This report looks at all the CHNAs conducted by the RHAs between 2012 and 2017.

Lamèque: Example of a CHNA done before 2012

The experience of Lamèque and its neighbouring communities in the development of the Lamèque Community Health Centre in 2003 demonstrated that community participation from the early stages of the planning process created a solid foundation for the partnerships that developed and facilitated stronger community engagement over the long term. The process used engaged the community in decision-making related to certain activities and in hiring resources corresponding to the needs and priorities they had established. Many challenges were faced using authentic engagement; good planning process; strong leadership; commitment and follow-up. These elements were key to their successes. [5]

The *Community Health Needs Assessment Guidelines for New Brunswick*

In an effort to guide the RHAs in conducting the assessments, the Community and Institutional Services Division of the Department of Health, in partnership with the RHAs, developed the *Community Health Needs Assessment Guidelines for New Brunswick*.[1]

The guidelines described the primary goal of the CHNAs as establishing priorities that improve the health status of the population, and stated that the information from the CHNAs must help guide planning for health services and create the capacity to track changes. It also outlined a process for conducting CHNAs consisting of the following five key activities:

1. Community engagement
2. Data collection
3. Analysis
4. Development of recommendations/priorities
5. Reporting back to the community

The NBHC used the goal and purposes in the guidelines as the basis for its evaluation.

Note: in the remainder of the document, we will refer to this document as simply the *guidelines*.

The NBHC's questions

The intent of the NBHC was to evaluate whether the community health needs assessments conducted by the RHAs since 2012 fulfilled the goal and purposes described in the guidelines document. Before starting our evaluation, meetings were held with both Regional Health Authorities to share and discuss evaluation scope and methods.

Specific evaluation points	Reason
1. Did the CHNAs establish priorities that would lead to the improvement of the health status of the population?	The guidelines state that "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".
2. Does the information from the CHNAs serve to guide planning for health services?	The guidelines state the "information must also serve to guide planning for health services that are rooted in evidence".
3. Does the CHNA work focus on strengthening primary health care?	The community health needs assessments were announced as part of a framework on improving primary health care in the province.
4. Does the information from the CHNAs create the capacity to track changes over time?	The guidelines state the CHNAs "must also impart the capacity to track changes over time".

Primary health care, as defined in the *Primary Health Care Framework*

As stated in *A Primary Health Care Framework for New Brunswick*, primary health care means the first level of contact of individuals, a family or the community with the health system and the first level of a continuing health care process and may include health education, promotion and prevention at the individual or community level, assessment, diagnostic services, intervention and treatment.
- *A Primary Health Care Framework for New Brunswick* (2012)

How the NBHC conducted the evaluation

To assess whether the CHNA work fulfilled the intended goal and purposes, the NBHC used the following evaluation methods:

- A review of all 21 publicly available CHNAs (as of January 2017)
- A series of questions sent to the nine managers or directors who have the responsibility of overseeing the CHNAs (see appendix)
- A number of consultations with experts in the field, including:
    - Public health professionals in Ontario who have supported the Local Health Integration Networks (LHINs) with their CHNAs
    - Senior Program and Policy Analyst, Manitoba Health who has also contributed to the Community Health Assessment Guidelines for Manitoba
    - Professor, Health System Performance Measurement and author of The Health Planner's Toolkit
    - Key informants in New Brunswick who have experience in conducting CHNAs (Lamèque, Albert County and Saint John)
- A stakeholder meeting which reviewed and discussed preliminary findings with the senior managers of the RHAs and the Department of Health and staff responsible for CHNAs.

The NBHC also drew upon the experience of its staff who, between 2012 and 2017, had interactions with citizens who took part in these CHNAs or who were supporting or working to implement initiatives. NBHC interactions with citizens took place in all parts of the province, in most of the 33 communities.

Key reference documents used to provide comparative insights and support our observations include:

- *The Health Planner's Toolkit* (7 modules) produced by a team of health system experts retained by the Ministry of Health and Long Term Care in Ontario [6]
- *Community Health Assessment Guidelines* from Community Health Assessment Network of Manitoba [7]
- *Evidence Review: Health Assessment & Disease Surveillance* from BC Ministry of Health [8]

Description of work done by the RHAs

Which communities were assessed

In 2012, the Minister of Health directed the RHAs to conduct CHNAs for an initial set of 10 communities. All of these were completed within two years. In the case of Zone 1 where the two RHAs share responsibility for all communities, it is worth noting that although Horizon was directed to conduct assessments for Moncton and Riverview, and Vitalité for Moncton and Dieppe, the two RHAs chose to work together to conduct a combined assessment for these three communities.

Initial set of 10 communities:

- Horizon: Fredericton, Oromocto, Salisbury, St. Stephen, Moncton-Riverview, Saint John
- Vitalité: Edmundston, Bathurst, Moncton-Dieppe, Campbellton

There were concerns within the RHAs about the initial set of 10 communities selected for needs assessments. The low level of engagement with the RHAs on the selection of these communities contributed to the development of these concerns. In spite of this, the initial set of 10 communities did not change. Vitalité chose to only conduct the assessments they were asked to do, whereas Horizon decided to conduct all the ones in their catchment areas.

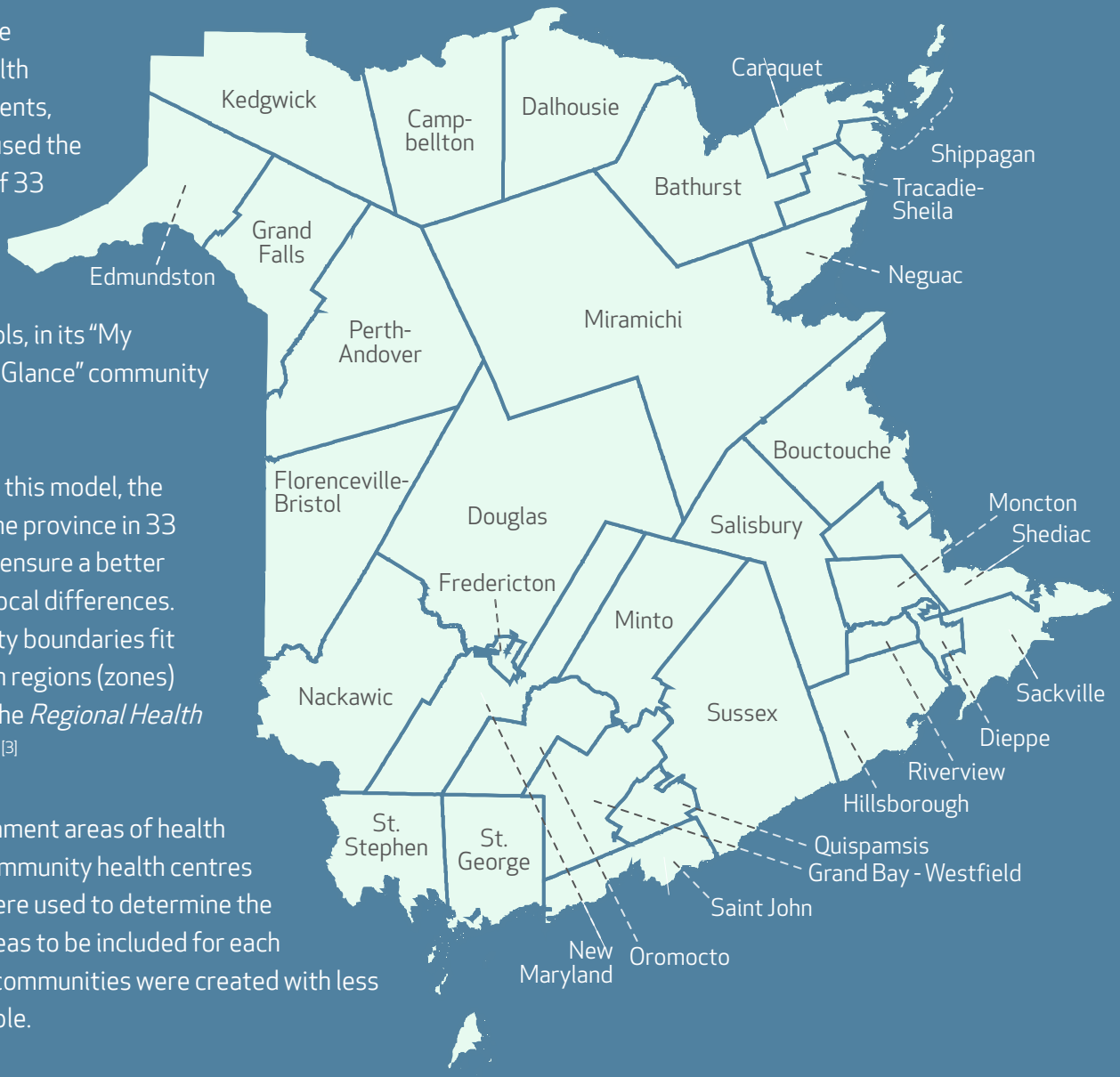
The table on page 12 shows which communities have been assessed among the 33 communities in the province.

THE PROVINCE'S 33 COMMUNITIES

In conducting the Community Health Needs Assessments, the RHAs have used the NBHC's model of 33 communities (which the NBHC uses, among other tools, in its "My Community at a Glance" community profiles [9]).

To come up with this model, the NBHC divided the province in 33 communities to ensure a better perspective of local differences. These community boundaries fit within the health regions (zones) established by the *Regional Health Authorities Act.* [3]

The actual catchment areas of health care centres, community health centres and hospitals were used to determine the geographical areas to be included for each community. No communities were created with less than 5,000 people.



A NOTE ABOUT HOW COMMUNITIES ARE COUNTED

The grouping of communities can lead to them being counted differently. For example, in the Minister of Health's directive to RHAs that listed 10 communities, "Moncton-Dieppe" and "Moncton-Riverview" were each counted as a single community, These are counted as three separate communities in the NBHC model. This explains why the Minister's initial set of 10 communities add up to 11 in the NBHC model.

Communities for which CHNAs have been done (2012-2017)

- Communities included in the Minister of Health's 2012 directive
- Other communities for which CHNAs were conducted (as of January 2017)

	Community	Name of CHNA document	RHA
Health zone 1 Moncton/ South-East	Bouctouche	CHNA not done	Vitalité
	Dieppe Moncton Riverview	Moncton and Surrounding Area	Horizon Vitalité
	Hillsborough	Albert County Area	Horizon
	Sackville	Tantramar Area	Horizon
	Salisbury	Petitcodiac, Salisbury and Surrounding Area	Horizon
	Shediac	CHNA not done	Vitalité
Health zone 2 Fundy Shore/ Saint John	Grand Bay-Westfield Quispamsis Saint John	Saint John	Horizon
	St. George	Eastern Charlotte County Area	Horizon
	St. Stephen	St. Stephen, St. Andrews and Surrounding Area	Horizon
	Sussex	Sussex and Surrounding Area	Horizon
Health zone 3 Fredericton/ River Valley	Douglas	Central New Brunswick Area	Horizon
	Florenceville-Bristol	Carleton County Area	Horizon
	Fredericton New Maryland	Fredericton & Surrounding Area	Horizon
	Minto	Grand Lake Area	Horizon
	Nackawic	Done, but not available for NBHC evaluation	Horizon
	Oromocto	Oromocto and Surrounding Area	Horizon
	Perth-Andover	Tobique & Perth-Andover Area	Horizon
Health zone 4 Madawaska/ North-West	Edmundston	*Région Edmundston et ses environs*	Vitalité
	Grand Falls	CHNA not done	Vitalité
	Kedgwick	CHNA not done	Vitalité
Health zone 5 Restigouche	Campbellton	*Région Campbellton et ses environs*	Vitalité
	Dalhousie	CHNA not done	Vitalité
Health zone 6 Bathurst/ Acadian Peninsula	Bathurst	*Région Chaleur et ses environs*	Vitalité
	Caraquet	CHNA not done	Vitalité
	Shippagan	CHNA not done	Vitalité
	Tracadie-Sheila	CHNA not done	Vitalité
Health zone 7 Miramichi	Miramichi	Miramichi Area	Horizon
	Neguac	Neguac Area	Horizon
Total:	**24/33 communities**	**21 CHNA documents**	

Observations on the CHNA process

The guidelines outlined a process for conducting CHNAs consisting of five key activities. The table below summarizes the NBHC's observations on how well each activity was conducted and what some of the challenges or concerns were.

1. Community engagement

What was expected (based on the guidelines)	→	**What happened** (NBHC observations)
• RHAs are to give residents, community leaders, community groups, health providers and other stakeholders the opportunity to dialogue on health and wellness issues and to articulate a health and wellness vision.		• In general, the elements (participants, methods, etc.) linked to community engagement have been properly respected.
• The degree and form of participation must be clear, and expectations must be realistic in terms of health resource allocation.		• The degree and form of participation were clearly documented but there appears to have been a lack of clarity or consistency on ensuring that expectations would be realistic, such as beginning a CHNA with an emphasis on repurposing current resources versus expecting new resources. This shows that parameters for health resource allocation may not have been set before the start of the process, or that changes in funding occurred during the process.
• Organizing and conducting a CHNA becomes an impetus to assemble Collaborative Service Committees (CSC), which ensure linkages between the community, the RHAs and the professionals providing care, serving to effectively engage community partners and groups, providers and individuals in the planning of primary health care services.		• Since the Primary Health Care Framework was not guiding activities, no Collaborative Service Committees (CSCs) were established. Instead, Community Advisory Committees (CACs) were formed to provide an advisory role in decision support.

2. Data collection

What was expected	What happened
• For data collection, RHAs are to use a list of core indicators that can be applied consistently across all communities. Additional data may be used if it meets specific criteria.	• All CHNAs used existing and available quantitative data (including but not limited to, data compilations such as My Community at a Glance [9] and the NBHC Primary Health Survey)[10]. Resource information on health care providers and others in the community would have added to the exercise.
• To collect more information, RHAs can consult the community in the form of focus groups, community meetings, key informant interviews and meetings with key stakeholders.	• Qualitative data was also collected using the various forms suggested in the guide.

3. Analysis

What was expected	What happened
• RHAs are to identify needs and assets in the community.	• There was clear direction regarding the core indicators with respect to determinants of health, but information around collection of community assets was vague and inconsistent.
• RHAs are to summarize findings of quantitative analysis and analyze qualitative data.	• Both the quantitative and qualitative analyses have been properly done with all CHNAs. The use of various consultants and differing approaches to the analysis required the RHAs to develop new templates for consistent public reporting and accountability. Although community level assets were identified, an inventory of existing health care facilities and health services resources was not properly developed for targeted communities.

4. Development of recommendations and priorities

What was expected	What happened
• RHAs are to assess priorities based on the following criteria: preventability, population potentially affected, population actually affected, preventable premature death or potential years of life lost, severity, public concern, and economic burden.	• The criteria given were properly applied to develop the final list of priorities. A summarized list of issues was then presented to the community for feedback, and community members were asked to participate in a prioritization exercise. More information on resources and assets would have benefitted the exercise.
• RHAs are to share and facilitate the use of CHNA findings to help with planning and with program and policy development.	• Both RHAs have developed their respective processes to share and facilitate the use of CHNA's findings either through their websites, in published magazines such as "In Your Community" or individual letters to their respective Community Advisory Committees. As of January 2017, some still remain to be communicated. In addition, each CHNA was presented to the board of the RHA that created it.

5. Reporting back to the community

What was expected	What happened
• RHAs are to invite feedback from community and stakeholders.	• Both RHAs provided documented progress reports on the status of initiatives undertaken to respond to the different priorities for action. On-going meetings with CACs and various subgroups working on initiatives or actions are meant to create feedback opportunities.
• Priorities and actions are to be aligned with the objectives of the provincial health plan and the Primary Health Care Framework.	• The alignment of priorities and actions with the provincial health plan was not evident or consistent. As previously noted, the Primary Health Care Framework was not guiding the planning process. By the start of 2017, both RHAs began to enhance the process of aligning CHNA content with their regional health and business plans.

Findings from the NBHC's evaluation

1. Did the CHNAs establish priorities that improve the health status of the population?

The community health needs assessment work produced priorities and recommendations that may lead to improvement in the health status of the population and provide insight to support allocation of resources. Addressing barriers to health or health services or addressing certain social determinants of health have been shown to reduce health disparities and/or improve health outcomes. [11]

When key determinants of health and gaps in health services are addressed, there is evidence of observed improvement in health status. In summary, we noted:

- 40 priorities related to overcoming barriers to health or health services
- 15 priorities related to public health promotion and prevention
- 66 related to health services

(The table on the following page breaks these down further.)

Although priorities that would lead to improvement in the health status of the communities were identified, ensuring implementation of the best solutions to respond to these priorities will be important for improvement to occur.

Priority areas outlined in the communities where CHNAs were completed

		Barriers to health and health services				**Health services**								
Zone	Community	Transportation	Food insecurity and nutrition	Navigation of services	Affordable housing	Public Health / Promotion and prevention	Mental health and addictions	Primary health care / chronic conditions	Seniors / Home care	Sexual health	Rehabilitation	Palliative care	First Nations	Other (Integrated services / continuity)
1	Dieppe Moncton Riverview					1	1	1	1				1	2
	Hillsborough	1	1	1	1	1	1	1	1					1
	Sackville	1	1			1	1	1	1					
	Salisbury	1	1	1		1		1						1
2	Grand Bay-Westfield Quispamsis Saint John	1	1	1		1	1			1	1			2
	St. George	1	1		1	1	1	1						1
	St. Stephen	1		1	1		1	1	1					1
	Sussex		1		1		1	1						1
3	Douglas	1			1	1	1		1					1
	Florenceville-Bristol	1	1	1	1		1	1	1					
	Fredericton New Maryland			1		1	1		1					
	Minto			1		1	1					1		1
	Oromocto	1			1	1	1	1	1					1
	Perth-Andover	1				1	1						1	2
4	Edmundston	1				1	1	1						
5	Campbellton	1				1	1	1						
6	Bathurst	1				1		1	1	1				
7	Miramichi	1	1	1		1	1		1				1	1
	Neguac	1	1	1			2		1				1	2
		15	**9**	**9**	**7**	**15**	**18**	**12**	**11**	**2**	**1**	**1**	**4**	**17**

2. Does the information from the CHNAs serve as a guide for planning for health services?

Given New Brunswick's economic situation, demographic shifts and increasing demand for health care, finding solutions within our limited resources will require tremendous effort and joint planning by many stakeholders. RHAs have now completed several health needs assessments in their regional catchment areas. The next step will be to set priorities for resource allocation and business plan proposals that improve the health status of their local and regional populations.

As the NBHC reviewed managers' and directors' answers to the questions it sent related to the use of CHNAs in supporting planning efforts and accountability, various challenges were revealed at various points throughout the work. These challenges include: an unclear understanding by senior leaders of the scope, purpose and expectations of CHNAs at the start of the process, and managing the list of priorities and expectations at the end of the process. Changes in leadership (senior RHA officials, staff at DH responsible for supporting CHNAs and those responsible for the Primary Health Care Framework) compounded the challenges and impacted the collective understanding of the process.

Budget constraints and resource availability were not taken into consideration in the identification of priorities. The absence of clear financial parameters made it even more challenging to manage the expectations already set in those communities which have moved to the solutions stage.

CHNA initiatives that involved partnerships with community agencies in dealing with barriers to health services are, for the most part, moving forward. Meanwhile, community initiatives requiring cross government departments collaboration appear to be off-track or stalling.

Budget constraints and resource availability were not taken into consideration in the identification of priorities. The absence of clear financial parameters made it even more challenging to manage expectations already set in those communities.

3. Does the CHNA work focus on strengthening primary health care?

Although the 2012 announcement aimed to strengthen primary health care in New Brunswick, health system discussions were launched in absence of a common understanding on how to operationalize "strengthening primary health care." This included a lack of clarity regarding roles and responsibilities and accountability for the changes required for the improvement of these services. The Family Health Teams model was initially identified as a preferred model but it was paused during this period, which added to the confusion regarding provincial directives.

The definition for primary health care provided in the *Primary Health Care Framework* may represent a different bredth, scope or range of services in different areas depending on the type or mix of resources available at the local level. As a result, there was no clear direction on what "strengthening primary health care" meant and what the expectations were during the CHNA work.

4. Does the information from the CHNAs create the capacity to track changes over time?

This will be difficult without clarity on shared health system planning goals, measures, targets and benchmarks to track improvements at local, regional and provincial levels. For CHNAs to be used in planning, there needs to be capacity building in the choice and development of key indicators to track and monitor initiatives or solutions. Also, additional capacity is required at a regional level to align and track key performance indicators related to the priorities identified across all communities. Currently, there is no process to guide the monitoring or evaluation of initiatives to ensure they are meeting the needs of the communities as well as meeting regional strategic objectives. Such a process would support decision-making and potential corrective action during annual planning cycles.

Thoughts on planning

The evaluation of the 2012 CHNA initiative represents a learning opportunity for the provincial health system. As indicated in the CHNA guidelines, "the CHNA is a dynamic, on-going process". Improved understanding represents the opportunity to enable elected officials and the health system leadership to shift to a citizen-centred approach to health services planning. Many health system leaders, managers and community members have shared their experiences and views regarding the CHNA process and the resulting observations include the following:

Community Health Needs Assessment process

Sufficient guidance and detail was provided in undertaking three out of the five key activities: 1) community engagement, 3) development of recommendations and priorities, and 5) reporting back to the community. Two areas for improvement include the data collection (activity 2), where additional information on resources could have been collected, as well as in the analysis activity (activity 4) where more clarity and support would have assisted in identifying specific individual assets in the community.

Although community level assets were identified, an inventory of existing health care facilities and health services resources was not properly developed for targeted communities to support the solutions or initiatives.

Planning for CHNAs

Clarity on objectives and scope of the process of CHNA

Having clarity on the purpose, scope, budget constraints and resource availability related to CHNAs prior to their undertaking would help to create "realistic expectations" for those communities being engaged.

Directives for future CHNA initiatives should be developed in a more collaborative fashion between the Department of Health and the RHAs since RHAs are responsible for the populations they serve.

If specific communities are targeted, the choice should be based on selection criteria determined by those responsible in undertaking the CHNAs and who must then respond to the health needs of these communities. Both RHAs must understand the needs of all of their communities. Therefore, any future CHNA initiative or directive by the Minister should reflect this reality.

Having clarity on the purpose, scope, budget constraints and resource availability related to CHNAs prior to their undertaking would help to create "realistic expectations" for those communities being engaged.

Roles and responsibilities

RHAs, by legislation, shall determine the health needs of the population they serve. The *Regional Health Authorities Act* requires the Minister to consult with the RHAs. The Department of Health has a role to play in coordinating and supporting the CHNA work, as resources are often required to both perform and respond to priorities identified in communities.

Directives for any future CHNA initiatives should be developed in a more collaborative fashion between the Department of Health and the RHAs since RHAs are responsible for the populations they serve.

The addition of electoral platform commitments (particularly the list of commitments related to "Ensuring every New Brunswicker has access to a family doctor"[12]) during the selection of communities to undergo assessment may have been counterproductive. There is no question of the validity of having platform commitments. The issue is when platform commitments, developed without an adequate understanding of community challenges and health outcomes, dictate where and how resources are to be organized or to what level resources should be allocated.

Using CHNAs for planning

Joint prioritization and planning among stakeholders is required to achieve better health outcomes using limited resources. The use of information from CHNAs becomes even more important, given the economic situation of the province, demographic shifts in the population, and increasing demand for health care.

A key to successful needs assessment is the understanding of how it is related to the rest of the planning process. This includes embedding the process of conducting CHNAs into regional and health system planning cycles along with their findings. Doing this requires clarifying the role CHNAs have in influencing planning and decision-making regarding resource allocation and business plans.

The NBHC's mandate to measure, monitor and assess population health and health service quality in the province, results in data that contributes to the ability to monitor the progress or improvement in determinants of health or health outcomes. This information is available on our website at the provincial, regional and the community level and the NBHC regularly updates its community level information to support monitoring efforts.

A key to successful needs assessment is the understanding of how it is related to the rest of the planning process.

Conclusion

This evaluation by the NBHC has highlighted the reality that New Brunswick's approach to CHNAs has included:

- an awareness of a need for improvement
- changes made while the process was ongoing
- efforts that produced better results
- and the identification of further areas for improvement

From the legislated mandate for CHNAs in 2002 until the ministerial directive in 2012, assessments occurred on an *ad hoc* basis. The ministerial directive provided the impetus for RHAs to begin performing CHNAs on a provincial basis, but the implementation of the directive suffered from a variety of challenges such as:

- inadequate consultation in the selection of the initial communities
- mandating the CHNAs without sufficient collaboration in the development of the assessment process and follow-up
- lack of key supports for the next planning phases after the CHNAs were not implemented
- a lack of financial parameters provided to those being consulted
- insufficient information provided regarding resources and assets
- CHNAs not being adequately integrated into the planning process
- undertaking the process without clear and expected outcomes to support participants

These procedural deficiencies were combined with certain activities being dropped, such as the Family Health Teams, that were meant to be key supports for the original CHNA process. The resulting challenges created a need for the RHAs to innovate and to adjust the CHNA work during the assessments, leading to divergences in practice.

With improved assessments, more experience in carrying them out and a commitment to greater collaboration among health system organizations for ongoing improvement, the CHNAs have the potential to provide even greater insight into the health needs of local communities, and the appropriate planning to address them.

Just as in the past, change will bring new challenges, but with commitment and resolve, the New Brunswick health system can continue to build stronger, more responsive planning mechanisms that can lead to better health services and health outcomes.

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Appendix - Questions sent to managers and directors

1. Is the Collaborative Services Committee in place? If yes, please describe when it started and the membership.

2. If no Collaborative Services Committee is in place, what process supports decision-making, accountability and implementation?

There were no Collaborative Services Committees established based on the description from the Primary Health Care Framework document. There were Community Advisory Committees (CACs) established to develop the priorities and assign accountability to work plans. These CACs are at different maturity levels, some are just establishing the priorities and others are implementing solutions.

3. What objectives guided the recommendations and priorities for CHNAs?

In terms of responses to what guided the priorities, some responded that they needed to align with the provincial health plan and Primary Health Care Framework, and others may not have been as clear.

4. Were senior leaders clear regarding scope, purpose and expectations of CHNAs?

The most varied responses were in relation to senior leaders being clear on purpose and expectations of CHNAs. There was no clear consensus on how CHNAs would support or influence planning and decision-making. Also, when leaders changed or those involved in performing CHNAs changed, some wanted more information to understand resources and assets to support planning, and others were content with just having the needs identified. There was inconsistency on how the CHNAs would be leveraged to support development and prioritization of business cases when enhancement of services or changes to the current models of care was suggested. This was even more problematic when the Department of Health committed to certain resources, models or platform commitments that they may have abandoned, changed or modified along the way.