Health and Wellness Study 2014

Prepared by:
Melissa Atkinson,
Health Promoter
Grand River Community Health Centre

Grand River Community Health Centre

Executive Summary

The Canadian Index of Wellbeing (CIW) framework clusters diverse factors which impact the health and wellbeing of individuals and communities into 8 domains: community vitality, education, income, healthy populations, democratic engagement, culture and leisure, time use and environment. Collectively, the domains seek to capture a comprehensive picture of health and wellness.

Grand River Community Health Centre (GRCHC) utilized the CIW framework to develop a survey which sought to identify issues that impact the health and wellbeing of our clients and individuals accessing our internal or community partnership programs. Additionally, a small focus group was conducted with GRCHC staff members who see clients one on one. Ultimately these processes sought to assess health and wellness issues impacting the GRCHC community in order to inform the establishment of priorities for the health promotion and community development team (HP-CD team).

367 survey responses were collected through various internal and external strategies including participant recruitment: in the GRCHC lobby and at GRCHC programs and flu clinics, during one to one counselling sessions, and through outreach at community events including a meal program and a neighbourhood association event. Survey data was compared to existing regional data to identify health, social and economic disparities facing our population. Further, survey responses were stratified by geographical, social, economic and demographic factors to identify groups within the population who exhibited disparities in issues related to health and wellness.

Healthy Populations:

Perceived health, stress and chronic conditions

When compared to the general population, survey respondents were less likely to rate their physical health and mental health as very good or excellent (27% vs. 58% and 38% vs. 68% respectively) and were more likely to rate their stress level as high or very high (34% vs. 23%). Stress levels were highest among the lowest and highest income earners. Perceived health improved with increasing income and education levels.

The most prevalent chronic conditions reported include: arthritis, chronic pain and diabetes. The prevalence of chronic conditions increased with age. Younger respondents were more likely to report living with chronic pain, asthma and arthritis while individuals age 65 and older were most likely to report arthritis, diabetes and chronic pain. The top three conditions that survey respondents indicated needing help managing include: mental health issues, chronic pain, and diabetes or diabetes related complications.

Factors that were identified which were most closely associated with perceived health include: income and employment, social connectedness and food security.

Health behaviours

Survey respondents were more likely than the general population to be current smokers and were less likely to eat the recommended number of fruits and vegetables in a day. The most commonly cited reason survey respondents did not meet healthy eating recommendations was cost.

41% of survey respondents indicate participating in low to moderate activity for over half an hour a day while 58% of respondents indicated participating in less than 10 minutes of vigorous activity a day. Barriers to physical activity identified in the staff focus group include: lack of motivation, lack of affordability, lack of available welcoming, non-judgemental weight management options and lack of access to physiotherapy and occupational therapy.

Service Access

Respondents were asked to rate access to various health and wellness services. Generally, survey respondents with higher income and education levels were more likely to rate service access as "Very Good" or "Excellent." Individuals making less than $20,000 a year were most likely to rate service access as poor for the following: complementary health practitioners (36%), dental care (24%) and rehabilitation services such as physiotherapy (26%).

Consistently, focus group results suggest service access issues impact clients' health and wellbeing specifically related to dental care, mental health crisis services and rehabilitation services such as physiotherapy. Barriers to service access identified include: lack of availability or affordability, a lack of knowledge of existing programs and services in the community and a lack of referral follow-up due to transportation issues or communication issues related to a lack of phone or computer.

Income:

Generally, perceived health improved with increasing income. 45% of survey respondents report making less than $20,000. When compared to those who make more than $20,000 a year, these individuals were nearly 4 times as likely to rate their mental health as poor or fair (OR=3.7) and 3 times more likely to rate their physical health as poor or fair (OR=3.2). Lower income individuals were more likely to: be current smokers, rate access to key health and wellness services as poor and were more likely to experience regular food security issues.

Economic and food security:

43% of survey respondents rely on OW/ODSP as their main source of income. Those on OW/ODSP were 17 times more likely to rate their physical health as poor and 3 times more likely to rate their mental health as poor than those relying on employment. Education level was predictive of employment status with 67% of university graduates and only 14% of elementary school grads indicating employment as their main source of income.

19% of survey respondents indicated experiencing food security issues "most or all of the time," 77% of whom earned less than $20,000 a year and 95% of whom made less than $30,000. These individuals were 14x more likely to rate their physical health as poor and 17x more likely to rate their mental health as poor than those who never experience food security issues.

Focus group results suggest food security is a high priority and that single men may be at higher risk of food security issues due to declining access to food banks or community meal program because of pride or feelings that "someone else needs it more." Poor access to dental care may exacerbate food security issues by further limiting what an individual can eat.

Education:

Educational attainment levels among survey respondents were comparable to the regional average. Generally as education levels rose, perceived health status improved; however the relationship observed was not as strong as the relationship between income and perceived health.

Of note, 13% of survey respondents indicated elementary school as their highest educational attainment, most of who were over the age of 45. 65% made less than $20,000 a year; however this did not translate into significant differences in self-reported health status. Additionally, despite a younger age distribution, individuals with a post-secondary or trades certificate were disproportionally more likely to: rate their physical and mental health as poor, smoke, report high or very high levels of stress and require assistance managing chronic conditions.

Numerical literacy appeared to be the biggest issue among survey respondents; however given issues in question ambiguity it is believed respondents may have related the question to income and not literacy. Therefore, unfortunately few conclusions about literacy can be drawn from survey results.

Community Vitality

To assess Community Vitality, survey questions focused on factors which impact an individual's connection to their community and their interpersonal relationships. 87% of survey respondents indicated they felt they belonged in the community. Themes identified which contribute to one's sense of belonging include: social connectedness (especially to family and neighbours), community attitudes toward diversity, involvement in the community, perception of crime and safety, housing, access to service and amenities and the environment.

Generally, those who indicate they do not belong did not know or did not trust their neighbours, they did not have friends or family in the area and they may have felt discriminated against by individuals or organizations due to race, religion, physical limitations or disabilities or sexual and gender identity. They may have personal experience with crime, may experience housing security issues and may feel unconnected to nature.

The number of close friends and family members that an individual has was strongly associated with perceived health, with those indicating 0-1 being 5 times more likely than those with 6 or more to rate their physical health as poor or fair and 13 times more likely to rate their mental health as poor or fair.

Culture and Leisure and Time Use

Screen time was the most frequent leisure time activity noted by survey respondents, followed by time spent with friends and family. Generally daily screen time increased with lowering educational levels, while time spent with friends and family increased with increasing income until a threshold of $60,000.

40% of survey respondents indicated having volunteered in the last month. Generally, volunteerism increased with increasing income and education level. Over 60% of respondents dedicate less than 10 minutes a day to activities related to arts and culture.

Democratic Engagement

The proportion of survey respondents that indicated voting in the last election was higher than the provincial average (58% vs. 52%). Education and literacy level were more predictive of voting behaviours than income. Of those who did not vote, 40% indicated they did not care about politics, 20% were unhappy with candidates and 11% did not know how.

Environment

The majority of survey respondents indicated being somewhat or very satisfied with the local environment; however 90% of respondents indicated concern about one or more environmental issues. In order of most commonly cited issues: water quality, air quality, road safety and recycling and composting and land development. Water quality and air quality were of higher concern to lower income earners while recycling and composting were priorities for higher income earners.

Advice for GRCHC

Survey respondents were asked a series of qualitative questions to provide advice for GRCHC going forward. An overwhelming number of positive comments were received regarding the positive impact the Centre and Centre staff have had on individuals. The following recommendations were developed based on this feedback as well as focus group results:

- Increase advertising of internal and external programs and services
- Seek to improve service access with a priority on after hours care, reducing wait time for new clients to receive a doctor or nurse practitioner, mental health crisis services, dental care and rehabilitation services such as physiotherapy.
- Facilitate clients' connections to existing health and wellness programs and services in the community by expanding or introducing system navigation staff roles (such as a community support facilitator).
- Open up priority populations with a focus on: those experiencing chronic pain, LGBTQ, and those living with a disability.
- Address issues related to clients' perception of safety in the waiting room.
- Continue to expand community health initiatives and wellness programs particularly in the areas of mental health, stress and anger management, budgeting, as well as support programs for young mothers and LGBTQ.

Introduction

The Canadian Index of Wellbeing (CIW) framework assesses the many factors that impact the health and wellbeing of individuals and communities. The CIW framework clusters ***determinant of health*** measures into 8 domains: community vitality, democratic engagement, education, environment, healthy populations, leisure and culture, living standards and time use. Collectively, the CIW measures assess social, environmental and economic conditions which impact health and wellbeing. A description of each domain is provided below.

- The **Healthy Population** domain measures the health and wellbeing of the population by assessing health status, health behaviours and service access.
- **Community Vitality** refers to richness and inclusiveness of social life by assessing relationships among residents and between residents and local organizations.
- **Living Standards** refer to issues related to disparities in wealth distribution such as food, job, and housing security.
- **Education** refers to literacy, educational attainment and skill levels of adults and children which may impact one's ability to function in society.
- **Environment** refers to the health of the natural environment.
- **Democratic Engagement** assesses the participation of citizens in public life and governance.
- **Leisure and Culture** refers to the extent and type of participation in the broad categories of culture and recreational activities.
- **Time Use** assesses how people use their time, what factors control time use and how this impacts health and wellbeing.

Objective:

In line with the Association of Ontario Health Centre's focus on the CIW framework, Grand River Community Health Centre (GRCHC) will utilize this framework to identify issues that impact the health and wellbeing of our clients and individuals accessing our internal or community partnership programs. Findings will inform future processes to establish health and wellness planning priorities for the Health Promotion and Community Development (HP-CD) team.

Methodology

Data Collection Tools

Data collection was based on a needs assessment survey, available in paper and electronic formats, and a small focus group consisting of GRCHC staff members involved in the Quality Improvement Group.

The electronic survey was developed using Survey Monkey. Paper survey responses were entered into Survey Monkey as they were received. The Canadian Index of Wellbeing formed the basis of the survey development process. Indicators were developed based on the CIW, analysis of existing community-level data for comparison purposes, and through examining CIW-based surveys conducted by other CHCs (Somerset West, and Woolwich). Questions were vetted through GRCHC staff members and an external strategic planning consultant. Revisions were completed as needed.

Participants

The focus group consisted predominantly of health professionals who see GRCHC clients on a one to one basis, including a nurse practitioner, a registered nurse, a counsellor two doctors, and a dietitian. The group also included the Leader (Director) Primary Care & Community Health.

Survey responses were sought through a blend of social media and community outreach strategies in addition to various internal activities including: promoting the survey at registration for flu clinics, recruiting participants in the lobby, at a community meal program, at community events in a priority neighbourhood and facilitating the survey in one to one counselling sessions and at various internal programs. Tim Horton's Gift Cards were given out as incentives for survey completion and raffles for 2 gift baskets were conducted during Community Health and Wellness Week.

Sample Size

For the purpose of the survey, sample size calculations were based on the population of individuals accessing GRCHC internal programs and services (Table 1). Given the nature of programs and events it was not possible to ensure that participants are unique from rostered and non-rostered clients. Therefore, upper and lower limits were established based on the absolute number of unique individuals (primary care and non-rostered clients) and the potential number of unique individuals (clients + program participants + event attendees) in our population. The sample size calculation will be based an average of these two numbers. [a1]

Table 1: Population Estimate, Purkinje; Sept. 2014

Absolute unique individuals			Potential unique individuals	
Primary care clients	2577		Clients	4277
Non-rostered clients	1700		Program participants*	300
Total (lower limit)	4277		Event attendees	868
			Total (upper limit)	5445

*Due to ongoing nature of programs the number of participants from Q1 will be used to represent the yr. (limitation)

GRCHC target population estimate = 4277 (lower limit), 5445 (upper limit)

Average = 4861

Based on a 95% confidence interval and 5% margin of error the goal sample size is: ***357***

Data Analysis

Themes identified in the focus group will be woven throughout the report, where appropriate. The report will be presented within the context of the CIW framework.

Survey data was aggregated to develop a descriptive profile of issues impacting the health of respondents. Where available, comparable data collected by Statistics Canada will be presented at the Brant County Health Unit level which encompasses the entire GRCHC catchment area of Brantford and Brant County. Comparison of survey data to data from the general population will allow us to identify any potential health and wellness disparities experienced by GRCHC population. The analysis will also compare survey data across population groups to identify health and wellness disparities across and within groups. Specific analyses will include:

- Comparison between Brantford and Brant County regarding key measures (health status, community vitality, service access)
- How demographic and socio economic factors impact self-reported health status (income, age, education, literacy, social connectedness, etc)

For the purpose of this report, data analysis will focus on identifying high level trends surrounding factors that impact the health and wellbeing of the GRCHC population. While this report will be high level, there is a wealth of opportunity to continue to use the data bank to support practical applications such as program planning, evaluation etc.

Limitations

Issues in methodology will also be analyzed throughout to identify limitations in the process which should be addressed in future iterations. Flagged issues include:

Representativeness of sample: as the goal of the survey was to learn about issues impacting the health and wellness of the GRCHC population, we sought to receive as many responses as possible and to offer everyone equal opportunity to provide feedback. That being said, there were no strategies in place to ensure the sample was exclusively representative of the GRCHC client population.

Statistical significance: given the lack of focus on defining a representative sample, statistical significance cannot be established.

Survey length: the length of the survey may have resulted in lower response rates to questions due to survey fatigue. Future iterations of this process should try to limit survey length to 5-10 minutes (rather than the 10-15 minutes the recent version took).

Question structure: Upon undertaking data analysis it was discovered that issues related to some question wording and/or structure may limit the conclusions that can be drawn as outlined below:

- *Age categories* – we were not able to compare survey data to local data on the basis of age as the age categories did not align. This issue arose due to an oversight while translating

the survey results to Survey Monkey. A stock 'Survey Monkey' question related to age was used along which came preloaded with age categories. In future iterations, age categories should be manually entered to ensure they line up with Statistics Canada.

Additionally as the youngest age category provided was 16-24 this limited our ability to make conclusions about high school graduation rates as this category clustered individuals that were not eligible for graduation with those that were.

- *Service access* – the word access could mean different things to different people. Future iterations should define access. Further, "not applicable" would be a more useful category to include than "unsure."

- *Chronic conditions* – a question regarding whether someone is living with a chronic condition should be asked before asking which chronic conditions they are living with. This will allow conclusions to be drawn about the prevalence of chronic conditions among survey respondents.

- *Gender* – in an effort to be as inclusive as possible, the gender question was open ended. It was assumed that we could pull all like-qualitative responses for analysis purposes; however this was not the case. This prevented our analysis of responses received by gender. In future iterations, the gender question should be multiple choice with an opportunity to comment further.

Results

367 people responded to the survey. The means by which survey responses were received are presented in ***Table 2***.

Table 2: Survey responses by outreach strategy

Strategy	Primary population reached	Number of surveys
Online	Non-clients	19
Health and Wellness Week	Clients and non-clients	81
Lobby collection	Rostered and non-rostered clients	104
GRCHC Internal Programs (Men's Group, Women's Group, Easy Fit, Gentle Yoga, Cooking Classes, LGBT Groups, COPD group)	Clients and program participants	32
Community Programs (Eagle Place Neighbourhood Association, St. Andrew's Meal Program, GRCoA)	Clients and non-clients	73
Flu clinic	Clients and non-clients	47
Counsellors and Social Workers	Clients	11
		367

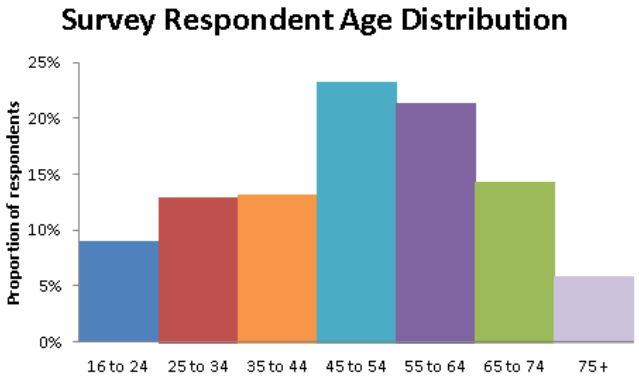
Although the number of surveys received met our pre-established target, individuals tended to skip questions throughout the survey likely because they were not applicable, the question required too much time to answer or the question was too personal. The majority of questions received between 340 and 350 responses. Questions with lower response rates included: qualitative questions and questions related to income and service access.

Of the 367 individuals that responded to the survey: 34% indicated that they do not receive services at GRCHC; 46% see a doctor or nurse practitioner; 10% see a dietitian; and 17% receive counselling or social work services and 20% attend wellness programs. The high proportion of individuals indicating they do not receive services from GRCHC is likely due to data collection strategies during "Health and Wellness Week," flu clinic days and community programs outreach.

A comparison of service access across income categories reveal that dietitian services and wellness programs are accessed more by lower income individuals; whereas 'counselling and social work' and 'doctor and nurse practitioner' services are accessed proportionally across income categories. Of note, only 30% of individuals who perceived their mental health as poor accessed the counselling and social work services at GRCHC.

Survey respondents identified as 60% female, 39% male and 1% transmale. The age profile of respondents was as follows:

- 22% of respondents were age 16-34
- 37% were 35-54
- 21% were 55-64
- 14% were 65-74
- 6% over the age of 75



The age distribution was comparable between respondents from Brantford and Brant County.

79% of respondents live in Brantford and are concentrated in the following neighbourhoods: downtown (18%), West Brant (14%) and Eagle Place (12%).

During the development of the survey outreach plan, it was noted that GRCHC ties to the County were limited and as a result there was no survey outreach in the County. This translated into a low response rate from County residents (35) which limited our ability to assess differences in issues impacting health and wellbeing among County and City residents

1.0 Healthy Populations

Survey questions from the "healthy populations" domain focused on: perceived health, chronic conditions, stress, health behaviours related to healthy eating and physical activity and access to services.

Perceived health

Survey results for perceived health are presented in ***Table 2***. No significant differences were observed in self-reported health status between County and Brantford residents. Local data which encompasses Brantford and Brant County residents is presented for comparison purposes (Statistics Canada, 2013).

Table 2: Self-Reported Physical and Mental Health Status

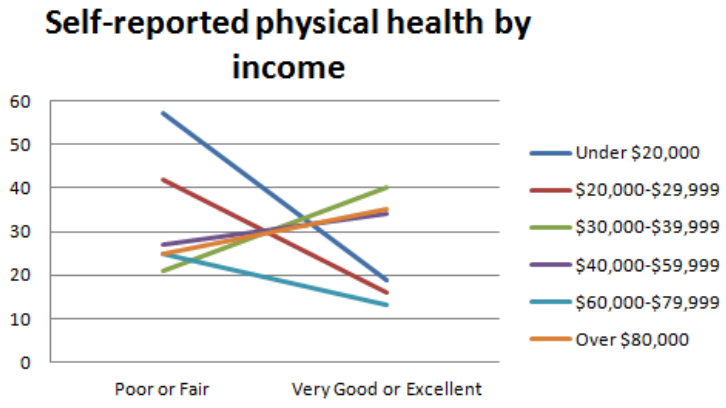
	Survey Data			Local Data*
	Poor or Fair	Good	Very Good or Excellent	Very Good or Excellent
Physical	40%	33%	27%	58%
Mental	35%	27%	38%	68%

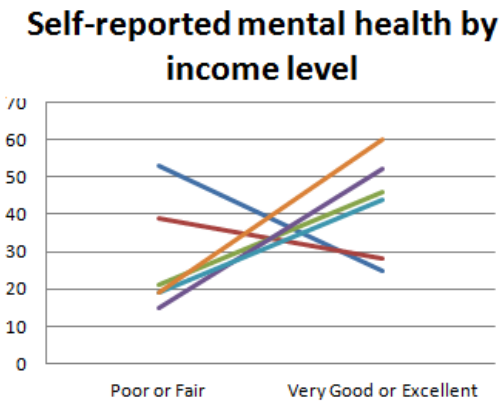
*Statistics Canada. 2013. Brant County Health Unit. *Health Profile*. Statistics Canada Catalogue no. 82-228-XWE.

Overall, 27% of survey respondents rated their physical health as very good or excellent while 38% indicated mental health as very good or excellent. This is lower than the general population where 58% of people rate their physical health as very good or excellent and 68% rate their mental health as very good or excellent (Statistics Canada, 2013).

40% of survey respondents rated their physical health as poor or fair, 35% respondents rated mental health as poor or fair. 36% of people indicated that a mental health issue prevented them from taking part in their regular activities this month.

Marital status was associated with one's perceived health. Of those who perceived their physical and as poor 45% were single while 54% of those who perceived their mental health as poor being single. Marriage was associated with better perceived health representing 44% of all those who rated their physical health as excellent and 41% of those perceiving their mental health as excellent.





The previous graphs summarize the connection between perceived health and income. The lines display the relationship between those rating their health as “poor or fair” and those rating their health as “very good or excellent” for each income category.

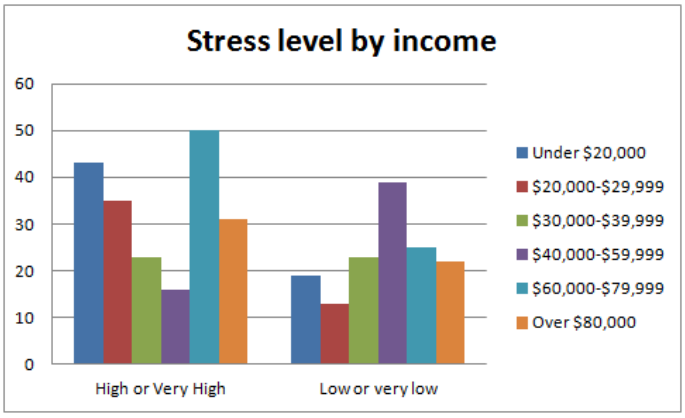
The downward sloping lines reveal that individuals in the two lowest income categories were more likely to rate their physical and mental health as poor or fair than very good or excellent. As indicated by the upward sloping lines, this relationship changed at an income threshold of $30,000 where people began to be more likely to rate their health as very good or excellent than poor or fair. The only exception was those making $60,000-$79,999, who were more likely to rate their physical health as poor or fair than very good or excellent.

Those in the highest income category were most likely to rate their mental health as very good or excellent followed by: those making $40,000-$59,999; those making $30,000-$39,999, etc.

Education was also associated with perceived health status but to a lesser degree than income. Generally, a higher prevalence of individuals with lower education attainment levels rated their health as poor or fair; whereas those with a higher education levels were more likely to rate their health as very good or excellent. This relationship will be assessed further in the “Education” section.

Stress

Stress negatively impacts health by increasing an individual’s risk of heart disease, stroke and high blood pressure. Further, stress is associated with unhealthy behaviours such as smoking, unhealthy eating and higher alcohol consumption (Heart and Stroke Foundation, 2010). Survey respondents were more likely to report high or very high levels of stress than the local average (34% vs. 23%) (Statistics Canada, 2013).



Generally, the percent of people indicating high or very high stress levels decreased with increasing income until an income threshold of $60,000 and began to increase again which could in part be due to higher income individuals having more work stress. Stress levels were higher among the working age population age 25-64 with the highest stress levels being seen among individuals age 45-54 and the lowest among those age 65 and older.

Stress level was less associated with educational attainment with those ranking stress levels as high or very high ranging between 26% (graduate level degree) and 31% (college degree). The obvious exception is those with a post-secondary certificate or trade certification, of whom 44% rated their stress level as high or very high.

The strongest connection observed was that of stress and perceived health status. Individuals that rated their mental health as poor or fair were 8 times more likely to indicate high or very high levels of stress when compared to those rating their mental health as good to excellent (OR=7.9). Individuals that rated their physical health as poor or fair were nearly 5 times more likely to rate their stress level as high or very high when compared to those rating their physical health as good to excellent (OR=4.5).

Chronic conditions

Local data suggests the prevalence of various chronic conditions in the general population are as follows: arthritis (22%), chronic pain (20%), COPD (6%), asthma (8.5%) and diabetes (8%) (Statistics Canada, 2013).

Of the 367 survey respondents, 93 indicated having one or more chronic conditions (25%). Among these individuals, arthritis was the most commonly cited chronic condition (30%) followed by chronic pain (27%), diabetes (20%), asthma (17%) and COPD (6%).

Unfortunately limitations in the survey indicator used to collect chronic condition data prevent comparison of local data to survey results as the question asked respondents to indicate which, if any chronic conditions they are living with. As there was no option to say “not applicable” this skews prevalence information by eliminating those who did not indicate a chronic condition and those who skipped the question from the calculation.

As one might expect, the prevalence of chronic conditions among survey respondents increased consistently with age. Younger respondents (age 16-34) who were living with a chronic condition were most likely to indicate having chronic pain (23%), asthma (22%) and arthritis (14%), while individuals age 65 and older were more likely to report living with arthritis (30%), diabetes (20%) and chronic pain (13%).

73 survey respondents indicated they required help managing chronic conditions. The conditions cited include: mental health issues including depression, anxiety, stress, post-traumatic stress disorder, addiction, anger, etc. (42%), chronic pain (41%), diabetes or diabetes related complications such as wound care (20%), COPD (6%), arthritis (6%), cancer support (4%), Hep C (3%) and epilepsy (1%).

Generally individuals with lower educational attainment levels were more likely to indicate needing assistance with managing chronic conditions; however the two groups that were most likely to indicate requiring assistance were those with a post-secondary certificate or trades certification (42%) and those with a graduate level degree (36%). As 30% of graduate educated individuals were over the age of 65, age may account for the high number of these individuals requiring assistance with managing a chronic condition. As those with a post-secondary certificate or trades certification displayed a younger age distribution than the survey average, age cannot account for the higher than average need for assistance in managing chronic conditions.

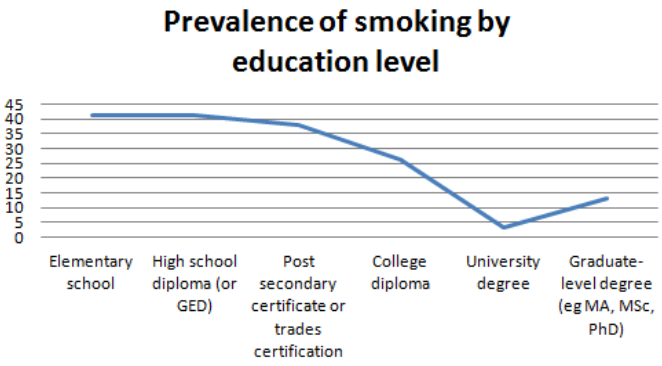
Health behaviours

The prevalence of various health behaviours among survey respondents and the general population are presented in ***Table 3.***

Table 3: Prevalence of various health behaviours

	Survey Respondents	BCHU Data*
Current Smokers	32%	25%
Healthy Eating *do not eat recommended amount of fruits and vegetables*	65%	41%
Daily Physical Activity *Low to moderate*	o 17% less than 10 minutes o 29% 10-30 minutes o 23% ½ hr to 1 hr o 18% more than two hours	
Vigorous activity that gets heart rate up	o 58% less than 10 minutes o 18% 10-30 minutes	

Survey respondents are more likely to be current smokers than the general community (32% vs. 25%). The highest proportion of smokers were age 35-44 (44%). Other age categories displayed a smoking rate of between 35% and 40% however smoking behaviours began to decline at age 55 with 13% of those age 55-64 being current smokers and 0% of those over age 75 being current smokers.



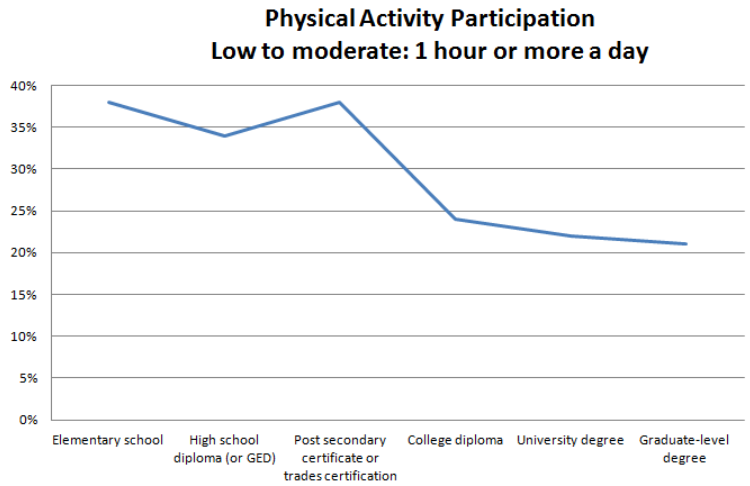
Smoking behaviours appeared to be most closely associated with education status. With the exception of individuals with a graduate degree, smoking behaviours predictably decreased with increased educational attainment levels with 41% of elementary graduates and only 3% of university graduates indicating they currently smoke.

Survey respondents were less likely than the broader community to report eating the recommended number of fruits and vegetables a day (35% vs. 59%). Generally, among survey respondents the percentage of those not eating the recommended amount decreased with increasing income and to a smaller degree education levels. Those who perceived their physical health as excellent were 25 times more likely to report eating the recommended number of fruits and vegetables in a day than those with poor health. The most commonly cited reason for why respondents do not eat the recommended amount was expense (50%), followed by a lack of time (20%) and disliking the flavour / not knowing how to properly cook (14%). Cost was more likely to be a factor for lower income individuals with time being more of a factor among higher income earners. Food security issues will be further explored in the "Income" section.

With respect to physical activity levels, the majority of respondents indicate participating in low to moderate physical activity for 10 minutes to 1 hr a day. Generally, physical activity levels

decreased with age with 54% of those age 16-24 indicating participating in low to moderate physical activity for at least an hour a day and 10% of those over the age of 75 indicating the same.

Education level more reliably predicted physical activity levels than income. Lower educational attainment was associated with more time being dedicated to low to moderate physical activity. This may be due to a greater reliance on manual and/or physical modes of transportation and/or having more leisure time.



17% of respondents indicate participating in low to moderate exercise less than 10 minutes a day. When compared to the survey average, these individuals are more likely to:

- make less than $20,000 (70% vs. survey average of 45%)
- rate their physical health as poor or fair (76% vs. survey average of 32%)

Far fewer respondents indicated participation in vigorous physical activity that gets their heart rate up with 58% indicating less than 10 minutes and 18% indicating 10-30 minutes. Comparable community-level data for physical activity participation does not exist as Statistics Canada aggregates information on nature, frequency and duration of physical activity into a score, ranking an individual as “inactive, moderately active or active.”

Focus group results suggest that barriers to physical activity experienced by clients include a lack of access to welcoming, non-judgemental weight management options and a lack of access to physiotherapy and occupational therapy. It was recognized that a lack of physical activity may play a role in perpetuating poor sleep patterns observed among clients, in addition to underlying mental health issues.

Access to services

Table 4 summarizes survey respondents' ratings of access to key health and wellness services. Overall, the services which received the highest proportion of "poor access" ratings include: complementary health practitioners (19%), dental care (16%) and rehab services (15%). The services that received the highest proportion of "excellent" ratings include: doctor or nurse practitioner (33%), dental care (26%), and physical activity programs (21%).

Table 4: Health and Wellness Service Access Ratings

	Poor	Excellent	Unsure
Doctor or Nurse Practitioner	11%	33%	2%
Rehab services such as physiotherapy	15%	12%	26%
Mental health and addiction support	9%	20%	23%
Complementary health practitioners such as: naturopaths, chiropractors	19%	13%	28%
Dental care	16%	26%	10%
Family violence prevention and support	9%	15%	33%
Dietitian services	9%	18%	26%
Healthy eating classes	9%	17%	26%
Programs to manage chronic conditions	13%	13%	33%
Physical activity programs	12%	21%	19%
Skill development programs	10%	16%	33%
Safe and affordable childcare services	14%	14%	45%
Smoking cessation programs	8%	12%	48%
Stress management	12%	14%	31%
Anger management	10%	10%	39%

Table 5: Geographical comparison of top service access issues

Brantford	Brant County
Rehabilitation services (21%)	Complementary health practitioners (10%)
Complementary health practitioner (21%)	Programs to manage chronic conditions (9%)
Safe and affordable childcare services (20%)	Dental care (7%)
Dental care (17%)	Safe and affordable childcare (6%)
Skill development programs (17%)	Dietitian and healthy eating classes (5% each)

Geographical differences existed in service access ratings. ***Table 5*** summarizes the top five issues with service access in the County and Brantford. Both County and Brantford residents identified access to complementary health practitioners, dental care and safe and affordable childcare as poor. Brantford residents also rated access poor for rehabilitation services and skill development programs while the County residents experience poor access to programs to manage chronic conditions, dietitian services and health eating classes.

Income more strongly predicted service access ratings than education level. Generally, service access ratings improved with income with lower income individuals being more likely to rate service access as poor or fair across all categories. Individuals making less than $20,000 a year were most likely to rate service access as poor for the following: complementary health practitioners (36%), dental care (24%), rehab services (26%) and programs to manage chronic conditions (23%).

When data is stratified by smoking status, 30% of current smokers rate access to smoking cessation programs as poor or fair, while 27% indicate being “unsure.” This may mean they do not know how to access a program or have never tried.

When stratified by perceived mental health status, 32% of those who rated their mental health as poor rated access to mental health and addiction support services as poor or fair while 44% rated access as very good or excellent. 16% were unsure.

Services that had the lowest response rates include: safe and affordable child care (205), smoking cessation programs (212), skill development programs (226), family violence prevention and support (234), complementary health practitioners (242).

Low response rates and the high percentage of “unsure” responses may have occurred as people do not need to access these programs or they do not know how. It may also be explained by various factors related to the survey itself such as: survey fatigue (it was a long question positioned late in the survey) and wording ambiguity (“access” could mean different things to different people).

Service access was one of the main issues identified in the focus group as impacting clients’ health and wellbeing. Specific service access issues discussed include poor access to: dental care, physiotherapy and rehabilitation services, mental health crisis services and cognitive and dialectical behavior therapy options (CBT/DBT). Further, programs to support young moms was identified as a gap including education on nutrition, how to stimulate your child through reading and play, etc.

Barriers to service access among our client population identified in the focus group include: lack of availability, lack of affordability, lack of knowledge of existing programs and services, and poor follow-up on referrals which may stem from lack of transportation and lack of access to phone or computer to communicate. It was also identified that GRCHC should undertake strategies to become more informed of programs and services in the community to support connections between clients and existing services.

The survey asked a series of qualitative questions were asked to identify areas that GRCHC should offer or expand programs and services. Responses related to service access suggest that people have issues:

- Finding after hours care. Several people suggested GRCHC offer a walk in clinic
- Finding a doctor or nurse practitioner. It was suggested GRCHC reduce waiting time for individuals without a primary care provider.
- Obtaining ongoing free or low cost counselling services.
- Accessing affordable dental care

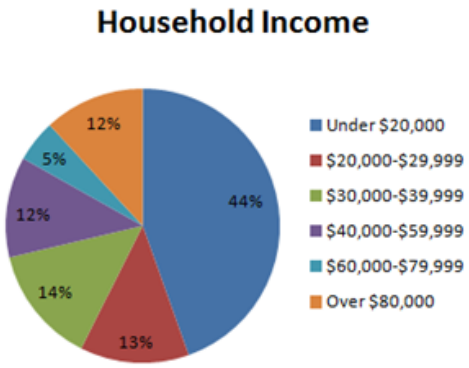
Further, 100 individuals indicated they could use help with the following health and wellness issues: stress management (18%); budgeting (10%); employment and income assistance (6%); healthy eating support (5%); counselling (4%); physical activity and help with government paperwork (2% each); family violence prevention and support, massage therapy, occupational therapy, help with activities of daily living, transportation, childcare (1% each).

2.0 Living Standards

For the purpose of this survey, living standard questions focused on income and employment, food security and economic security.

Income

Household income of survey respondents is summarized in the pie graph. 45% of survey respondents reported making less than $20,000/year. The most comparable data available at the community level is percentage of people living below the low income cut off. Within the Brant County Health Unit area, 11% of families are identified as low income (Statistics Canada, 2013).



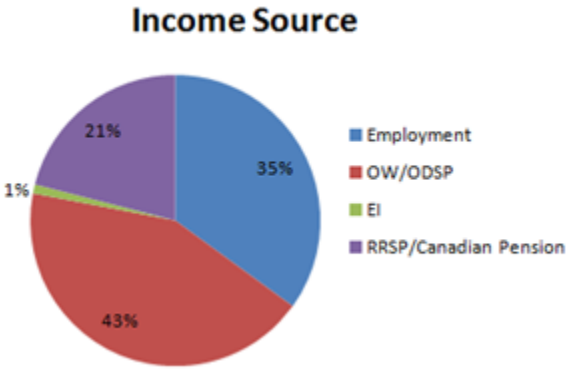
The likelihood of one making less than $20,000 a year declined with age with 75% of those ages 16-24 and 23% of those age 75+ indicating said income. The obvious exception was those age 55-64 of whom 59% indicated making less than $20,000 a year.

As mentioned previously, the proportion of survey respondents rating their physical and mental health as poor or fair increased with lowering income levels. Of those rating their physical health as poor, 83% made less than $20,000 a year while 70% of those rating their mental health as poor report making less than $20,000 a year. When broadly compared to those that make more than $20,000 a year, individuals that make less than $20,000 a year were:

- Nearly 4 times as likely to rate their mental health as poor or fair (OR=3.7)
- 3 times more likely to rate their physical health as poor or fair (OR=3.2)

Generally, income rose with education level. 65% of people whose highest level of schooling was elementary school earned under $20,000 a year while 25% of individuals with a university degree and 40% of individuals with a graduate level degree cited a household income of more than $80,000. 70% of high school graduates earned less than $30,000 a year.

Employment



The majority of respondents relied on OW/ODSP as their main source of income (43%), followed by employment (35%), RRSP/Canadian Pension (21%) and EI (1%).

Individuals age 16-24 were most likely to indicate being on OW/ODSP (60%) followed by age 55-64 (53%) and age 45-54 (51%). Those ages 25-54 were most likely to be employed (range of 46%-52% across all age categories). Employment was associated with improved health status. The majority of individuals rating their physical and mental health as excellent relied on employment as their primary source income (48% and 43% respectively).

Individuals rating their physical and mental health as poor were more likely to rely on OW/ODSP as their primary source of income (81% and 68% respectively). Those relying on OW/ODSP were 17 times more likely to rate their physical health as poor and three times more likely to rate their mental health as poor than those relying on employment.

Education level was predictive of employment status with 67% of university educated respondents relying on employment as their main source of income and 14% of elementary school graduated relying on employment as their main source of income.

Focus group results suggest programs to support job placement would benefit our clientele. As these programs already exist in the community, an opportunity may exist to facilitate connections.

Economic and Food Security

The proportion of individuals indicating that they never had issue making ends meet increased with income; however no income level was immune from economic security struggles, with 30% of those making above $80,000 indicating they had issues making ends meet up to several times in a year.

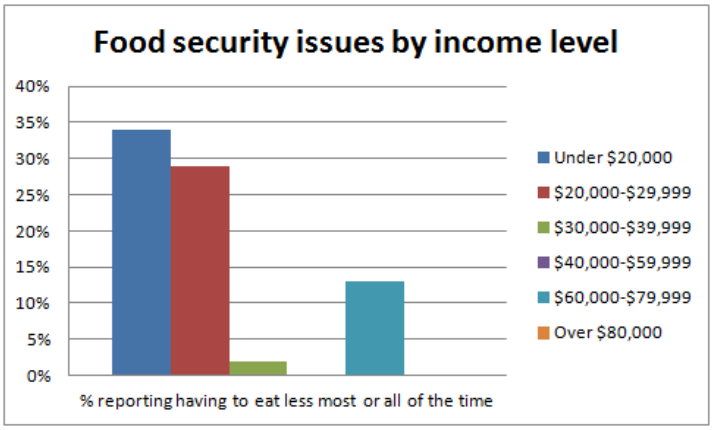
18% of all survey respondents indicated that they had trouble making ends meet on a regular basis (weekly or monthly). Of these people,

- 70% made less than $20,000 / year
- 20% indicated elementary school as their highest level of schooling completed
- 52% eat less than they wanted to “most or all of the time” due to food being too expensive (vs. survey average of 19%)
- 51% rated their physical health as poor or fair (vs. 41% survey average)
- 55% rated their mental health as poor or fair (vs. 34% survey average)

37% of respondents indicated that money was a barrier to participating in activities that bring them happiness. The frequency that money was a barrier increased with decreasing income.

Focus group attendees recognized that the cost of prescriptions were prohibitive and a barrier to promoting health among clients.

Generally, the likelihood of someone experiencing food security issues decreased with increasing income. 19% of survey respondents indicated that in the last year, they have to eat less than they wanted to "most of the time" or "all of the time." Of these people, 77% earned less than $20,000 a year while 95% made less than $30,000. These individuals were 14x more likely to rate their physical health as poor and 17x more likely to rate their mental health as poor than those who never experience food security issues.



Cost was identified by 50% of respondents as the reason why they do not eat the recommended number of fruits and vegetables in a day.

Focus group results suggest that poor access to dental care may perpetuate food security issues by further limiting clients' ability to eat a range of available foods. Further, single men may be at increased risk of food security issues due to declining access to food banks or community meal program because of pride or feelings that "someone else needs it more."

3.0 Education and Literacy

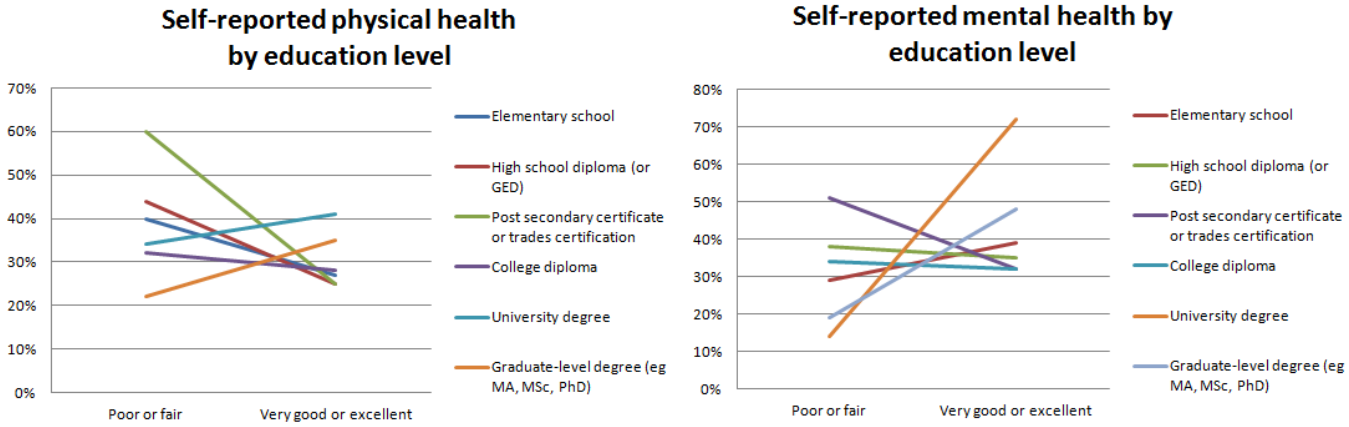
Educational attainment levels among survey respondents appear to be similar to regional averages; however given differences in defined age categories and question structure,[1] side by side comparisons are not possible.

- At the BCHU level, 87% of individuals age 24-29 indicate having graduated high school while 59% age 25-54 indicate being post-secondary graduates (Statistics Canada, 2013).
- 88% of survey respondents over the age of 25 indicated high school or above as their highest level of educational attainment while 52% of respondents over the age of 25

[1] Survey data was collected based on the following age categories 16-24, 25-34, 35-44 etc. With respect to educational attainment, the survey asked what the highest level of achievement was and it is assumed if post-secondary studies are indicated that high school was completed although this may be a flawed assumption.

indicate finishing post-secondary programs (university, college or certificate or trades certification).

Nearly 13% of respondents indicated elementary school as their highest educational attainment. The majority of these people were age 65-74 (10), followed by age 45-54 (7), age 75+ (5), age 35-44 (4) then age 25-34 (2). Individuals who identified elementary school as their highest achievement were more likely to make less than $20,000 (65% vs. survey average of 45%); however this did not translate into a significant difference in self-reported health status. 35% of those indicating elementary school as their highest level of education relied on RRSP or Canadian Pension as their primary source of income while 51% relied on OW/ODSP.



The[a2] graphs above portray the relationship between perceived health and education level. Downward sloping lines indicate that a higher proportion of individuals rated their physical or mental health as poor or fair than very good or excellent. For physical health, this included individuals whose highest level of education attained was: post-secondary certificate, high school diploma, elementary school and college. For mental health this included those with a post-secondary certificate and to a much smaller degree those with a high-school diploma.

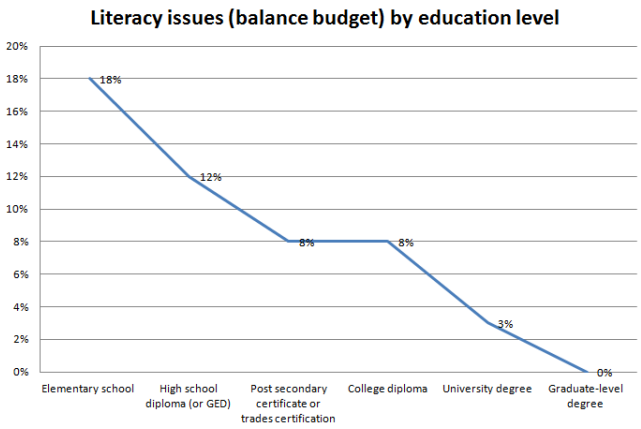
The upward sloping line indicates that a higher proportion of individuals rated their physical or mental health as very good or excellent versus poor or fair. For physical health this included only those in the highest levels of educational attainment (university and graduate degrees). For mental health this included all categories except post-secondary certificate and high-school diploma.

Those individuals with a post-secondary certificate were disproportionately more likely to rate their physical and mental health as poor or fair (60% and 51% respectively). They were three times more likely to rate their physical health as poor or fair than individuals with a university degree. These individuals displayed a younger age distribution than the survey average so differences in self-reported physical health status cannot be attributed to age. Individuals with a post-secondary certificate were more likely than all other educational levels combined to indicate

they had to take time off their regular activities in the last month for a mental health or emotional issue (58% vs. 32%).

On the whole the majority of respondents indicated that they felt their reading, writing and math skills were strong enough to participate in activities required for daily life (read medications, balance budget and complete job application). Numerical literacy appeared to be the biggest issue among respondents with 11% of people indicating they did not feel they could balance a budget and 6% indicating they could not read and follow the instructions for medications. 9% of people that responded indicated they could not fill out a job application.

Unfortunately due to some of the justifications provided on the survey form, it seems possible that this question was misunderstood by respondents. For example, many of those who indicated they were incapable of filling out a job application justified that age or disability made them ineligible to work. Likewise, those indicating that they could not balance a budget may have been referring to income issues rather than literacy issues.



As one might expect cited literacy issues were higher among individuals with lower educational attainment levels with 18% of those indicating elementary school as their highest level achieved indicating issues with balancing a budget, 13% with issues writing a job application and 10% with reading and following the directions on medication. Likewise, individuals that report earning less than $20,000 a year exhibit lower literacy levels with 13% report being unable to fill out a job application and 19% report being unable to balance a budget.

Of all of the respondents who indicated literacy issues:

- 100% lived in Brantford, downtown being the most commonly cited neighbourhood.
- 83% made less than $20,000 /year
- 75% were on OW/ODSP
- 58% rated both their mental and physical health as poor or fair (vs. 37% of individuals without literacy issues)
- 58% rated their mental health as poor or fair (vs. 32% of individuals without literacy issues)
- 100% did not eat 5-10 servings of fruits and vegetables
- 80% were age 16-24, 35-44 or 55-64

Ultimately, those with lower literacy and educational attainment levels tended to be more likely to rate their physical health as poor or fair than individuals with higher education attainment

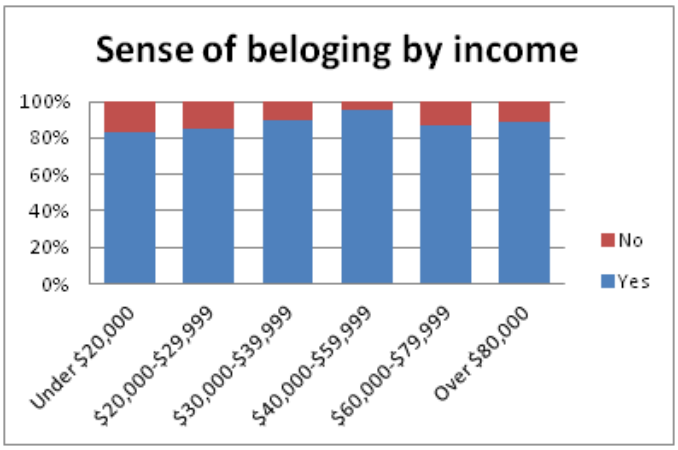
levels and no literacy issues. Those with a post-secondary certificate or trades certification were more likely than all other groups to rate their physical health as poor.

3.0 Community Vitality

To assess Community Vitality, survey questions focused on factors which impact an individual's connection to their community and their interpersonal relationships. Given the qualitative nature of the data collected in this domain an overview of themes will be outlined based on questions.

Question 1. Do you feel like you belong in your community? Why or why not?

87% of respondents indicated that they felt they belonged in their community. This did not differ significantly between Brantford and Brant County residents. Sense of belonging increased with income level until $60,000 and then began to decline.



Various aspects of the social and built environment were cited as the main reason why a person did or did not feel as though they belong (see below), with the social environment playing a much larger role for more people. When appropriate, additional statistics from the survey will be used to back up qualitative responses.

Theme 1: Social Connectedness

31% of people that indicated they do not feel like they belong cited a lack of social connection due to: having just moved here, not knowing anyone, or not having anything in common with anyone. Of the social connections mentioned, neighbours and family were most frequently cited as reasons why someone felt they belonged or didn't belong.

Neighbours play an important role in fostering a sense of belonging. Many of those that felt they belong credited their trust and reliance on neighbours.

- 59% of people who indicated they felt like they belonged indicated they trusted "many or most" of their neighbours. More people in the County trusted many or most of their neighbours than Brantford; however this didn't result in more County residents indicating they feel they belong. Mirroring the sense of belonging trend, the proportion of individuals who trusted many or most of their neighbours increased with income until a threshold of $60,000 and began to decline.

- Those people that indicated they did not feel like they belonged in their community were more likely to say they trust none or very few of their neighbours than those that do (32% vs. 10%).

Family living close by was credited for why someone felt they belonged, particularly having children grow up in the area. Conversely, some individuals commented that not having kids excluded them from taking part in many community events and they found a lack of children a barrier to meeting people with similar interests. Likewise, someone commented that now that their kids were grown they felt they had outgrown Brantford.

Individuals who identified as LGBT were more likely to indicate they did not feel they belonged due to a lack of social connectedness. They indicated feeling there was a lack of opportunity to connect with people who were "like" them.

Theme 2: Community Culture

Residents' friendliness, openness to new people and non-judgemental nature were cited as reasons that people felt they belonged. Conversely, individuals that felt discrimination due to race, culture, ethnicity, sexual orientation, were more likely to say they did not belong. This was particularly evident among individuals who identified as LGBT.

Theme 3: Involvement in the Community

Involvement in the community was often credited as a reason a person felt they belonged or not.

- Those that indicated they felt they belonged cited involvement in boards, committees, community events or programs.
- Reasons that people didn't feel they belonged were that they had a hard time connecting with people in the community that were "like" them or that the community events were mainly focused on families.

Theme 4: Perception of crime or safety

An individual's perception of crime or safety played a role in determining whether they felt they belonged or not. Those that felt they did not belong blamed high crime rates and past personal experiences with crime. Cited issues included violent crime, theft, vandalism, and drugs and alcohol. Those that indicated they do not feel like they belong in their community were more likely to say they would not walk alone at night (51% vs. 25%).

People that felt they did belong credited feeling safe at home due to their housing situation (retirement complex and locked condo building).

Theme 5: Housing

As mentioned previously, several people credited their housing situation for why they felt they belonged in their community, particularly due to how safe they felt there. Others felt they

belonged because they owned their home or because their home was in close proximity to friends and family.

Conversely, people who felt threatened in their home did not feel they belonged. In one particular instance a respondent referenced an ongoing mould issue with why they felt they did not belong.

Theme 6: Access to service and amenities

Access to services and amenities was frequently mentioned as to why someone feels they belong or not. People that felt they belonged mentioned that all the amenities they needed were close by or walkable. Specific services and amenities that were mentioned included: community centres, the health centre, parks, faith based organizations and soup kitchens.

People that did not feel like they belong indicated barriers to accessing services and amenities. One person felt that there was a lack of services available to them because they were gay. Another individual mentioned that they did not feel they belonged because they were in a wheelchair and not everywhere was accessible.

Theme 7: Natural environment

The natural environment was credited for feelings of belonging both positively and negatively. Someone who had recently moved to Brantford missed the open spaces of the County and felt they didn't belong. Others that did feel they belonged credited trail access, beautiful scenery and clean parks.

Question 2. Do you feel safe walking alone in your neighbourhood at night?

71% of respondents indicated that they felt safe walking alone in their neighbourhood at night. More County residents felt safe walking alone at night; however this did not translate into higher sense of belonging in the County. There were no significant differences across Brantford neighbourhoods as to whether someone would feel safe walking alone at night.

Those with poor physical and mental health were less likely to feel comfortable walking alone at night than those in excellent health.

Question 3: How many friends or relatives do you feel comfortable calling for support?

The Canadian Index of Wellbeing suggests that a measure of health is the number inter-personal relationships that a person has. Evidence indicates that people with 6 or more close friends will have better health outcomes. As outlined in Table 6, 17% of survey respondents indicated they had 6 or more close friends, while 22% indicated having 0-1. The majority of respondents indicated having 2-3 (40%).

Individuals who indicated having 0-1 close friends or relatives were nearly 13 times more likely to rate their mental health as poor or fair than someone with 6 or more (OR=12.8) and nearly five times as likely to rate their physical health as poor or fair (OR=4.5).

Table 6: Perceived health by relationships

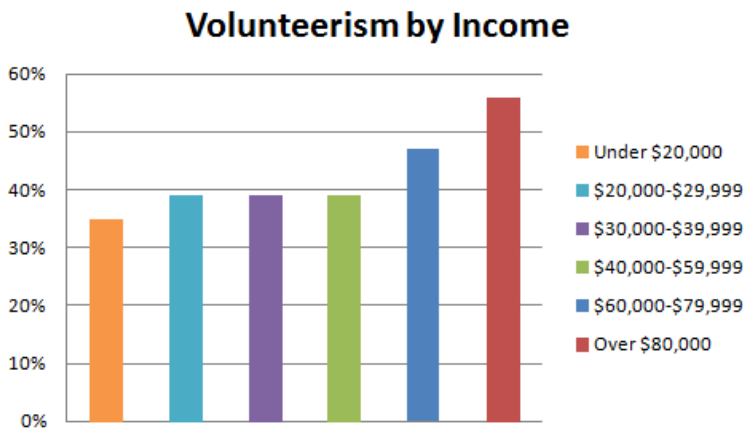
	Mental Health		Physical Health	
	Poor or Fair	Very Good or Excellent	Poor or Fair	Very Good or Excellent
0-1	56%	20%	60%	16%
6+	9%	67%	25%	52%

Individuals who indicated they had 0-1 close friends were five times more likely to indicate having had to take time off their regular activities due to a mental health or emotional issue than those with 6 or more (49% vs. 16%, OR=5). Further the average number of days taken off in the last month was also higher for individuals with 0-1 friends (15 days vs. 6).

4.0 Culture, Leisure and Time Use

"Culture and Leisure" and "Time Use" domains assess how people use their time, what factors control time use and how this impacts health and wellbeing. The survey focused on time dedicated to: arts and culture, volunteerism, and friends and family; and time as a barrier to participating in activities that bring happiness.

40% of respondents indicated volunteering within the last month. The proportion of individuals indicating volunteerism increased with income from 35% of those making less than $20,000 to 55% of those making more than $80,000. Likewise, higher education level was associated with higher volunteerism with university graduates being nearly four times as likely as elementary school graduates to indicate volunteerism (OR=3.7). There was no difference in sense of belonging to community among respondents that indicated volunteering and those that didn't; however, based on qualitative feedback volunteering was recognized as fostering an individual's sense of belonging.



Community organizations were identified as the most frequent volunteer location (38%) with the most cited places being: CMHA, food bank or meal provider programs, nursing homes, and GRCHC. Informal volunteering for family or within the neighbourhood was identified by 16% of respondents, followed by school and faith based organizations at 11% each. Less common were personal interest groups and service organizations such as lions and optimist (less than 1% each).

Time was indicated as a barrier to participating in activities that bring respondents' happiness. The frequency that time was a barrier increased with increasing income.

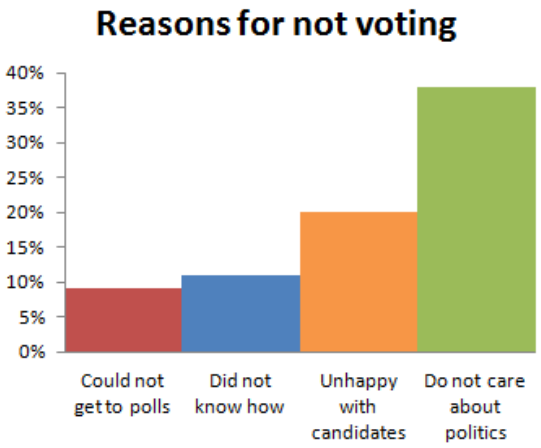
With respect to leisure time use:

- Screen time was the most frequent leisure time activity for respondents with 57% of people spending more than 2 hours a day watching television or using screen-based technology (smart phone, tablet, etc.). Generally, screen time increased with lowering education levels with 82% of those indicating elementary school and 40% of graduate educated respondents dedicating more than 2 hours a day to screen time.
- 42% of individuals spend more than two hours daily with family a friends. Time during the day spent with family or friends increased with income until the threshold of $60,000 yearly earnings.
- 60% of individuals dedicate less than 10 minutes a day to arts and culture. The proportion of individuals dedicating less than 10 minutes a day to arts and culture increased with lowering education levels.

5.0 Democratic Engagement

Democratic engagement refers to the participation of citizens in "public life and governance." Given that questions regarding volunteerism and involvement in community organization governance were reported earlier, the survey focus for this domain was voting and confidence in local decision makers.

58% of respondents indicated that they voted in the last election which is higher than the average in the latest provincial election (52%).[2] Education level more strongly predicted voting behaviours than income with 50% of elementary school and 83% of graduate educated respondents indicating having voted in the last election. Literacy also played a significant role in predicting whether someone voted with up to 70% of individuals with literacy issues indicating not voting.



Of those people that did not vote in the last elections: 40% (51) indicated it was because they didn't care about politics, 20% (27) were unhappy with the candidates, 11% (15), did not know how and 9% (13) could not get to the polls.

Individuals in lower income categories tended to indicate not caring about politics. 67% of retired individuals cited their reason for not voting as being unhappy with the

[2] Elections Ontario preliminary results as reported by "The Star"
http://www.thestar.com/news/canada/2014/06/13/voter_turnout_in_ontario_election_increases_for_first_time_in_two_decades.html

candidates. The remainder of individuals cited reasons such as: not being a citizen, not being old enough, they did not receive voting card in mail, or they did not subscribe to the political agenda.

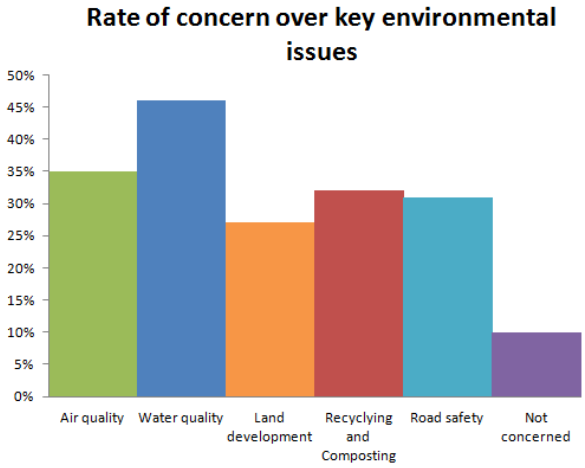
When asked whether they believe that local decision makers respect differing opinions raised by constituents, 38% of individuals "agreed or strongly agreed" while 22% indicated they "disagree or strongly disagree." 40% of respondents indicated that they "do not know." The proportion of individuals indicating they "do not know" increased with lowering income and literacy levels. This may represent a general lack of interest or involvement in local politics; however 42% of these people indicated they voted in the most recent election.

6.0 Environment

The environment domain refers to the health of the natural environment. For the purpose of this survey, we sought to identify respondents' satisfaction with the local environment and issues of concern.

The majority of respondents indicated they were somewhat or very satisfied with the local environment; however, 90% of respondents indicated they were concerned about one or more environmental issues.

In order of most commonly cited issues of concern water quality, air quality, road safety and recycling and composting and land development.



Water quality and air quality were of higher concern to lower income earners while recycling and composting were priorities for higher income earners.

Advice for GRCHC:

In addition to requesting information to assess the health and wellbeing, the survey requested feedback to assess how GRCHC is doing and how we might improve programs and service delivery. Given the qualitative nature of these questions, responses were compiled and manually analyzed to determine themes. Reporting will be based on the themes identified.

Question 1: Are there any groups of people or communities that you feel GRCHC could serve better?

There were 107 people that responded when asked whether there were any groups of people that GRCHC could serve better. The top groups identified were:

- Those experiencing chronic pain – 11 responses
- LGBTQ – 9 responses
- Physically challenged or those living with a disability – 7 responses
- People living with mental health issues – 5 responses
- People who are experiencing stable or safe housing issues – 4 responses
- First Nations (on reserve and urban) – 5 responses
- Children and youth – 4 responses
- People with autism or developmental delays – 3
- Enhance outreach services for people who can't or won't leave house - 3
- People with no primary care provider or insurance – 3
- Caregivers – 2
- Respite – 1

Of note, the phrasing of the question included examples to promote question understanding. The examples provided were "individuals living with a disability or experiencing chronic pain, the LGBT community." Given that the top three results were the examples provided it is possible that question wording may have biased the results.

Question 2: Do you have any thoughts or feelings about GRCHC or any advice for us going forward that you would like to share?

144 responses were received, an overwhelming number of which praised GRCHC's high quality, responsive services; the welcoming, clean environment; and the kind, compassionate and helpful staff. Some quotes reflecting these responses:

- Thank-you for all the work you do [in the LGBTQ] area so far. I am looking forward to seeing what happens next.
- I feel that this place in comparison has the friendliest and warmest feel/vibe to it in all of Brantford. Great environment. Happy, understanding staff. Awesome programs available.
- I am glad that this is where my doctor is, I have never been looked after like this ever before. I'm so lucky to have this building to come to.
- Best health care providers in our community. You have formed an intricate part in my life and I certainly appreciate it.
- I've never been in a better facility than this one. You look after all people that I can see.
- Very happy with GRCHC and all the services and support we have received for our family... Even at last minute (appointments etc).

There were also many responses received regarding the positive impact of programs offered on both individuals and the community, such as:

- I think you do a great job engaging the community and offering relevant and interesting programs.

- I enjoy the program I'm in, Caring for COPD. It has taught me a lot about caring for my condition. Thanks for the wonderful support group.
- Promoting of community health - eating healthy and community garden programs are great initiatives
- I've really enjoyed the programs I use (creative). They get me out of the house and out of being depressed (sleeping).
- I LOVED the SELF program, there should be a second part

Nearly 10% of responses suggested GRCHC advertise services and programs more widely in the community to increase public awareness of what is offered.

Additional suggestions received include:

1. Increase service access, specifically in the following areas:
    - walk in clinic or after hours care options (5)
    - reduce waiting time for clients requiring a primary care provider (4).
    - Improve wait times for specialists (2)
    - offer free or low cost counselling supports (4)
    - increase outreach to seniors in their home and to the local church dinners (3)
    - improve access to dental care, especially for seniors (5)
    - offer anonymous HIV testing in Brantford (1)
2. Continue to promote individual and community health:
    - Support care co-ordination (5). Specific areas mentioned included: enhance advocacy and co-ordination services for health and legal issues, limit "bouncing from one person to the next," and assist clients in obtaining a health card.
    - Increase program offerings (10). Program areas suggested include:
        - "skill development, general interest courses open to everyone, health-related info sessions in a group setting eg. diabetes, mental health, how to help family members,"
        - more programs like the healthy eating and community garden projects
        - art based programs for men (like the women's craft group) and for people with mental health issues (like the one that used to be offered at St. Leonards)
        - a book club, art club and cooking class for people with mental health issues
        - more general support groups
        - programs for the elderly
        - physical activity programs that are longer than 6-8 weeks.
        - LGBT programs for youth
3. Improve built and social environment for clients at Centre:
    - Increase sensitivity to people with hearing and motor disabilities (1)
    - Offer high chairs for people with back issues (1)
    - Enhance number and sensitivity of services for native people with trust issues (1)

- Offer coffee and tea in waiting areas (1)

4. Improve communication
    - "Without a phone or computer it is difficult to coordinate appointments" (1)
    - Eliminate auto voicemail (1)

One of the main issues identified in the focus group was that clients do not feel safe in the lobby, predominately due to other clients. This issue is especially evident among clients with anxiety issues. It was mentioned that there have been several occasions where clients have left before their appointment as they could not wait in the waiting area.

Co-ordination was also identified as an issue in the focus group, specifically due to a lack of knowledge of existing programs and services in the community that they can refer clients. Existing databases were identified that providers can refer too; however as time during regular appointments is prohibitive it was suggested that a client be referred to a staff member who can help address clients "social needs" such as a community support facilitator.

Program opportunities identified in the focus group include: job readiness programs, winter clothing drive, programs to address prohibitive cost of prescriptions, [a3]physical activity and weight management programs, and programs for young mothers to support their transition into motherhood.

Discussion

This section will be dedicated to summarizing where the greatest disparities were observed, which factors were most connected to perceived health and additional health and wellness issues and the top comments received regarding how GRCHC can improve program and service delivery.

Compared to the general Brantford and Brant County populations, survey respondents were:

- Less likely to rate their physical and mental health as very good or excellent
- More likely to participate in negative health behaviours, including:
    - More likely to be current smoker
    - Less likely to eat the recommended number of fruits and vegetables a day
    - More likely to make less than $20,000

Factors which were most likely to impact perceived health include:

1. Social connectedness:
   One of the strongest predictors of individual's perceived health was social connectedness. Individuals with 0-1 close friends or relatives were nearly 13 times more likely to rate their mental health as poor or fair than someone with 6 or more (OR=12.8) and nearly five times as likely to rate their physical health as poor or fair (OR=4.5).

2. Income:
   Generally, the proportion of individuals rating their physical and mental health as poor or fair increased with lowering income levels. Ultimately, individuals who made less than $20,000 a year were:
   - More likely to perceive their mental health and physical health as poor
   - More likely to smoke
   - Less likely to eat healthy and the reason why is more likely to be cost
   - More likely to experience regular food and economic security issues
   - More likely to dedicate time to low to moderate physical activity; however less likely to participate in vigorous physical activity
   - More likely to dedicate spare time to "screen time"
   - More likely ate service access as poor, especially for complementary health practitioners (36%), dental care (24%), rehab services (26%) and programs to manage chronic conditions (23%).

3. Employment
   Employment was associated with better health outcomes. Individuals relying on OW/ODSP were 17 times more likely to rate their physical health as poor and three times more likely to rate their mental health as poor than those relying on employment.

4. Food Security
   Individuals who experience food security issues "most or all of the time" were 14x more likely to rate their physical health as poor and 17x more likely to rate than mental health as poor than those who never experience food security issues. Generally, the likelihood of someone experiencing food security issues decreased with increasing income.

Educational attainment was also associated with health status; however less predictably than the aforementioned factors. Generally, those with lower literacy and educational attainment levels tended to be more likely to rate their physical health as poor or fair than individuals with higher education attainment levels and no literacy issues. Education level was predictive of employment status with 67% of university educated respondents relying on employment as their main source of income and 14% of elementary school graduated relying on employment as their main source of income. Based on educational attainment level, the greatest disparity in health and wellness was observed among individuals with a post-secondary certificate or trade certification. Despite exhibiting a younger age distribution these individuals were:

- More likely to rate their stress level as high or very high
- More likely to need help managing a chronic condition
- More likely to rate their physical and mental health as poor or fair

Based on the results of the survey, a demographic profile of individuals rating their physical and mental health as poor and excellent are presented in ***Table 8.***

Table 8	Poor physical health	Excellent physical health	Poor mental health	Excellent mental health
Age	Age 45-54	Age 55-64	Age 45-54	Age 65-74
Marital Status	Single	Married	Single	Married
Education	Highschool graduate or postsecondary certificate/ trades certification	College graduate	Highschool graduate	Highschool graduate
Employment	OW/ODSP	Employed	OW/ODSP	Employed
Income	Under $20,000	Over $80,000	Under $20,000	$30,000-$39,999

Table 7: Connection between education and income and various health and wellness issues

Education	Income
Smoking behaviour	Time / money as barriers to happiness
Volunteerism	Healthy eating and food security
Screen time	Environment concern
Physical activity	Service access issues
Literacy	
Voting behaviours	

Disparities in additional health and wellness issues observed within the survey respondent population were most commonly linked to income and education. ***Table 7*** provides an overview of which factors were more strongly linked to income and education**.** Generally, factors more closely related to income included: time and money as barriers to happiness, healthy eating, issues of environmental concern and issues with service access. Education level was most closely related to: health behaviours such as smoking, physical activity participation and screen time; involvement in the community through volunteerism and democratic engagement.

Finally, the top areas where survey respondents suggested GRCHC could improve our health and wellness services include:

1. Increase advertising of programs and services
2. Improve service access with a priority on after hours care, affordable dental care, reducing wait time for new clients to receive a doctor or nurse practitioner, and free or low cost counselling and mental health crisis services.
3. Open up priority populations. Top 3 priority groups suggested: those experiencing chronic pain, LGBTQ, and those living with a disability
4. Continue to expand community health initiatives and wellness programs
5. Address issues related to clients' perception of safety in the waiting room.
6. Create or expand a "community support facilitator" role on staff to help connect clients to services in the community which will promote their health and wellbeing.

Next Steps

In order to support the establishment of health and wellness priorities the GRCHC HP-CD team will work with a facilitator to:

- Review findings
- Identify which findings most align with the CHC mandate and organizational priorities. This step will involve deciding which results are within our purview to address.
- Identify the best strategies to address key findings based on action areas outlined in the Ottawa Charter for Health Promotion. This process will include: an assessment of work already being done by GRCHC and in the community, the identification of gaps and opportunities to undertake internal activities or to work with existing or new partners to address findings.
- Establish priorities and goals for the following year based on the above activities.

The data can also be used to support program planning at the Centre to ensure programs are responsive to the needs and interests of our community. For example, when planning mental health promotion programs or initiatives, we have the capacity to identify key issues impacting all survey respondents who rated their mental health poorly. This can practically support program content as well as specific strategies to enhance accessibility.

Finally, the report will be disseminated to the community and brought to relevant community planning tables to share results and further encourage community action surrounding key findings.

References

Heart and Stroke Foundation (2010). "Heart Disease." *Health Information*. Last updated April 2010. http://www.heartandstroke.ca

Statistics Canada. 2013. Brant County Health Unit (Health Region), Ontario and Canada (table). *Health Profile*. Statistics Canada Catalogue no. 82-228-XWE. Ottawa. Released December 12, 2013.