Ontario's Community Health Centres
Les centres de santé communautaire en Ontario

Final Report on the Use of Community Engagement Funds

Grand River Community Health Centre

Prepared by the Centre Development Team
of the Association of Ontario Health Centres

Submitted by the Board of Grand River Community Health Centre
to the Hamilton Niagara Haldimand Brant
Local Health Integration Network

April 2008

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EXECUTIVE SUMMARY

This Final Report on the Use of Community Engagement Funds documents the research and community consultation carried out by the Association of Ontario Health Centres' (AOHC) Centre Development Team, on behalf of the Steering Committee of the Grand River Community Health Centre between September 2007 and March 2008, and approved by the Board of the Grand River CHC in April 2008.

In November 2005, the Ministry of Health and Long-Term Care (MOHLTC) announced that the City of Brantford was designated to receive a Community Health Centre (CHC). By 2006, the MOHLTC hired the AOHC to conduct a preliminary community engagement (CE) process with the main deliverable of mobilising a committee of local representatives to lead the development of the new CHC. This steering committee, through funding awarded by the Hamilton Niagara Haldimand Brant Local Health Integration Network (HNHB LHIN), contracted the AOHC to undergo an in-depth community engagement process within the municipalities of Brantford and Brant County in 2007.

The CE process was multi-faceted, designed to develop the population health profile of area residents, establish links with local health and social service providers, gain insight into the health needs of Brant residents, increase awareness of the Grand River CHC and understanding of the CHC model by the greater community, and encourage both community members and service providers to contribute their input to the development of and become actively involved with the Grand River CHC.

The key recommendations that have emerged from the CE process include identification of the Grand River CHC's:

- **Catchment area**, covering the municipalities of the City of Brantford and the County of Brant;

- **Priority populations**, including those residents living within the identified catchment area who are not registered with a primary healthcare practitioner, and experience poverty and other barriers to primary healthcare access, with emphasis on: people experiencing homelessness or who are under-housed, seniors, Aboriginal populations living off-reserve without a status card, people with disabilities (physical and/or developmental), mental health and/or addictions issues, recent immigrants, children and youth;

- **Programmes, services and staff**, with a focus on: addressing primary healthcare needs; illness prevention and health promotion programming; chronic disease prevention and management; the social determinants of health; system navigation and the integration of services across the continuum of care; mental health and addictions issues; transportation barriers; and providing accessible healthcare;

- **Locations**, with the primary location in the downtown core of Brantford, and points of access throughout the catchment area that are determined through partnerships with other community agencies.

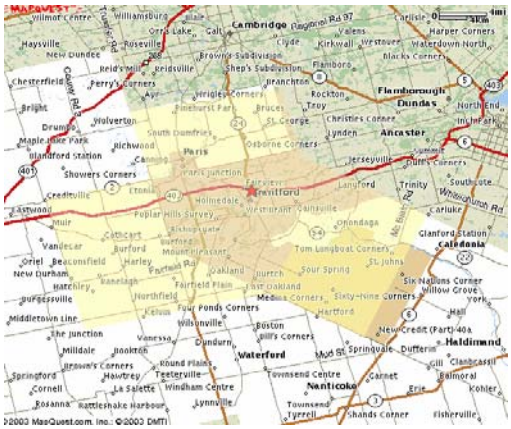
The process also resulted in the election of the Grand River CHC's first Board of Directors.

Following the approval of the Final Report, it is the Steering Committee's intent to communicate these findings to the public, and immediately begin the next phase of pre-operational development of the Grand River CHC. The Board anticipates the opening of the Grand River CHC's doors by the end of the 2008-09 fiscal year.

1. UNDERSTANDING THE COMMUNITY

The municipalities of Brant County and Brantford (commonly referred to as Brant) are located in southern Ontario on the Grand River, covering a land mass of 1,072.9 square km.[1] The City of Brantford, geographically surrounded by Brant County, is bordered by the Region of Waterloo, City of Hamilton, Haldimand County, Norfolk County and Oxford County. The County of Brant, which underwent amalgamation in 2000, includes the former municipalities of Brantford, Burford, Glen Morris Mount Pleasant, Paris, Oakland, Onondaga, St. George, Scotland and South Dumfries. Also included in the census division, but not part of the Brant County municipal government, are Six Nations of the Grand River and Mississaugas of New Credit First Nation. The 2006 population of Brantford (90,192) and Brant County (34,415) combines for a total of 124, 607.[2] Between 2001 and 2006, the combined population grew at an overall rate of 5.6%, although growth rates were higher for Brant County (8.7%) as compared to the City of Brantford (4.4%).[3] The Brant area includes both urban and rural land area.

Figure 1 – Municipalities of the City of Brantford and the County of Brant



[1] Statistics Canada. (2007). *2006 Community Profiles*. Retrieved March 24, 2008 from, http://www.statcan.ca/
[2] Ibid.
[3] Ibid.

1.1 What are your proposed priority populations and catchment area?

Catchment Area

Through the CE process, community members and service providers within the City of Brantford and the County of Brant have indicated that additional health and social services are greatly needed throughout both municipalities.

It is the intention of the Grand River CHC to provide a range of primary healthcare services to residents within Brantford and the County of Brant with focus on those identified as priority populations.

Proposed Priority Populations

The Grand River CHC will provide primary healthcare to residents living within the defined catchment area without a primary healthcare provider, who experience poverty and other barriers to accessing primary healthcare services, with emphasis on:

- *People experiencing homelessness or who are under-housed*
- *Seniors*
- *Off-reserve Aboriginal populations who do not have a status card*
- *People with disabilities (physical and/or developmental) , mental health and/or addiction issues*
- *Children and youth*
- *Recent immigrants*

1.2 Describe the demographic profile of the priority populations and catchment area your CHC intends to serve. Indicate the quantitative and qualitative sources you have used to develop this profile.

The following population health profile provides an overview of Brantford and Brant County residents, as compared to regional and provincial rates, using the most recently available data regarding:

- Demographic Characteristics and Socio-Economic Indicators (Section 1.2)
- Health Status and Health Practices (Section 1.3)

Notes:

- *Statistics Canada data:* The Brantford Census Metropolitan Area (CMA) includes the City of Brantford and the County of Brant.
- *Hamilton Niagara Haldimand Brant LHIN data*: The term 'Brant' encapsulates all of the Brant census divisions (Brant County and the City of Brantford). Please note that the HNHB LHIN extends from Fort Erie to Turkey Point and Paris to Lowville, covering an

estimated 7,000 square kilometres.[4] It includes Brant, Burlington, Haldimand, Hamilton, Niagara and Norfolk. Ten percent of the HNHB population resides in Brant compared to: 38% in Hamilton, 32% in Niagara, 12% in Burlington, and 8% in Haldimand-Norfolk.[5]

- *Brant County Health Unit or the Brant Community Healthcare System data*: 'Brant' is also used to encompass the City of Brantford and County of Brant.

- When available and appropriate, this report separates statistics specific to the County of Brant and City of Brantford. However, when citing public health, hospital and other data, often these divisions between City and County are not available.

A. Demographic Characteristics

i. Population Size and Growth Rate

The population growth rate is an indicator of demographic change in a population. It allows crude estimates to be made of future changes in a population, based on past trends. It is also useful for the planning of programmes and services related to the growth in the total population or certain sub-groups.[6]

Table 1 – Population Size and Growth Rate, Ontario and Brantford CMA, 2001 to 2006[7]

Location	2006	2001	2001 to 2006 population change (%)
Ontario	12,160,282	11,410,046	6.6
Brantford CMA	124,607	118,086	5.5

Highlights:

- Between 2001 and 2006, the population of the Brantford CMA grew at a slower rate than the province as a whole. The City of Brantford's population growth rate (4.4%) was less than that of Brant County (8.7%) during the same time period.[8]

- The Ministry of Finance forecasts that Brant's population will reach 171,700 residents by the year 2031.[9]

- The provincial population is projected to grow by 30.7 % or 3.9 million, from an estimated 12.54 million on July 1, 2005 to 16.40 million on July 1, 2031. The population is expected to reach 14.54 million under the low-growth scenario and 17.85 million under the high-growth scenario by 2031.[10]

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[4] Hamilton Niagara Haldimand Brant Local Health Integration Network. (2006). *Socio-Economic Indicators Atlas* [Electronic version]. Health System Intelligence Project.
[5] Hamilton Niagara Haldimand Brant Local Health Integration Network. (2006). *Quality Care in Community Hands: Building an Integrated Health Service Plan – Phase One* [Electronic versoin].
[6] Regional Niagara Public Health Department. (2006). *Regional Niagara Community Health Profile* [Electronic version].
[7] Statistics Canada. (2007). *2006 Community Profiles*. Retrieved March 24, 2008 from, http://www.statcan.ca/
[8] Ibid.
[9] Ministry of Finance. (2006). *Ontario Population Projections Update*.
[10] Ibid.

ii. Population by Age

Population structure by age reflects events which affect composition of a population (i.e. "baby boom") that can be combined with other variables to highlight population characteristics of interest (i.e. linguistic, socioeconomic).[11]

Table 2 - Percentage of Population by Age, Ontario, Brantford CMA, 2006[12]

Age Group (years)	Ontario (%)	Brantford CMA (%)
0 – 14 yrs	18.2	18.7
15 – 24	13.4	13.4
25 – 44	28.4	26.4
45 – 64	26.5	26.9
65+	13.6	14.6

Highlights:

- Relative to the province, the Brantford CMA has higher proportions of residents in the following age groups: 0 – 14, 45 – 65, and 65+.
- It is estimated that between 2006 and 2016, the number of people age 65+ will increase by 32% in Brant.[13] Nationally, rapid aging is expected to last until 2031, when seniors will account for 23 – 25% of the total population; almost double of the current proportion of 13%.
- The HNHB area is home to over 200,000 seniors age 65+; the largest number of seniors across the fourteen LHIN populations of Ontario, representing 15.1% of the total HNHB LHIN population.[14]
- There is a projected decrease in the population age 0 to 29 years. With fewer people in the 'prime working years' (20 – 44 years), there is and will be significant implications for Brant's workforce as "working capital ratio," dependents per 100 persons in workforce will be relatively high.[15]
- Sixteen census metropolitan areas (CMAs) had a higher proportion of children less than 15 years compared to the national average (17.7%). Nine of these sixteen CMAs were in the heavily industrialized southern Ontario region: Barrie (20.8%), Oshawa (20.5%), Kitchener (19.1%), Windsor (19.0%), Brantford (18.7%), Guelph (18.6%), Toronto (18.6%), Hamilton (17.9%) and London (17.7%).[16]

iii. Population by Gender

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[11] Regional Niagara Public Health Department. (2006). *Regional Niagara Community Health Profile* [Electronic version].
[12] Statistics Canada. (2007). *2006 Community Profiles*. Retrieved March 24, 2008 from, http://www.statcan.ca/.
[13] Ministry of Finance. (2006). *Ontario Population Projections Update* [Electronic version].
[14] Hamilton Niagara Haldimand Brant Local Health Integration Network. (2006). *Community Profile* [Electronic version]. p.6.
[15] Hamilton Niagara Haldimand Brant Local Health Integration Network. (2006). *Quality Care in Community Hands: Building an Integrated Health Service Plan – Phase One* [Electronic version].
[16] Ministry of Finance. (2006). *Ontario Population Projections Update*[Electronic version].

Gender refers to the array of society-determined roles, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the sexes on a differential basis. 'Gendered' norms influence the health system's practices and priorities. Many health issues are a function of gender-based social status or roles.[17]

- 51.5% of the population in the Brantford CMA is female. This is similar to the provincial rate (51.2%).[18]

- Relative to the province (48.8%), the Brantford CMA has a slightly lower proportion of males (48.5%).[19]

iv. Aboriginal Identity

Aboriginal Canadians face substantially greater health inequalities relative to the rest of the Canadian population, including lower life expectancy and higher rates of a wide range of illnesses. Within Canada's cities, the low income rate in 2000 for Aboriginals is 42% compared to 17% among other Canadians.[20]

- In the 2006 Census, three point one percent of Brantford CMA residents identified as Aboriginal. This rate is higher than the province as a whole (two percent). Non-aboriginal residents account for 96.9% of the population in the Brantford CMA, compared to 98.0% in Ontario.[21]

- According to the 2006 Census, 50% of Aboriginal peoples living in the Brantford CMA are age 24 or younger, compared to 32.5% among the general population of Ontario.[22]

- While 14.6% of the Branford CMA's 2006 population was 65 years of age and older, 4.8% of Aboriginals residing in the Brantford CMA were in this age category.[23]

Table 3 – Size of Aboriginal, Métis and Inuit populations, Brantford CMA, 2006 and 2001[24]

Brantford CMA	2006	2001
Total Aboriginal population	3,865	2,915
Indian	3,140	2,365
Métis	600	435
Inuit	0	10
Other*	115	110

**'Other' includes residents who indicated more than one Aboriginal identity.*

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[17] Federal, Provincial and Territorial Advisory Committee on Population Health. (1999). *Toward a Healthy Future: Second Report on the Health of Canadians* [Electronic version]. Canadian Public Health Association.
[18] Statistics Canada. (2007). *2006 Community Profiles*. Retrieved March 24, 2008 from, http://www.statcan.ca/
[19] Ibid.
[20] Hamilton Niagara Haldimand Brant Local Health Integration Network. (2006). *Socioeconomic Indicators Atlas* [Electronic version]. p.4.
[21] Statistics Canada. (2007). *2006 Community Profiles*. Retrieved March 24, 2008 from, http://www.statcan.ca/
[22] Gamble, S. (2008, January 16). Aboriginal population up in city. *The Brantford Expositor*. P.A2.
[23] Ibid.
[24] Ibid. p.A1.

The Six Nations of the Grand River is the largest of the 608 First Nations in Canada. The community is comprised of the Cayuga, Oneida, Onondaga, Mohawk, Seneca and Tuscarora Nations.

- As of April 2007, the Band Council Registration Office indicated that 22,764 persons were registered with the Six Nations Reserve.

- Approximately 50% of the total Six Nations population lives on reserve, while 50% live off reserve. The off-reserve population may reside elsewhere and move back to the reserve at any time.[25]

- The on-reserve population has experienced a 34% increase from 1994 due to individuals moving back to the reserve, as well as a growing youth population.

References for data related to the Six Nations of the Grand River:

Anand, S., Yusuf, S., Jacobs, R., Davis, D., Yi, Q., Gerstein, H., Montague, P., Lonn, E. (2001). Risk factors, atherosclerosis, and cardiovascular disease among Aboriginal people in Canada: the Study of Health Assessment and Risk Evaluation in Aboriginal Peoples (SHARE-AP). *The Lancet*, 358(9288).

Bomberry, Stephen. (2000). *Long Term Care Needs Assessment Update. Final Report.* Prepared for Six Nations Health Services.

Diegel, D. (2006). *Needs Assessment Brant County Mental Health Services For Persons with Serious Mental llnesses In Conflict with the Law*.

Health Canada. (2006). *Public Opinion Syndicated Research Summary: First Nations Syndicated Study.* Public Opinion Research and Evaluation Division Communications, Marketing and Consultation Directorate.

Kuzmich, K. (2007). *Population Health Report*. Brant Community Healthcare System.

RHS at a Glance. (2003). *Regional Health Survey: Selected Findings from the First Nations Regional Longitudinal Health Survey* (2002/03).

Six Nations of the Grand River Community Health Review. (1994). *Six Nations of the Grand River Health Needs Assessment 1994*.

Six Nations of the Grand River. (1999). *Community Profile*.

Six Nations Health/Social Services. (2005). *Client Satisfaction Survey: Final Report.*

v. Language

Not speaking an official language is also related to socio-economic status. Over recent decades, immigrants have increasingly come from countries where English and French are not official languages, with the result that the lack of knowledge of official languages is related to recent immigrant status and to lower income.[26]

[25] Kuzmich, K. (2007). *Population Health Report*. Brant Community Healthcare System.
[26] Ibid.

Table 4 – Mother tongue, Ontario and Brantford CMA, 2006[27]

Mother tongue (%)	Ontario	Brantford CMA
English only	68.4	87.7
French only	4.1	1.1
English and French	0.3	0.1
Other language(s)	27.2	11.0

- Compared to the province, the Brantford CMA has a higher proportion of residents whose mother tongue is English only; and a lower percentage of residents whose mother tongue is French only, English and French and other languages.

- In terms of non-official languages, one point eight percent of Brantford CMA residents speak Polish, followed by Italian (one point four percent) and Dutch (point nine percent).[28]

vi. Racialised Communities (Visible Minorities)

There is growing evidence that the experience of racial discrimination can have a pervasive and devastating impact on the health and well-being of racial minorities. One factor that has been implicated in the exacerbation of this impact is the current inadequacy in the delivery of healthcare services to provide culturally appropriate care to all individuals.[29]

Definition:

Racialisation: While biological notions of race have been discredited, the social construction of race remains a potent force in society. The process of social construction of race is termed racialisation. The Report of the Commission on Systemic Racism in the Ontario Criminal Justice System defined racialisation "as the process by which societies construct races as real, different and unequal in ways that matter to economic, political and social life." Groups and people that have only marginal physical distinctions from western European people have been racialised in Canada. For example, emigrants from southern or eastern Europe were deemed as "races" of less worth when they first came to Canada.[30]

- In 2001, Ontario's visible minority population (19%) was significantly higher than Brantford (5.3%) and Brant County (1.2%).

- In 2001, the three top visible minority groups living in Brantford were: South Asian, Black and Southeast Asian.

- In 2001, the three top visible minority groups living in Brant County were: Black, South Asian, and West Asian.

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[27] Statistics Canada. (2007). *2006 Community Profiles*. Retrieved March 24, 2008 from, http://www.statcan.ca/

[28] The Canadian Press. (2007). Area attracts few new Canadians, data shows. *The Brantford Expositor*. P.A2.

[29] Women's Health in Women's Hands. (2003). *Racial Discrimination as a Health Risk for Female Youth: Implications for Policy and Healthcare Delivery in Canada*.

[30] Ontario Human Rights Commission. (2007). *Policy and Guidelines on Racism and Racial Discrimination.*

vii. Immigration

While being an immigrant itself is not related to socio-economic status, time since immigration is, with more recent arrivals having substantially lower income than non-immigrants, and higher rates of unemployment.[31]

Table 5 – Proportion of Immigrant and Non-Immigrant Populations, Ontario and Brantford CMA, 2006

Immigrant status	Ontario (%)	Brantford CMA (%)
Immigrant population	28.3	13.0
Non-immigrant population	70.8	86.7

Highlights:

- Relative to the province, the Brantford CMA has a proportionately larger non-immigrant population and a lower proportion of immigrants. One out of every eight Brantford CMA residents was born in a country outside of Canada, while for Ontario; it is more than one out of every four.[32]

- Seven point five percent of immigrants in the Brantford CMA arrived between 2001 and 2006 compared with 17.1% of immigrants across Ontario during the same time period.[33] This represents an increase to 15,935 from 15,225 between 2001 and 2006.[34]

- In 2001, the HNHB LHIN (2.1%) had a smaller recent immigrant population less than the province as a whole (4.8%). The highest concentrations of recent immigrants in the LHIN were found in the urban centers of Hamilton (3.3%), St. Catharines (2.1%) and Niagara Falls (2.0%).[35]

- Between January 2003 and September 2007, Immigrant Settlement Services, YMCA of Brantford reported a caseload of 1348 clients from 114 countries, speaking a variety of 73 first languages.[36]

- In terms of country of origin, the highest proportion of immigrants came from the United Kingdom, followed by Poland, Italy, the Netherlands and the United States.[37]

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[31] Hamilton Niagara Haldimand Brant Local Health Integration Network. (2006). *Socioeconomic Indicators Atlas* [Electronic version].
[32] The Canadian Press. (2007, December 5). Area attracts few new Canadians, data shows. *The Brantford Expositor*. P.A1-2.
[33] Statistics Canada. 2007. *2006 Community Profiles*. Retrieved March 24, 2008 from, http://www.statcan.ca/
[34] The Canadian Press. (2007, December 5). Area attracts few new Canadians, data shows. *The Branford Expositor.* A1.
[35] Hamilton Niagara Haldimand Brant Local Health Integration Network. (2006). *Socioeconomic Indicators Atlas* [Electronic version].
[36] Immigrant Settlement Services. October 2007. YMCA of Brantford.
[37] The Canadian Press. (2007, December 5). Area attracts few new Canadians, data shows. *The Brantford Expositor*. P.A2.

viii. Faith and Spirituality

Table 6 – Population by Religion, Ontario, Brantford, Brant County, 2001[38]

	Religion	% of Total Population	Religion	% of Total Population	Religion	% of Total Population
Ontario	Protestant	34.9	Roman Catholic	34.3	Muslim	8.7
Brantford	Protestant	45.5	Roman Catholic	28.2	Christian (no denominational attachment)	6.7
Brant County	Protestant	57.5	Roman Catholic	22.1	Christian (no denominational or other religious affiliation	7.1

Highlights:

- Residents of Protestant faith make up the largest religious group in Ontario, Brantford and Brant County, followed by Roman Catholic and Muslim faith groups.

ix. Family Composition

Family composition, in terms of lone parenthood, may also impact health status. On its own, single-mother family status is a significant predictor of aggregated psychiatric problems, controlling for income, gender, family size, education and personal psychosocial characteristics of the parent. Because female-headed lone parent families have substantially lower income than male lone parent families, each was included separately rather than combining genders into a single lone parent category.[39]

Definition:

Census family: A married couple (with or without children of either or both spouses); a couple living common-law (with or without children of either or both partners); or a lone parent of any marital status, with at least one child living in the same dwelling. The couple living common-law may be of the opposite or same sex.[40]

[38] Statistics Canada. (2001). *2001 Community Profiles*. Retrieved March 24, 2008 from, http://www.statcan.ca/
[39] Hamilton Niagara Haldimand Brant Local Health Integration Network. (2006). *Socioeconomic Indicators Atlas* [Electronic version].
[40] Statistics Canada. (2007). *2006 Community Profiles*. Retrieved March 24, 2008 from, http://www.statcan.ca/

Table 7 – Census Families, Ontario and Brantford CMA, 2006[41]

Location	Total # of Census Families	Couple Families		Lone Parent Families (%)
		Married Couple Families (%)	Common-Law Couple Families (%)	
Ontario	3422315	73.9	10.3	15.8
Brantford CMA	35685	71.1	12.4	16.5

Highlights:

- Compared to the province, the Brantford CMA has a higher percentage of common-law and lone parent families, and a lower proportion of married couple families.

- In 2006, female lone parent families constituted 80.4% of all lone parent families in the Brantford CMA, compared to 81.6% of all lone parent families in Ontario.[42]

- 19.6% of lone parent families in the Brantford CMA were headed by males in the 2006 Census. This rate is higher than the provincial figure (18.4%).[43]

x. Living Arrangements

Support from families, friends and communities is associated with better health. Such social support networks could be very important in helping people solve problems and deal with adversity, as well as in maintaining a sense of mastery and control over life circumstances. The caring and respect that occurs in social relationships, and the resulting sense of satisfaction and well-being, seem to act as a buffer against health problems.[44]

- In 2001, 28.5% of seniors in Brant lived alone. 25.1% of seniors lived alone across Ontario.[45]

xi. Sexual Health

The Student Health Survey was administered to students within the Grand Erie District School Board and Brant Haldimand Norfolk Catholic District School Board in the fall of 2003. The survey was a collaborative project between the Brant County Health Unit and the Haldimand-Norfolk Health Unit. In order to generalize the results, schools were selected in a representative manner and a large sample of students was included. The survey was completed by 2317 students in Grades 5, 7, 9 & 11 (approximately 20%). The survey covered a range of subjects including nutrition, alcohol use, tobacco, sexual health, physical activity, mental health, sleep and gambling, yielding the following results:

[41] Statistics Canada. (2007). *2006 Community Profiles*. Retrieved March 24, 2008 from, http://www.statcan.ca/
[42] Ibid.
[43] Ibid.
[44] Federal, Provincial and Territorial Advisory Committee on Population Health, (1999). *Toward a Healthy Future: Second Report on the Health of Canadians.* Canadian Public Health Association.
[45] Ontario Trillium Foundation. (2004). *Regional Profile – Grand River* [Electronic version]..

- Nine percent of students reported being bisexual, homosexual, or unsure about their sexual orientation. Sexual orientation differed by grade level. Of the students who identified themselves as being either homosexual or bisexual 1% were in Grades 7, 5% in grade 9, and 3% were in Grade 11.[46]

B. Socio-Economic Indicators

Socio-economic status (SES) is recognized as an important determinant of health and the link between health status, utilization of health services and SES is well established. Socio-economic disadvantage is an important determinant of inequalities in health; at the individual level, socio-economic inequalities in health are generally thought to be related to the prevalence of behavioural risk factors and/or access to material resources…Population health models suggest that health is influenced by social, economic and physical, personal health practices, individual capacity, coping skills and health services.[47]

i. Education

Education is a core marker of SES. Although highly correlated with income and age, education also encompasses other health-related dimensions.[48]

Table 8 – Level of Educational Attainment, Ontario and Brantford CMA, 2006[49]

Level of Educational Attainment	Ontario (%)	Brantford CMA (%)
No certificate, diploma or degree	22.2	28.5
High school certificate or equivalent	26.8	28.5
Apprenticeship or trades certificate or diploma	8.0	9.6
College or other non-university certificate or diploma	18.4	19.6
University certificate or diploma below the bachelor level	4.1	2.8
University certificate; diploma or degree	20.5	11.1

Highlights:

- Relative to the province, the Brantford CMA has a higher proportion of residents that
  - do not have a certificate, diploma or degree
  - have a high school certificate or equivalent, apprenticeship or trades certificate or diploma, college or other non-university certificate or diploma

[46] Brant Early Years. (2002). *Brant Early Years Community Report Card*.
[47] Hamilton Niagara Haldimand Brant Local Health Integration Network. (2006). *Socio-Economic Indicators Atlas* [Electronic version].
[48] Ibid.
[49] Statistics Canada. 2007. *2006 Community Profiles*. Retrieved March 24, 2008 from, http://www.statcan.ca/

And a lower proportion of
  - Residents with a university certificate or diploma below the bachelor level, university certificate, diploma or degree.

- This year's enrolment at Wilfrid Laurier University is about 1,900 students.[50]

ii. Employment

Unemployment, underemployment, stressful or unsafe work are associated with poorer health. People who have more control over their work circumstances and fewer stress related demands of the job are healthier and often live longer than those in more stressful or riskier work and activities.[51]

Definitions:

Participation rate – Refers to the labour force in the week (Sunday to Saturday) prior to Census Day (May 15, 2006), expressed as a percentage of the population 15 years of age and over.[52]

Employment rate - Refers to the number of persons employed in the week (Sunday to Saturday) prior to Census Day (May 15, 2006), expressed as a percentage of the total population 15 years of age and over.[53]

Unemployment rate – Refers to the unemployed expressed as a percentage of the labour force in the week (Sunday to Saturday) prior to Census Day (May 15, 2006).[54]

Table 9 – Proportion of Population Aged 15 years and over by Labour Force Activity, Ontario and Brantford CMA, 2006[55]

Labour Force Activity	Ontario	Brantford CMA
Participation rate	67.1	67.9
Employment rate	62.8	63.8
Unemployment rate	6.4	6.0

Highlights:

- Relative to the province, the Brantford CMA has higher participation and employment rates, and a lower unemployment rate.

- The labour force in Brant County and Brantford has historically been industrially based. Currently, the City of Brantford is considered to be a diverse urban growth centre characterized by an expanding business park, increasing employment opportunities and growth, vigorous residential development, intensification and renewal projects and a growing

[50] Ruby, Michelle. (December 2007). Laurier top choice of many. *The Brantford Expositor*.
[51] Federal, Provincial and Territorial Advisory Committee on Population Health. (1999). *Toward a Healthy Future: Second Report on the Health of Canadians.* Canadian Public Health Association.
[52] Statistics Canada. (2007). *2006 Community Profiles*. Retrieved March 24, 2008 from, http://www.statcan.ca/
[53] Ibid.
[54] Ibid.
[55] Ibid.

post-secondary education campus at Wilfrid Laurier University.[56] In the industrial sector, Brantford and Brant County house over 470 manufacturing companies within their boundaries. Of the top 10 major employers in Brantford and Brant County, seven are manufacturers who produce electric, consumer products, plastics, vinyl siding and accessories and pharmaceutical powders.[57]

- In 2001, the unemployment rate (age 15+) was lower in Brant County (4.0%) than Brantford (6.8%), the HNHB LHIN (5.8%), and the province (6.1%); the County of Brant's participation rate (71.0%) was higher than the City of Brantford (65.6%), the HNHB LHIN (65.1%) and Ontario (67.3%) for the population age 15+ in the same year.[58]

iii. Income

Income is perhaps the most commonly used measure of SES. Lower income, both relative and absolute, has been found to consistently result in lower health outcomes whether the measure is morbidity or mortality.[59]

Definition:

Low Income Cut-Offs (LICO) is set at after-tax levels differentiated by size of family and area of residence, where families spend 20% or more of their after-tax income than the average family on food, shelter and clothing.[60]

Table 10 – Low income cut-offs (1992 base) after tax, Ontario and Brant, 2001 and 2006[61]

Location	2001		2006	
	Single employable individual	Four-person family	Single employable individual	Four-person family
Ontario	$15,744	$29,768	$17,570	$33,221
Brant	$13,149	$24,862	$14,859	$28,095

Highlights:

- According to 2001 Census data, 13,245 individuals in Brant were living below the low income cut-off.[62] That year, the Brant family poverty rate was 13% and 14% across the province.[63]

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[56] Housing Resource Centre and Social Services throughout Brant/Brantford. (2007). *Community Plan 2007 – 2009: Homelessness Partnering Strategy*.
[57] City of Brantford. (2007). *Economic Development: Brantford/Brant – Your Advantage Point*. Available at: http://brantfordbrant.com/publications/DataSheet_2007_Final.pdf
[58] Hamilton Niagara Haldimand Brant Local Health Integration Network. (2006). *Community Profile* [Electronic version].
[59] Hamilton Niagara Haldimand Brant Local Health Integration Network. (2006). *Socioeconomic Indicators Atlas* [Electronic version].
[60] Statistics Canada. (2007). *2006 Community Profiles*. Retrieved March 24, 2008 from, http://www.statcan.ca/
[61] Income Statistics Division. (2007). *Low Income Cut-offs for 2006 and Low Income Measures for 2005* [Electronic version]. Statistics Canada.
[62] Housing Resource Centre and Social Services throughout Brant/Brantford. (2007). *Community Plan 2007 – 2009: Homelessness Partnering Strategy*.
[63] Brant Early Years. (2002). *Brant Early Years Community Report Card*.

- In 2001, more than 20% of Brant children were living in families whose income fell below poverty rates: Eagle Place (26.0%), the Core (24.9%), Homedale-William (22.1%), and East Ward (21.6%). Eagle Place had the highest socio-economic indicators (highest percentages of poverty, lone parent families and children living in poverty).[64]

- The proportion of residents who received income from government transfer payments was higher in Brant County (10.1%), Brantford (13.4%) and the HNHB LHIN (11.7%) than the province (9.8%) in 2001.[65]

- In 2001, the percentage of households spending 30% or more of their income on housing in the HNHB LHIN (24.3%) was less than the province as a whole (25.2%). The highest percentages in the LHIN are were found in Hamilton (26.8%), St. Catharines (26.1%) Niagara Falls (25.7%) and Brantford (25.5%). The lowest percentage of households spending thirty percent of more of their income on housing in the entire LHIN was found in Brant County (15.1%).[66]

iv. Housing

Home ownership rates are direct markers of socio-economic status and also have substantial geographic implications. Ownership is linked to mobility and population stability, with home owners far less likely to undertake intra- or inter-community moves compared to renters. In urban areas, the differentiation between rental and owned housing results in population sorting and consequent income segregation. Above and beyond its status as a marker of material success, home ownership may also reflect other elements of well-being that may potentially impact health.[67]

Table 11 – Occupied Private Dwellings Characteristics, Ontario and Brantford CMA, 2006[68]

Occupied Private Dwelling Characteristics	Ontario (%)	Brantford CMA (%)
Owned Dwellings	71.0	73.7
Rented Dwellings	28.8	26.3

Highlights:

- In 2006, 68.9% of the privately occupied dwellings in Brantford were owned, and 31.1% were rented (compared to 66.8% and 33.2% respectively in 2001).[69]

- In 2006, 87.7% of the privately occupied dwellings in Brant County were owned and 12.3% were rented (compared to 84.6% and 15.3% respectively in 2001).[70]

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[64] Brant Early Years. (2002). *Brant Early Years Community Report Card.*
[65] Hamilton Niagara Haldimand Brant Local Health Integration Network. (2006). *Socioeconomic Indicators Atlas* [Electronic version].
[66] Hamilton Niagara Haldimand Brant Local Health Integration Network. (2005). *Community Profile* [Electronic version].
[67] Hamilton Niagara Haldimand Brant Local Health Integration Network. (2006). *Socioeconomic Indicators Atlas* [Electronic version].
[68] Statistics Canada. (2007). *2006 Community Profiles*. Retrieved March 24, 2008 from, http://www.statcan.ca/
[69] Hamilton Niagara Haldimand Brant Local Health Integration Network. (2006). *Socioeconomic Indicators Atlas* [Electronic version].
[70] Ibid.

- According to the City of Brantford Public Health, Safety and Social Services Department, the 2,338 rent-geared-to-income housing units are functioning at capacity.[71]

- In 2006, the Out of the Cold Shelter was open 67 nights and used a total of 700 times. Out of the Cold Program Coordinator Anne Whittingham stated that, "They're people who don't have any other shelter. They're predominantly men, but a family used the service last year. Some people are actually working homeless." [72]

A variety of local reports have raised concerns about issues affecting the availability of affordable housing in Brant:

- The *2003 Brant/Brantford Affordable Housing Strategy* reported that:

    - There were just over 1,500 persons on the waiting list for social housing units, often leaving an applicant with a wait of close to five years or more to secure a unit.[73]

    - The high incidence of low income amongst singles indicates that more emphasis needs to be placed on providing smaller affordable units for singles throughout Brant, especially in the City of Brantford where 38.4% of singles had income below the poverty line.[74]

- Diegel's 2006 report, *Needs Assessment Brant County Mental Health Services For Persons with Serious Mental Ilnesses In Conflict with the Law*, conveyed that:

    - On average households can expect to wait between 2 years and 10 years for housing, dependent on the type of housing required. There is a particular need for one bedroom units.[75]

    - The development of Wilfrid Laurier University in the Brantford core is having an impact on mental health consumers, especially in terms of access to rental accommodation. In discussion with service providers and through a review of previous reports, it has been indicated that many mental health consumers lived in or near the core. Affordable housing and access to services were given as reasons for this location choice. With the increasing demand for student housing and the changing social structure in the core, there is a possibility that persons living with mental health issues will find it difficult to access housing in this area.[76]

- The *Community Plan 2007 – 2009: Homeless Partnering Strategy* stressed that:

    - Tighter rental market conditions have encouraged rents to increase, however, when adjusted for inflation, rent levels still remain relatively low compared to other neighbouring municipalities.[77]

    - There are currently 250 on the Brantford Native Housing wait list.[78]

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[71] Housing Resource Centre and social services throughout Brant/Brantford (2007). *Community Plan 2007-2009: Homelessness Partnering Strategy*.
[72] The Brantford Expositor. (2007). Programs offer food, shelter to those in need.
[73] Social Housing Strategists. (2003). *Brant/Brantford Affordable Housing Strategy*.
[74] Ibid.
[75] Diegel, D. (2006). *Needs Assessment Brant County Mental Health Services for Persons with Serious Mental Ilnesses In Conflict with the Law*.
[76] Ibid.
[77] Housing Resource Centre and social services throughout Brant/Brantford (2007). *Community Plan 2007-2009: Homelessness Partnering Strategy*.

- With the rapidly increasing 65+ age group, there is need for a variety of housing for seniors in all parts of Brant County and Brantford.[79]

- There are increasing and desperate needs for aboriginal housing, student housing, persons with physical disabilities.[80]

- Addressing homelessness is complex. Services such as emergency shelters, food banks, and mental health outreach programs and organizations addressing violence against women all work to address homeless variables. These services are funded through different sources by the same or multiple ministries and levels of government. This creates funding and reporting 'silos' that complicates the service providers' efforts to coordinate and plan together.[81]

Other important issues relevant to Brantford and the County of Brant:

i. Food Security

In developed societies, food insecurity is defined as "the inability to acquire or consume an adequate diet quality or sufficient quantity of food in socially acceptable ways, or the uncertainty that one will be able to do so."[82]

Food insecurity includes problems in obtaining nutritionally adequate and safe foods due to a lack of money to purchase them, or the limited availability of these foods in geographically isolated communities.[83]

Food insecurity is dynamic in nature and defined by a sequence of events and experiences. These vary among different groups. For poor families, people first feel anxious about running out of food. At the next stage, they begin to compromise on the quality of the foods they eat by choosing less expensive options. As resources get scarcer, food insecure people feel hungry because they are unable to purchase enough food to satisfy their needs. At the most severe stage, food insecurity is experienced as not eating at all. There are negative psychological, social and physical consequences across this continuum.[84]

In Brantford and the County of Brant:

- An average of 1, 166 households utilize the food bank each month. Children make up 38-40% of those served at food banks.[85]

- Almost half of the 200 students at Our Lady of Fatima School in Eagle Place eat breakfast provided by the Brant Food for Thought program five days a week.[86]

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[78] Housing Resource Centre and social services throughout Brant/Brantford. (2007). *Community Plan 2007-2009: Homelessness Partnering Strategy*.
[79] Ibid.
[80] Ibid.
[81] Ibid.
[82] Davis B. and Tarasuk V. (1994). Hunger in Canada. *Agriculture and Human Values,* 11, 50-57.
[83] Campbell C. (1991). Food insecurity: A nutritional outcome or a predictor variable? *Journal of Nutrition, 121,* 408-415.
[84] Tarasuk V. (2002). Health Consequences of Food Insecurity. Presentation given at The Social Determinants of Health across the Life-Span Conference, Toronto, November 2002.
[85] Housing Resource Centre and social services throughout Brant/Brantford. (2007). *Community Plan 2007-2009: Homelessness Partnering Strategy*.
[86] The Brantford Expositor. (2007, December 12). Fuel for learning. P.A3

- In 2007, Salvation Army Family and Community Services provided Christmas food baskets to 430 families in need across Brantford and 90 in Paris.[87]

- Rev. Allan Lynk of St. Andrew's United Church said, "The problem of hunger and homelessness isn't going away," noting that attendance at his church's meal program has remained fairly consistent throughout 2007, with up to 200 people sitting down to eat at each meal.[88]

- In 2006, 25, 762 people were served through four emergency meal programs in Brantford and Brant County.[89]

ii. Rurality

- In 2001, 14.4% of HNHB LHIN-area residents lived in rural areas, slightly below the provincial average of 15.3%. The communities within Brant (except the City of Brantford), Haldimand and Norfolk had rural populations greater than 50%.[90]

- The Ontario Trillium Foundation's 2004 Regional Profile of the Grand River reported that, "A considerably higher proportion of people in Grand River Region* (34.1%) lived in rural areas compared to Ontario (15.3%), with over one-half (55%) of the residents of Haldimand-Norfolk Regional Municipality residing in primarily rural areas."[91] (*The areas that comprise the Grand River region include Haldimand-Norfolk Regional Municipality and Brant County)

- Research compiled for the *Community Plan 2007-2009: Homelessness Partnering Strategy* indicated that members of Brant County's farming community are finding it increasingly difficult to compete in the economic market. Due to a lack of resources and supports for rural farmers, poverty is on the increase. Rural poverty is expected to result in more strain on City resources as County residents travel to Brantford to access services. The number of rural residents also has significant implications for health planning as rural residents face challenges in equitable access to healthcare services.[92]

iii. Transportation

Table 12 – Mode of Transportation to Work, Ontario and Brantford CMA, 2006

Mode of Transportation to Work	Ontario (%)	Brantford CMA (%)
Car, truck, van; as driver	71.0	80.2
Car, truck, van; as passenger	8.3	9.5
Public transit	12.9	3.1
Walked or bicycled	6.8	5.9
All other modes	1.0	1.2

Highlights:

[87] The Brantford Expositor. (2007). *A Very Generous City.* p.A3.
[88] The Brantford Expositor. (2007). *Programs offer food, shelter to those in need.*
[89] Housing Resource Centre and social services throughout Brant/Brantford (2007). *Community Plan 2007-2009: Homelessness Partnering Strategy*.
[90] Kuzmich, K. (2007). *Population Health Report*. Brant Community Healthcare System.
[91] Ontario Trillium Foundation. (2004). *Regional Profile – Grand River* [Electronic version].
[92] Housing Resource Centre and social services throughout Brant/Brantford. (2007). *Community Plan 2007-2009: Homelessness Partnering Strategy*.

- The Brantford CMA has a higher proportion of residents who travel by car, truck or van, both as a driver and passenger, than the province as a whole.

- A significantly smaller percentage of the Brantford CMA uses public transit compared to the province. This is due largely to the fact that there is no public transportation that connects the municipalities of Brantford and the County of Brant.

C. Health Status

1.3 Describe the health needs of the priority populations and catchment area your CHC intends to serve. Describe any populations facing a higher than average burden of illness or health risks profile. Indicate the quantitative and qualitative sources used to develop this profile.

i. Births

Low birth weight is a key determinant of infant survival, health, and development. Low birth weight infants are at a greater risk of having a disability and for diseases such as cerebral palsy, visual problems, learning disabilities and respiratory problems than infants with a normal birth weight.[93]

- In 2001, Brant County (6.6%) had the highest rate of low birth weight babies as compared to the rest of the HNHB LHIN (5.3%). The provincial rate was 5.7%.[94]

Infant mortality is a long-established measure, not only of child health, but also of the well-being of a society.[95]

- As of 2001, the infant mortality rate in the HNHB LHIN area was 5.8 per 1000 live births, higher than the provincial rate of 5.4 per 1,000.[96]

ii. Life Expectancy

- As of 2001, life expectancy measured at birth for males within the HNHB LHIN area was 76.8 years and 81.5 years among females, significantly lower than the life expectancy for Ontario males and females (77.5 and 82.1, respectively).[97]

iii. Deaths

- In 2001, the age-standardized all-cause mortality rate* in the HNHB LHIN area was 629.8/100,000 population, higher than the provincial rate (602.6/100,000). Within the HNHB LHIN area, significantly high age-standardized rates of mortality were in Brant (679/100,000), Haldimand and Norfolk (661.7/100,000), Hamilton (634.8/100,000) and Niagara (625.7/100,000).[98] (*Age-standardized rate of death from all causes per 100,000 population).

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[93] Hamilton Niagara Haldimand Brant Local Health Integration Network. (2006). *Community Profile* [Electronic version]. p.19.
[94] Ibid.
[95] Ibid. p.21.
[96] Ibid.
[97] Ibid.
[98] Ibid. p.22.

- The HNHB LHIN's Community Profile (2006) indicated that circulatory disease and neoplasms was the largest contributor to high HNHB mortality rates based on 2001 statistics.[99]

Potential Years of Life Lost (PYLL) represents the number of years not lived by an individual from birth to age 75 due to premature death. The PYLL rate provides the total years of life lost before age 75 to the total population under 75.[100]

- Within the HNHB LHIN, PYLL rates are significantly higher than the provincial average (from 10 to 20% higher) in the communities of Hamilton Brant, Haldimand, Norfolk and Niagara.[101]

iv. Hospitalizations

- In 1999, as part of the ongoing efforts in healthcare restructuring, the Willett Hospital in Paris and the Brantford General Hospital (BGH) became the first two partners in the Brant Community Healthcare System (BCHS), a community-wide organization that supports the improvement of programs and services provided through the two facilities.[102] The Brantford General is the area's acute care facility, providing all of Brantford and Brant County's specialty programs and services for 120,000+ residents. The Willett serves Brant County, the Six Nations territory and some areas of the surrounding townships in Oxford County and the Regional Municipality of Waterloo.[103]

- In 2003-04, the age-standardized hospitalization rate for the HNHB LHIN area (8,221.2 per 100,000) was higher than the provincial rate (7,746.7 per 100,000).[104]

Case mix groups represent a Canadian patient classification system used to group and describe types of inpatients discharged from acute-care hospitals.[105] The following table highlights the top ten case mix groups of the Brant Community Healthcare System in 2005-06:

Table 13 – Top Ten Case Mix Groups, Brant Community Healthcare System, 2005-06[106]

Condition	Number of Cases
Neonatal, Normal Newborn	828
Vaginal Delivery	706
Esophagitis, gastroenteritis, and Misc. Digestive Diseases	706
Simple Pneumonia and pleurisy	273
Heart Failure	242
Vaginal delivery with complicating diagnosis	233
Major Uterine and adnexal Proc. No malignancy	230

[99] Hamilton Niagara Haldimand Brant Local Health Integration Network. (2006). *Community Profile* [Electronic version]..
[100] Hamilton Niagara Haldimand Brant Local Health Integration Network. (2005). *Population Health Profile* [Electronic version]. p.4.
[101] Hamilton Niagara Haldimand Brant Local Health Integration Network. (2006). *Community Profile* [Electronic version]. p.23.
[102] Brant Community Healthcare System. (2004). *The Brant Community Healthcare System*. Available at: http://bchsys.org/int_html/Aboutus.html
[103] Ibid.
[104] Hamilton Niagara Haldimand Brant Local Health Integration Network. (2005). *Population Health Profile*. p.3.
[105] Manitoba Centre for Health Policy. (2003). Retrieved October 18, 2007 from http://www.umanitoba.ca/centres/mchp/concept/dict/cmg/CMG_overview.html
[106] Kuzmich, K. (2007). *Population Health Report*. Brant Community Healthcare System.

Knee Replacement	224
Chronic Bronchitis	220
Cardiovascular disorders except TIA	177

Chronic Obstructive Pulmonary Disease (COPD) refers to two lung diseases, chronic bronchitis and emphysema, that are characterized by obstruction of airflow that interferes with normal breathing. Both of these conditions frequently co-exist. The term does not include other obstructive diseases such as asthma.[107] The following data was presented in the BCHS Population Health Report (2007):

- As a percentage, COPD was most frequently seen among Brant County patients than the other conditions.[108]
- As a percentage of overall admissions, declines were seen for pneumonia, tracheobronchitis and asthma. However, COPD increased from 0.96% to 1.32%.[109]
- The vast majority of patients with asthma, were four year of age and younger.[110]
- In Brant, crude hospitalization rates (i.e., not age-adjusted) for neoplasms were below the provincial average. For cardiovascular diseases, both Brant and Haldimand-Norfolk exceeded the provincial hospitalization rate.[111]

v. Emergency Room Visits

- Of the more than 113,000 visits to emergency departments by seniors in Brant, Haldimand and Norfolk in 2005/06, the most common disorders were those of the circulatory system.
- Triage level of 2005/06 emergency visits shows that the proportion of less-urgent and non-urgent visits for Brant residents (38.9%) is comparable to that of the HNHB LHIN overall (39.3%).[112]
- The top 6 locales for emergency visits were (2003-04): Brantford (71.1%); Brant County (14.6%); Norfolk County (2.5%); Six Nations (1.8%); Haldimand County (1.68%); Unknown (3.5%)

vi. Injuries

- In 2005-06, the leading causes of injury and poisoning related hospitalizations at the Brant Community Healthcare System were:

  i. Complication of treatment: 58
  ii. Drugs causing adverse effects: 43
  iii. Minor injuries and trauma diagnosis: 18

- According to the BCHS' 2007 Population Health Report, ninety percent of all injuries were predictable and preventable. Most of the injuries occurred among children and seniors.

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[107] American Lung Association. (2006). *Chronic Obstructive Pulmonary Disease Fact Sheet*. Retrieved October 18, 2007 from, http://www.lungusa.org/site/pp.asp?c=dvLUK9O0E&b=35020
[108] Kuzmich, K. (2007). *Population Health Report*. Brant Community Healthcare System.
[109] Ibid.
[110] Ibid.
[111] Ibid.
[112] Ibid.

- Nationally, sixty-six percent of all childhood unintentional injuries happen in and around a child's home. Unintentional injuries are the number one cause of childhood death and disability in Canada. More than 20,000 children each year are seen in emergency departments across Canada due to injuries that occurred in the home.

BCHS statistics (2007) regarding hospitalizations and deaths due to injuries or accidents:

- Falls were the number one cause of hospitalization among children age 14 years and younger.[113]

- Burns and scalds were the number one cause of death among children age 14 years and younger.[114]

- Poisoning was the second leading cause of hospitalization for children age 14 yrs and younger.[115]

- Choking, suffocation and strangulation were the leading causes of death in infants, and the second leading cause of hospitalization.[116]

- Drowning deaths are highest among one to four year olds.[117]

vii. Prevalence of Chronic Disease

Chronic health conditions such as arthritis, obesity, high blood pressure, asthma, pain and diabetes place a high burden on the healthcare system and reduce the quality of life of those who suffer from the condition.[118]

- In 2005, residents of the HNHB LHIN displayed higher rates of arthritis/rheumatism, diabetes and asthma, compared to Ontario as a whole.[119]

viii. Mental Health and Addictions

- The accepted incidence rate for Severe and Persistent Mental Illness (SPMI) is approximately 2.5% of the population age 15 and over. SPMI is defined by the type of mental illness, the severity of the illness and the length of illness. In 1996 it was identified that almost 2000 people in Brant had a SPMI. This number had increased to almost 2400 by 2001.[120]

- BCHS estimated that less than 30% of their mental health inpatients are clients of community-based programs at the time of admission. This means at least 70% are either new mental health consumers or are not involved with community-based programming.[121]

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[113] Kuzmich, K. (2007). *Population Health Report*. Brant Community Healthcare System.
[114] Ibid.
[115] Ibid.
[116] Ibid.
[117] Ibid.
[118] Hamilton Niagara Haldimand Brant Local Health Integration Network. (2006). *Community Profile* [Electronic version]. p.17.
[119] Ibid.
[120] Grand River District Health Council. (2002). *A home, a friend, a job: A Functional Review of the Community Mental Health Programs in the Grand River District*. Retrieved March 24, 2008 from http://www.dhcarchives.com/protected/uploaded/publication/mohhomefriendjob.pdf
[121] Diegel, D. (2006). *Needs Assessment Brant County Mental Health Services for Persons with Serious Mental Ilnesses In Conflict with the Law*.

- Ten to fifteen percent of inpatient admissions were persons with schizophrenia.[122]

- The top five case mix groupings (CMG) for mental health disorder patients discharged from BCHS are:

    1) Depressive mood disorders No ECT/axis 3
    2) Schizophrenia and other psychotic
    3) Adjustment disorders
    4) Depressive Mood Disorders LOS <6 days
    5) Psychoactive Substance dependence[123]

- Psycho-active Substance Dependence overtook bi-polar mood disorders as the fifth highest CMG within mental health disorders at BCHS when 2003-04 data are compared.[124]

- The vast majority of mental health patients at BCHS were between 25-44 years of age.[125]

- There were 771 mental health admissions at BCHS, which accounted for 6.8% of all admissions. The Brantford General Hospital has 24 beds allocated to mental health patients.[126]

- In June 2006, March 2007 and again in October 2007, a survey was conducted to identify the unmet needs of the individuals with severe mental illness in Brant. 'Unmet needs' were defined as a total lack of a service or the need for expanded service. The most recent findings of this survey were published in March 2007, outlining the top eight unmet needs as expressed by consumers of mental health services:

    1) Affordable Permanent Housing
    2) Withdrawal Management
    3) Transitional Housing
    4) Emergency Housing
    5) Case Management
    6) Family Doctor
    7) Food
    8) Transportation[127]

- In April 2003, the Ministry of Health and Long-Term Care asked District Health Councils (DHCs) across the province to review the 2003-04 operating plans of community mental health and addictions programmes. This review identified the following major issues for existing mental health and addictions programmes for 15 years:

    1) No increase to base budgets
    2) Reductions in critical mental health & addiction services and staff
    3) Growing waiting lists for services
    4) Case loads of existing services are resulting in staff burnout and turnover
    5) Inability to discharge clients from costly inpatient care due to the unavailability of community services[128]

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[122] Diegel, D. (2006). Needs Assessment Brant County Mental Health Services for Persons with Serious Mental llnesses In Conflict with the Law.
[123] Kuzmich, K. (2007). *Population Health Report.* Brant Community Healthcare System.
[124] Ibid.
[125] Ibid.
[126] Ibid.
[127] Diegel, D. 2006. *Needs Assessment Brant County Mental Health Services for Persons with Serious Mental llnesses In Conflict with the Law*.

6) An increase in ethnically diverse individuals requiring services unique to their cultural awareness and interpretation of addiction & mental health

Results from Brant County Health Unit's *Student Health Survey* (2003):

- Current research has shown that in Ontario about one out of five, 4 to 16 year olds suffer from some type of psychiatric disorder.[129]

- 22% of all students surveyed felt unhappy or depressed in the last few weeks, including 46% of Grade 11 females. Ten percent of all students surveyed had seriously considered attempting suicide in the past year, including 20% of Grade 11 females.[130]

- More students in Grade 11 sought help for mental health reasons (21%) than in other grades. This is similar to the provincial finding where mental health care visits occur more likely among students in Grade 11 than in other grades.[131]

- Students at high-risk for mental health problems were:

    - Less likely to have slept seven to ten hours per night
    - More likely to have been at risk for gambling problems
    - More likely to have smoked cigarettes in the past 30 days, whether a beginner or current smoker
    - More likely to have drank alcohol weekly or engaged in binge drinking during the past month
    - More likely to have used cannabis during the past month or other drugs during their lifetime
    - Less likely to have viewed themselves as physically active
    - Less likely to have eaten breakfast everyday
    - Less likely to have rated their eating habits as very good or excellent[132]

- By Grade 11, 22% of students had smoked at least once during the past 30 days and more than half (55%) of those students were smoking every day. Students who smoked in all four grades surveyed were more likely to drink weekly than non-smokers during the past month. Overall, 45% of smokers felt somewhat or much more unhappy or depressed than usual over the past few weeks compared to 27% of non-smokers. 31% of student smokers trying to lose weight said they smoked for that purpose. Binge drinking (drinking more than five drinks on any occasion) during the past month was also associated with smoking.[133]

- Binge drinking during the past four weeks was reported by 40% of alcohol users in Grade 11.[134]

- Students who smoked cigarettes in Grades 7, 9 and 11 were more likely to have smoked cannabis in the past month. The proportion of students using cannabis at least once in their lifetime doubled between Grade 9 (26%) and Grade 11 (52%). Eighteen percent (18%) of Grade 11 students used cannabis at least once per week during the past month. 57% of

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[128] Halton-Peel District Health Council. (2003-2004). *Review of 2003-2004 Mental Health and Addictions Operating Plans* [Electronic version].
[129] Brant County Health Unit. (2003). *Student Health Survey*. Brant, Haldimand, Norfolk.
[130] Ibid.
[131] Ibid.
[132] Ibid.
[133] Ibid.
[134] Ibid.

students who used cannabis in the past four weeks also used another illicit drug at some point in their lifetime (compared to 3% who had not used cannabis during that time).[135]

- Over 1,200 or 16% of students who were in Grades 7, 9, and 11 reported having sexual intercourse while 84% had not. 35% of youth consumed alcohol or used drugs before the last time they had sexual intercourse. 70% of students who engaged in sexual intercourse also reported using cannabis. 57% of students who engaged in sexual intercourse also reported binge drinking in their lifetime.[136]

ix. Developmental Challenges

- About 13.0% of children in Brant County are experiencing developmental difficulties compared to 13.8% of children in the City of Brantford.[137]

- Neighbourhoods where more than 20% of children are experiencing developmental difficulties are considered at-risk neighbourhoods for children and include: Fairview Green Brier, Shellard's Lane, and the Core.[138]

- Neighbourhoods where less than 10% of children are experiencing developmental difficulties are considered thriving neighbourhoods for children and include West Brant, East South Dumfries, Henderson, Mayfair, and Brier Park.[139]

D. Health Practices

Poor health practices are known to be related to increased risk of chronic disease, mortality and disability[140].

The Canadian Community Health Survey (CCHS) is a cross-sectional survey that collects information related to health status, health care utilization and health determinants for the Canadian population. The following data regarding health practices was collected by the CCHS (2003) and presented in the HNHB LHIN Population Health Profile (2005).

CCHS definitions:

Heavy Drinkers: Participants aged 12 years or above were asked if they had consumed a drink during the past year. Those who reported one or more drinks in the past year were asked how often they drank alcoholic beverages, and how many times they had five or more drinks on one occasion (heavy drinkers).[141]

Physically Inactive: The Physical Activity Index is an index that represents the average daily energy an individual would expend on leisure time physical activity. Respondents aged 12 or above were asked about leisure time physical activity during the past 3 months. In addition to the above questions on physical activity, respondents between 12 and 17 years of age were asked

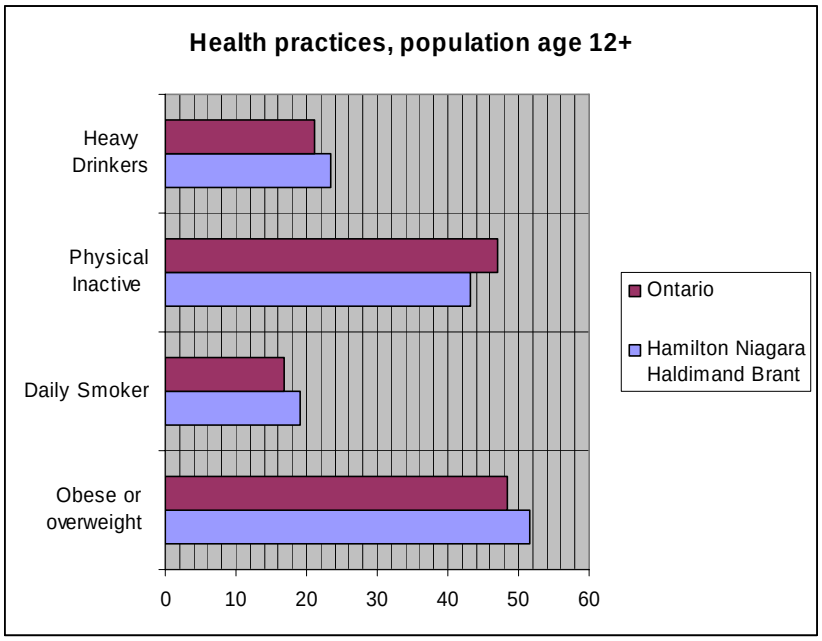
[135] Brant County Health Unit. (2003). *Student Health Survey*. Brant, Haldimand, Norfolk.
[136] Ibid.
[137] Brant Early Years. (2002). *Brant Early Years Community Report Card*.
[138] Ibid.
[139] Ibid.
[140] Hamilton Niagara Haldimand Brant Local Health Integration Network. (2006). *Population Health Profile* [Electronic version].
[141] Health Canada. (2004). *Canadian Community Health Survey*.

about the amount of leisure time they spent on a computer, playing video games, watching TV or videos, and reading.[142]

Daily smokers: Participants aged 12 years or above were asked if they had smoked a total of 100 or more cigarettes during their lifetime. Those who had were asked whether they currently smoked cigarettes daily, occasionally, or not at all. Current daily or occasional smokers were asked the number of cigarettes they smoked. Those who had stopped smoking were asked when they had stopped.[143]

Obese or Overweight: Data on height and weight were used to calculate Body Mass Index (BMI; weight in kg divided by the square of height in metres [m]), and BMI was subsequently classified as underweight, normal weight, overweight, or obese.[144]

Figure 2 – Health Practices, Population Age 12+, Ontario and Hamilton-Niagara-Haldimand-Brant, 2003[145]



Highlights:

- According to 2003 CCHS data, the HNHB area exhibited higher rates of heavy drinking, daily smoking and obesity as compared to the province. There were less physically inactive residents in HNHB than across the province.

- The overall rate of physical activity in the HNHB LHIN (51.5%) is higher than the provincial rate (51.3%). Within the HNHB LHIN area, the highest rates of physical activity are found in Brant (55.2%) and the lowest rates in Hamilton (48.9%).[146]

[142] Health Canada. (2004). *Canadian Community Health Survey*.
[143] Ibid.
[144] Ibid.
[145] Ibid.
[146] Hamilton Niagara Haldimand Brant Local Health Integration Network. (2006). *Community Profile* [Electronic version]. p.14.

Based on data collected by the Brant County Health Unit (2005-06) and Brant Community Healthcare System (2007), compared to the province, Brant residents had higher rates of inactivity, smoking, obesity and feeling a sense of community:

i. Lower activity levels

A statistically significant larger proportion of inactive persons in Brant were:

- Women
- 35 to 54 and 55 to 69 years of age
- Earning less than $30,000 per year
- Family / student / retired or 'not working'[147]

- 95% of students do not meet the daily requirements for 90 minutes of physical activity per day. Over 75% of students engaged in three or more hours of sedentary activities per day (TV, computer, playing cards). Physical education class has become an option for students after Grade 9.[148]

ii. Smoking

- 26.1% of Brant residents age 18 years and older indicated that they were current smokers, having smoked at least 100 cigarettes in their lifetime and still smoking.[149]

iii. Obesity

- Over half (56%) of Brantford area residents are overweight or obese. A statistically significant greater proportion of men were either overweight or obese, as compared to women.

- The proportion of adults with a healthy BMI (acceptable weight) was higher among women. The proportion of adults with a healthy BMI (acceptable weight) was higher among 18 to 24 year olds than any other age groups.[150]

iv. Feeling a sense of belonging to the community

Over the past 25 years, research has clearly demonstrated a causal relationship between social relationships and health. People who are socially isolated and have few ties to other individuals are more likely to suffer from poor physical and mental health and are more likely to die prematurely.

- 73% of Brant respondents reported a "sense of belonging," significantly higher than the national (64.1%) and provincial rates (65.5%).[151]

- There were no significant differences between gender, income, or education levels. The exception was low-income households, which reported significantly lower rates of strong sense of community belonging.[152]

- Differences between age groupings were noted: 12 – 17 year olds reported the highest rate (76.8%), while 18 to 29 year olds reported the lowest rates (54.7%).[153]

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[147] Kuzmich, K. (2007). *Population Health Report*. Brant Community Healthcare System.
[148] Brant Early Years. (2002). *Brant Early Years Community Report Card*.
[149] Brant County Health Unit. (2007). *Rapid Risk Factor Surveillance System 2006*.
[150] Ibid.
[151] Ibid.
[152] Ibid.

- Households with children under 12 years of age and those with married census families had higher rates of community belonging.[154]

Use of preventive care

i. Mammography

A mammogram is a safe low-dose X-ray of the breast that is used to detect tumours at an early stage. Currently, mammograms are recommended every two years for women aged 50 to 69.[155]

- As of 2005, 71% of HNHB females had a mammogram within the last two years, similar to the provincial rate.[156]

- In 2001, 51.8% of Canadian women aged 50 to 69 had received a routine mammogram screening within the preceding two years. That year, Brant's Public Health Unit reported mammography screening rates for the same peer group that were significantly lower than the national average (41.1%).[157]

ii. Influenza immunizations

The following data was obtained from data collected by the Brant County Health Unit using a 409-person sample over a four month period (January - April 2005).

- Forty-five percent (45%) of the sample received a flu shot.[158]

- A smaller proportion of those with an income of $70,000+ received a flu shot.[159]

- Fewer people categorized as 'working' (34.2%), received the flu shot compared to those who identified as family / student / retired (63.6%).[160]

- No statistically significant differences were noted for gender or education level.

iii. Contact with dentist in past 12 months

Poor oral health can significantly impact general health and appears to be a risk factor for chronic diseases such as diabetes and cardiovascular disease.

- A large number of adult Brant residents access emergency department services to address their oral health needs.[161]

- Men are significantly more likely than women to experience oral injuries.[162]

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[153] Ibid.
[154] Ibid.
[155] Statistics Canada. (2003). *Health Indicators 82-221-XIE*. Vol. 2003. no. 2.
[156] Hamilton Niagara Haldimand Brant Local Health Integration Network. (2006). *Community Profile* [Electronic version]. p.15.
[157] Statistics Canada. (2003). *Health Indicators 82-221-XIE*. Vol. 2003. no. 2.
[158] Brant County Health Unit. (2007). *Rapid Risk Factor Surveillance System 2006.*
[159] Ibid.
[160] Ibid.
[161] Ibid.
[162] Ibid.

Access to Primary Healthcare

Physician-to-population ratios are used to support health human resource planning. While physician-to-population ratios are useful indicators of changes in physician numbers relative to the population, they should not be considered to be measures of the adequacy of the physician supply.[163]

- Physician-to-population ratios vary across the HNHB LHIN area. As of 2004, there were 75 family physicians/100,000 population in the HNHB LHIN, significantly lower than the provincial rate of 86 family physicians/100,000 population.[164]

- According to the 2005 Canadian Community Health Survey, 93.5% of HNHB LHIN residents reported that they had a regular medical doctor. This reported rate was above the Ontario average (91.1%) and the highest of the 14 LHINs. 81.9% of HNHB LHIN residents reported that they had contact with a medical doctor in the last 12 months, slightly higher than the Ontario average of 81.5%.[165]

- Within the HNHB LHIN area, the UAP designated family physician vacancies varied by municipality, as follows: Niagara, 98; Brant, 4; Brantford, 15; Haldimand 6; Norfolk, 13; and, Burlington, 9.[166]

- Brant County has been designated as under-serviced for doctors since 1997: between 24,000 and 28,000 residents lack the services of a family doctor. And there is still need for four family doctors in the County, 15 in Brantford and specialists as well.

- Paris recently acquired new family physician with the addition of Dr. John Tamale to the PrimaCare Community Family Health Team, based in Paris, Ayr and St. George. Another family doctor will be joining PrimaCare in May 2008.

- "*On any given month, the hospital (BCHS) is short about 40 nursing workdays, although many are part-time and temporary positions*." Gary Chalk, Hospital spokesperson.[167]

- The Six Nations Reserve offers a comprehensive healthcare system which includes a federally run clinic with four full-time physicians, and a recently opened band-run clinic, White Pines Wellness Centre offering programs such as early childhood development, mental health services and nutritional programs. White Pines plans to offer dialysis treatment so that diabetic patients won't have to travel off reserve. With an annual budget of $14 million, this new centre serves 4,000 community members and employs 232 staff who provides approximately 22 wellness programs.[168]

1.4 Provide a list of key community and health service providers whose services may complement or overlap with those of your CHC/Satellite CHC. Identify which organizations you included in your consultations.

At the outset of the community consultation process, the GRCHC steering committee struck a sub-committee to provide local advice and support to the AOHC throughout the CE phase. The primary task of the CE sub-committee was to develop a list of local stakeholders with knowledge

[163] Hamilton Niagara Haldimand Brant Local Health Integration Network. (2006). *Community Profile* [Electronic version]. p.38.
[164] Ibid.
[165] Ibid.
[166] Ibid.
[167] Expositor Staff. (2007). Nursing recruitment kicks into overdrive*. The Brantford Expositor*.
[168] Brautigam, T. (2007). Six Nations among better off. *The Brantford Expositor*. p.A6.

and expertise regarding the primary healthcare needs of Brantford and Brant County residents to be engaged during the community consultation. AOHC further expanded the CE sub-committee's list by conducting an online environmental scan of organizations from a variety of sectors, and met with the CE sub-committee to prioritize the key organizations to be consulted. This collaborative process resulted in the development of the GRCHC stakeholder list (see Appendix A) which contains over one hundred and twenty-five agencies working in health and social services, corrections, education, cultural, faith, government, legal, recreation capacities etc. Overall, this list:

a. Provides an overview of the key regional, municipal and local stakeholders in Brantford and Brant County, including their current mandate and/or programming focus;
b. Highlights how these stakeholders have been consulted throughout the CE process;
c. Identifies potential partnerships and areas for collaboration with the GRCHC;
d. Assists the GRCHC in maintaining an inventory of service providers in the area as a tool for monitoring, enhancing and developing partnerships in both the short and long-term.

Of the 125 organizations listed in the inventory, seventy-five were consulted during the CE process via *key representative interviews*, *focus groups and/or an online survey.*

Table 14 - Organizations consulted, by method of consultation

Key Representative Interviews	Focus Groups	Online Survey
1. Adult Recreation Therapy Centre	1. Aberdeen Health & Community Services *(4 representatives)*	1. Brantford Vocational Training Association
2. Alzheimer Society of Brant	2. Best Start Francophone Advisory Sub-Committee *(8 representatives)*	2. Brantwood Centre
3. Beckett Adult Leisure Centre, City of Brantford, Parks and Recreation	3. Brant County Health Unit *(7 representatives)*	3. Canadian Mental Health Association, Brant County Branch
4. Brant Ambulance Service	4. Brant Haldimand Norfolk Catholic District School Board *(8 representatives)*	4. Children's Aid Society of Brant
5. Brant Community Healthcare System, Diabetes Education Centre	5. Brantford Vocational Training Association	5. City of Brantford, Parks and Recreation
6. Brant Community Healthcare System, Mental Health Services	6. Canadian Mental Health Association	6. Contact Brant
7. Brant Community Healthcare System, The Willett Hospital *(2 representatives)*	7. Children's Aid Society of Brant	7. Enterprise Brant
8. Brant Community Social Planning Council	8. Centre for Addiction & Mental Health*(2 representatives)*	8. Essential Physiotherapy
9. Brant Lactation Consultants Working Group *(2 representatives)*	9. Community Advisory Committee for Disability Issues *(12 representatives)*	9. Family Counselling Centre of Brant Inc.
10. Brant United Way	10. De dwa da dehs nye>s Aboriginal Health Centre	10. Kiwanis Brant County Lifeline
11. Brantford Mosque	11. Family Counselling Centre of Brant	11. Salvation Army Community Services
12. Brantford Native Housing	12. Grand Erie District School Board	12. The Canadian Hearing Society
13. Brantford Physiotherapy and Sports Medicine Centre	13. John Noble Home for the Aged	13. Victim Services of Brant
14. Brantford Police Service	14. Lansdowne Children's	14. Wincare Drug Mart
15. Brantwood Centre *(2 representatives)*		15. Woodview Children's Mental Health
16. Canadian Council of the		

Blind 17. Canadian Diabetes Association 18. Canadian Institute for the Blind 19. Canadian Red Cross Society 20. Children's Aid Society of Brant, Aboriginal Services Unit 21. City of Brantford, Mayor's office *(3 representatives)* 22. Community Legal Clinic, Brant, Haldimand, Norfolk 23. Community Living Brant 24. Community Resource Service 25. County of Brant, Mayor's office 26. De dwa da dehs nye>s Aboriginal Health Centre 27. Eagle Place Community Centre, City of Brantford, Parks and Recreation 28. Hamilton Niagara Haldimand Brant Community Care Access Centre 29. Hamilton Niagara Haldimand Brant Local Health Integration Network *(3 representatives)* 30. Heart and Stroke Foundation 31. Immigrant Settlement Services, YMCA of Brantford *(2 representatives)* 32. Kids Can Fly 33. Master Aging Plan 34. Mohawk College 35. Nipissing University, Concurrent Education Program 36. Ontario Early Years Centre: Brant 37. Ontario Provincial Police Brant County 38. Operation Lift 39. Paris Transportation Services 40. Pregnancy & Resource Centre *(2 participants)* 41. Prima Care Family Health	Centre 15. Local Pharmacy staff *(5 representatives)* 16. Nova Vita Domestic Violence Prevention Services 17. Ontario Early Years Centre: Brant *(2 representatives)* 18. Park Lane Terrace 19. Sexual Assault / Domestic Violence Program, Brant Community Healthcare System 20. Sexual Assault Centre of Brant 21. St. Joseph's Lifecare Centre *(2 representatives)* 22. Telfer Place Retirement Residence *(2 representatives)* 23. United Church Ministers *(3)*	

Team 42. Public Health, Safety and Social Services, City of Brantford 43. Salvation Army, Brantford Family and Community Services 44. Six Nations Family Health Team 45. St. Andrew's United Church 46. St. Leonard's Community Services 47. Stedman Community Hospice *(2 representatives)* 48. Victim Services of Brant 49. Why Not City Missions 50. Wilfrid Laurier University *(2 representatives)* 51. YMCA of Brantford		

***Key representative interview*:** This method involves individual interviews being conducted with community representative who have a broad understanding of the community and its healthcare needs, using the same schedule of questions.

Fifty-one agencies (totalling 70 participants) responded to the following questions in a phone or in-person interview:

1. What is the current mandate of your organization? What programs / services do you offer? Who are your clients?

2. In your experience, what groups of people are facing barriers to accessing primary healthcare services in Brantford and Brant County? What types of barriers are these?

3. Where do these populations reside? Can you pinpoint specific neighbourhoods where it is likely that these individuals reside?

4. Which specific programs, services and staff do you think the Grand River CHC should offer?

5. Where do you think the CHC should be located?

6. What potential partnerships may exist between your organization and the Grand River CHC?

7. Are there particular individuals or organizations that you feel we need to engage?

8. Are there focus groups with particular populations you think we should hold?

9. Are you aware of any recent studies / needs assessments that have been done on the region, specific populations, age groups etc?

10. Would you be interested in volunteering as a Board member, committee member, volunteer at the Grand River CHC?

A summary of the feedback gathered via key representative interviews is included in Appendix B.

Focus group: Invited participants are given a few open-ended questions to discuss. The facilitator encourages all to express their opinion and the points that are raised are recorded. There is no agreement required; it is purely an exploratory exercise to identify issues, needs, potential solutions and recommendations.

Twenty-three organizations participated via one of fourteen service provider focus groups held (totalling over seventy participants). Some focus groups were conducted with one agency, and included representation from staff in different departments. Others were facilitated with a variety of service providers who were connected by a similar client population or service mandate.

Focus group participants were asked to identify:

1. Populations in greatest need of primary healthcare and the barriers that they face when attempting to access primary healthcare services;

2. Specific programs, services and staff the Grand River CHC should offer to respond to the needs of these populations;

3. Opportunities for collaboration between existing service providers and the new CHC;

4. Possible location(s) for GRCHC or alternate points of access and,

5. Future involvement with GRCHC as a future Board, Committee member or volunteer.

If time was available, focus group attendees were also asked to submit:

6. Names of other service providers and community-based groups to be engaged during the community consultation process

7. Reports or needs assessments that highlight the needs and issues facing potential priority populations

Feedback collected during focus group is presented in Appendix C.

Online survey for service providers: Local service providers were invited to participate in an online survey as another means for providing input towards the development of the Grand River CHC. The survey was developed using Survey Monkey (http://www.surveymonkey.com/) and ran during the month of March 2008 with the purpose of:

- Increasing awareness of the GRCHC;

- Expanding understanding of the range of services that are currently being offered throughout the area, to be able to better identify the gaps in service that may be filled by the GRCHC.

Survey participants responded to the following questions:

1. Which geographic location(s) does your organization serve?
2. Which age groups does your organization deliver services to?
3. What are the specific gender groups that your agency serves?
4. What types of demographic populations do you cater to?
5. What types of health services do you offer?
6. What types of social services do you provide?
7. In what capacity could your organization collaborate with Grand River CHC?

8. How would you like to be involved with the Grand River CHC?
9. Would you like to stay informed about the development of the GRCHC?

Fifteen organizations participated in the online survey. Results from the online survey can be found in Appendix D.

1.5 Describe gaps and overlaps in service and how your CHC intends to address these

The following table provides an overview of gaps in service across Brantford and the County of Brant along with the potential programmes, services and staffing needed to address these gaps, as identified through the CE process.

Table 15 – Planning for Gaps in Service

Gaps in Service *Planning for…*	How the gap will be addressed
Access to primary healthcare practitioners Basic primary healthcare needs for those residents living in the designated catchment area who are without access to the full range of primary healthcare services, experience poverty and other barriers to access to primary healthcare, with an emphasis on: ❑ People experiencing homelessness or who are under-housed ❑ Seniors ❑ Aboriginal populations, living off reserve, without a status card ❑ People with physical and/or developmental disabilities; mental health and/or addiction issues ❑ Children and youth ❑ Recent immigrants	The main priority of the Grand River CHC in the first year of operation will be the delivery of primary healthcare services to the identified priority populations. These services will be provided by a collaborative, inter-disciplinary team with expertise across the lifespan, in staffing positions such as: • Clinical Programme Coordinator • Nurse Practitioners • Pharmacist (consulting) • Physicians • Registered Nurses and through mechanisms such as: ❑ Collaboration with the municipal family physician recruitment strategy (partnership between the City of Brantford, Brant Community Healthcare System, PrimaCare FHT and GRCHC) on an ongoing basis ❑ Provision of extended hours for each physician and Nurse Practitioner on staff. After-hours care will be provided on weekday evenings and Saturdays. Physicians and Nurse Practitioners will provide on-call services for additional hours. ❑ Partnerships with local primary healthcare providers (e.g., PrimaCare FHT, Brant Community Healthcare System, Brantford Urgent Care) to develop a network of extended hours ❑ Incorporation of the Tele-Health Advisory Service (THAS) and educate / inform clients that this service is available to them after hours ❑ Advanced access
Access to transportation between and outside of Brantford and the County of Brant	The Grand River CHC will address transportation barriers through staffing positions such as: • Community development workers • Community outreach workers

Developing a plan to address this barrier is critical for those seeking access to primary healthcare, and should include: ❑ Equipping and implementing a strategy for mobile healthcare and outreach (enabling staff to support clients outside of the CHC and where they are – e.g. in their homes, at school, on the street) ❑ Community partner points of access in the County of Brant ❑ Financial support for transportation in collaboration with municipal governments.	As well as: ❑ Be located in the downtown core of the City of Brantford, in close proximity to other service providers and accessible by public transportation ❑ Provide ample free and accessible parking, including an unloading zone ❑ Work with municipalities and local health organizations to implement a mobile health unit and points of access across the catchment area ❑ Collaborate with municipalities and local transportation agencies and services, in order to set up an affordable, sustainable and accessible transportation service for clients both locally and those that need to travel out of the area for healthcare services ❑ Examine how current volunteer transportation services and reduced fee-for-service transportation can be further coordinated and enhanced
System navigation and integration of services across the continuum of care The Grand River CHC needs to be a resource for the greater community for: ❑ System navigation and coordination ❑ Patient advocacy ❑ Information and resource library ❑ Education and community-capacity building ❑ Outreach and communications	The needs for navigation, collaboration, education, and outreach will be met via staff such as: • Community development workers • Community outreach workers The Grand River CHC will integrate and coordinate services to assist clients to move seamlessly across the continuum of care through the following activities: ❑ On an ongoing basis, through the community-governed Board of Directors, raise awareness of service gaps and improve continuity of care through community development, networking, planning and coordinating with other health, community and social service providers as well as the HNHB LHIN. ❑ Work with those that have indicated interest in partnering and with networks in a diversity of sectors across the region to improve health outcomes of clients. ❑ Utilize information technology and an information management system to better coordinate the CHC process and client care, e.g., use of electronic health records and videoconferencing technology for client care and networking with other providers ❑ Connect clients to other available services in the community through referrals, and to health information through an information library
Mental health and addiction services ❑ Mental health and/or addictions counselling for	Comprehensive mental health and addictions services and supports will be delivered to individuals across the lifespan, and their support networks, through staffing positions such as: • Age-specific mental health and addictions counsellors

people of all ages with particular attention to children, youth and seniors with mild to complex concerns ❑ Crisis management ❑ Family counselling ❑ Individual and group therapy ❑ Outreach ❑ Prescription management and education	• Community Mental Health Nurse • Consulting Psychiatrist (Sessional) • Consulting Psychologist (Sessional) • Social Workers Working in conjunction with community partners to enhance and develop age-specific Personal Development Groups in the following related areas: ❑ Gambling ❑ Grief and trauma ❑ Life skills ❑ Peer-led, self-help groups for caregivers ❑ Social and recreational activities ❑ Post-partum depression and … ❑ Community education to raise awareness and reduce stigma associated with mental health and addictions issues ❑ Collaboration with local mental health, addiction and other agencies (e.g., local school boards, corrections, organizations serving populations with dual diagnosis) to identify gaps, develop and/or enhance program delivery ❑ Crisis response and drop-in services

Lack of culturally-competent primary healthcare services An accessible environment with culturally-competent staff who have the necessary skills to serve all clients with dignity and respect, with particular attention paid to the unique needs of: ❑ Children, youth and seniors ❑ Urban Aboriginal populations ❑ Stigmatised populations (people with disabilities; people who are homeless or under-housed; people with mental health and/or addictions issues) ❑ Immigrant communities ❑ French-speaking populations	Culturally-competent services provided by all members of the primary healthcare team through the following mechanisms: ❑ Partnerships with community partners (e.g., Brantwood Centre, Community Advisory Committee on Disability Issues) to ensure that GRCHC is fully accessible for a variety of abilities ❑ Recruitment of culturally- and linguistically-appropriate staff such as a Traditional Healer, French language primary healthcare providers ❑ To foster an environment of cultural appropriateness and competency, staff and volunteers will receive regular and ongoing anti-oppression training ❑ Partnership development with Immigrant Settlement Services, YMCA of Brantford to provide qualified translation and interpretation services, including sign language ❑ Program space where diverse populations may congregate for cultural, spiritual, social and recreational events ❑ Ongoing assessment of the population's changing needs through community development, outreach, networking, planning and coordination with local health and social service providers and the HNHB LHIN ❑ Tools and resources that are relevant to the priority populations served such as TTY, visual and auditory appointment indicators; clearly visible, plain language signage; medicine wheel
Illness prevention and health promotion programming focussed on: ❑ Healthy eating ❑ Injury prevention ❑ Lactation support ❑ Oral care ❑ Personal development groups ❑ Physical activity ❑ Pre- and post-natal care ❑ Sexual health and reproductive health ❑ Smoking cessation ❑ Stress management …across the lifespan.	Health promotion programming needs will be delivered by the following staffing positions: • Health Promotion and Chronic Disease Programme Manager • Registered Nurses • Dietitians • Health Promoters • Dentist • Dental Hygienist • Programme Assistant in collaboration with local partners such as the Brant County Health Unit, YMCA of Brantford and through Personal Development Groups in the following related areas: ❑ Nutrition ❑ Parenting ❑ Physical fitness and through educational / coordinated events on: ❑ Anti-bullying, anti-violence ❑ Environmental health

	❑ Resilience training for youth

Chronic disease prevention and management Programming focussed on those living with: ❑ Asthma/rheumatism ❑ Arthritis ❑ COPD ❑ Chronic pain (from disease or injury) ❑ Diabetes ❑ Disability (physical and developmental) ❑ HIV-AIDS ❑ Obesity	Chronic disease management programming needs will be met through the staffing positions such as: • Physicians • Diabetic Nurse Educator • Dietitians • Health Promoters • Programme Assistant • Chiropodist and in collaboration with local partners such as the Brant Community Healthcare System's Diabetes Education Centre and the Canadian Diabetes Association and through clinics and educational / coordinated events that include, but are not limited to: ❑ Influenza, childhood vaccines, preventing breast cancer, ear and eye health, COPD, congestive heart failure etc.
Addressing the social determinants of health Programming focussed on addressing the following social determinants of health: ❑ Employment ❑ Food security ❑ Housing ❑ Income ❑ Literacy	Addressing the broader determinants of health and fostering social cohesion of CHC clients will be accomplished through the entire inter-disciplinary team with emphasis on staffing positions such as: • Community development workers • Community outreach workers through the following activities: ❑ Advocacy ❑ Community kitchen programmes ❑ Community-led interventions ❑ Counselling for employment skills and financial management ❑ Housing help ❑ Ongoing assessment of community health needs to identify avenues for new or enhanced programming ❑ Partnerships with other organizations that address issues that affect overall health outcomes at macro and micro levels ❑ Service coordination in collaboration with local partners such as Canadian Mental Health Association, Public Health, Safety and Social Services; Community Resource Service, St. Andrew's United Church, St. Leonard's Community Services, Community Legal Clinic, Why Not City Missions.
Administration that facilitates and supports the work and collaboration of the clinical	The administrative, information technology and management needs of the CHC will be addressed through the hiring of staff such as:

and social services team	• Executive Director • Receptionists and medical secretaries • Finance manager • Data manager • Plant manager / facility and maintenance worker • Accounting and payroll staff by contract Grand River CHC will explore opportunities for consolidating back office functions with other community organizations.

Overall, the Grand River CHC's staffing complement will comprise, but not be limited to the following positions: Executive Director, Clinical Programme Coordinator, Health Promotion and Chronic Disease Programme Manager, Physicians, Nurse Practitioners, Registered Nurses, Chiropodists, Dietitians, Dentists, Dental Hygienists, Social Workers, mental health and addictions counsellors, Health Promoters, Traditional Healers, Community development and outreach workers, Programme Assistants, receptionists and medical secretaries, Finance manager, Data Management Coordinator, Facilities manager, accounting and payroll staff by contract, consulting Psychiatrists, Pharmacists and Psychologists.

1.6 Identify other individuals, informal organizations and groups you consulted as part of the community engagement process (e.g., residents' groups, ethno-cultural organizations).

The broader community was consulted via attendance at local meetings and presentations to organizations. GRCHC Steering Committee / Board members and AOHC's Centre Development Team attended various local and regional events to network, gather resources, share and learn more about the CHC sector. Meetings attended include:

Meeting	Date
Master Aging Plan	October 5, 2007
Standing Together (poverty initiative)	October 3, 2007
AOHC South West Constituency Meeting	December 10, 2007
CHC Fest	December 18, 2007
Aging at Home Community Innovation Exchange	February 20, 2008
Every One Matters Campaign	March 18, 2008

The Chair of the Grand River CHC Steering Committee also delivered presentations regarding the new CHC to local organizations such as City of Brantford and County of Brant Councils. The presentations introduced attendees to the CHC Model of Care and provided an overview of the progress of GRCHC to date. Presentations were conducted with the following organizations:

Organization	Date
Social Services Committee, Brantford City Council	January 30, 2008
Kiwanis Club of Brantford	February 21, 2008
Brant Community Healthcare System Board	March 6, 2008

1.7 Describe the ways in which you consulted with potential service users and the broader community. Which groups did you identify as hard-to-reach and what strategies did you use to engage these group?

Potential users of CHC services and were consulted through *focus groups*, *a questionnaire* and *community forum events*. Individuals who participated in either of these methods of consultation were asked to identify:

- What are the health and/or social service programs that are currently working well in Brantford and Brant County? *(Community assets)*
- What health and/or social programs and services do you think are currently missing? *(Gaps in service, barriers to access)*
- What programs, services and staff should be a part of the Grand River CHC?
- How do you see yourself being involved with the new CHC?

Focus Groups: Nine focus groups with potential priority populations were conducted (totalling one hundred and sixty participants). These focus groups were meant to gather a first-hand account of the challenges facing these populations while highlighting recommendations and opportunities for GRCHC. Feedback gathered during focus groups with priority populations can be found in Appendix E.

Table 16 – Focus Groups with Proposed Priority Populations

Date	Potential Priority Population	Community Group Consulted
October 4, 2007	Individuals with disabilities *(12 participants)*	Community Advisory Committee for Disability Issues, City of Brantford
December 6, 2007	Individuals with mental health issues *(5 participants)*	Consumers of mental health services
February 13, 2008	Persons with addiction issues *(20 participants)*	Reflections group, St. Leonard's Community Services
February 19, 2007	At-risk youth *(12 participants)*	Youth Resource Centre, St. Leonard's Community Services
March 4, 2008	Seniors *(15 participants)*	Beckett Friendship Club
March 5, 2008	Urban Aboriginals *(4 participants)*	Native Women's Circle, Brantford Native Housing
March 10, 2008	Persons with developmental challenges *(5 participants)*	Self advocate group, Community Living Brant
March 10, 2008	Post-secondary students *(7 participants)*	Nipissing Student Advisory Committee, Concurrent Education Program
March 31, 2008	Persons experiencing low income and recent immigrants *(85 participants)*	Syndenham Street United Church

Questionnaire: Member organizations of the Brant Mental Health and Addictions Network distributed a questionnaire developed by the CE consultants to gather input from hard-to-reach populations. Approximately eighty individual completed the questionnaire, results of which are found in Appendix F.

Community Forum Days: Community members were invited to attend two forum events regarding the development of Grand River CHC on December 5, 2007 at 1:30 to 4:30 pm and 6:00 to 9:00 pm. These events provided an opportunity to:

- Inform community members about the CHC model of care;
- Report initial findings of the community consultation, including population health profile;

- Solicit feedback from participants regarding community assets, gaps in service and suggestions regarding programs and staff for the future CHC
- Invite expressions of interest from community members who would like to participate on the GRCHC Board of Directors or future committees.

A total of 100 participants attended the sessions, including both service providers and community members. Feedback collected during the community forum events is presented in Appendix G.

Hard-to-Reach Populations: A number of community groups have been identified as hard-to-reach populations through the CE process. The following table cites these populations, identifies the barriers they face, and highlights the strategies the Steering Committee and CE consultants undertook to address these barriers.

Table 17 – Strategies to engage hard-to-reach populations

Population	Barriers To Participation In CE Process	Strategies to engage these populations
Individuals and families that experience poverty	• Limited access to transportation • Not connected to mainstream health and social service agencies • Work multiple, low paying jobs and may not be able to attend evenings meetings, especially if they require child care	• Engaged community-based organizations currently providing service to these populations via key representative interviews and focus groups • Interviewed youth and adults utilizing the 'Hot Diggity Dog' programme at Why Not City Missions, an initiative that provides hot meals and clothing to homeless populations
Seniors	• Limited access to transportation • Socially isolated	• Engaged service providers working with these populations via key representative interviews and focus groups • Identified and conducted a focus group with a seniors club in downtown Brantford (e.g. Beckett Friendship Club)
People with mental, physical and/or developmental challenges, including addictions	• Limited access to transportation • Socially isolated	• Facilitated focus groups with networks of organizations working with these populations (e.g. Brant Mental Health and Addictions Network, Community Advisory Committee for Disability Issues and Council for Children, Youth and Developmental Services) • Worked with local organizations to coordinate and facilitate focus groups with members of these communities; provided refreshments and honorarium • Distributed questionnaire for individuals unable to attend focus groups
Youth	• Lack of connection with mainstream health and social	• Engaged service providers working with at-risk youth

	service agencies • Distrust of service providers, stigma and discrimination by service providers • Lack of engagement with their health	• Conducted focus group with youth in residence at a local shelter (St. Leonard's Community Services, Youth Resource Centre)
Urban Aboriginal population	• Mistrust of mainstream health and social service providers	• Interviewed agencies serving on and off reserve Aboriginal populations • Facilitated focus group with the Native Women's Circle at Brantford Native Housing

1.8 How did you ensure your activities were accessible to the broader community?

Communications Plan: In collaboration with AOHC's Centre Development Team, the Grand River CHC Communications sub-committee developed a communications plan to identify goals, audiences, key messages and communications tools to ensure that both the GRCHC and community engagement process were accessible to the broader community. The communications plan is available in Appendix H. The Grand River CHC's Community Coordinator was also instrumental in generating a list of Frequently Asked Questions (FAQs) to assist Steering Committee members with responding to inquiries from community members. The GRCHC FAQs are available in Appendix I.

Broad advertisement:

Community forum events were advertised among the following media:

- Articles local media (the Brantford Expositor, the Paris Star)
- Advertisement of the community forum events across Brantford and Brant County:
    - Newspapers:
        - The Brantford Expositor
        - Paris Star
        - Burford Times
        - Paris Chronicle
        - St. George Lance
    - Radio
        - CKPC
        - CD 98.9
    - TV
        - Rogers Cable 20
    - Libraries
        - County of Brant Public Library – Burford, Glen Morris, Paris and St. George Branches
        - Brantford Public Library – Main and St. Paul Branches
    - Others
        - Brant Free Net www.bfree.on.ca
        - Paris Chamber of Commerce
        - Burford Area Business Association
        - Brantford Brant Chamber of Commerce

Flyers community forum events were also distributed through the Steering Committee to their broader networks. The GRCHC community forum flyer is available in Appendix J.

Update newsletter: The Grand River CHC's Community Coordinator designed and distributed a newsletter to describe the community engagement process and provide an overview of the development of the new CHC (See Appendix K). An update newsletter will be developed to disseminate the outcome the final report on the use of community engagement funds and will be distributed in April 2008.

Efforts to ensure accessibility during CE activities:

- Advertisements for the forum identified assistance for those with special needs.
- The venue for the community forum events (John Noble Home for the Aged) was wheelchair accessible with free and accessible parking. Light refreshments were provided free of charge.
- Community forum events were held in the afternoon and evening to accommodate a variety of work schedules.
- Focus group with Best Start Francophone Advisory Sub-Committee was conducted entirely in French.
- Consumers of mental health service received lunch and a small honorarium for their participation in a focus group.

1.9 What strengths, assets and opportunities did you identify?

One of the greatest strengths contributing to the success of the community engagement process has been the experience and knowledge of the Grand River CHC Steering Committee / Board. Their expertise, networks and commitment has been significant in guiding the CE process.

There is significant local and provincial support for the CHC model, including the Mayor of the City of Brantford and the City of Brantford Council. MPP Dave Levac gave opening remarks at one of the community forum events, praising the CHC for its commitment to eliminating barriers to accessing primary healthcare services. Residents are also very enthusiastic about another primary care provider coming to the area. The GRCHC Community Coordinator receives calls from community members wanting to learn more about the new CHC on a regular basis.

Through community forum events, questionnaires and focus groups with priority populations, participants were given the opportunity to identify what they see as the community's strengths, assets and opportunities. Looking at the assets and resources helps a community to be aware of its capacity to meet the needs within the community. Community assets can include human resources, natural resources, physical assets, economic activity, social capital, cultural expression and spiritual aspects. Individuals and organizations that participated in CE activities noted the following community assets:

Organizations: Adult Recreation Therapy Centre, Boys and Girls Club, Brant Canadian Mental Health Association, Community Healthcare System's Diabetes Education Centre, Beckett Adult Leisure Centre, Brantford General Hospital, Community Resource Service, Family Counselling Centre Inc., Hamilton Niagara Haldimand Brant CCAC, Immigrant Settlement Services, Kids Can Fly, mental health crisis line, methadone clinic, needle exchange, Nurse Practitioners, Nova Vita, Ontario Early Years Centre: Brant, Ontario Works, St. Leonard's Community Services, spiritual

and religious organizations, Stedman Community Hospice, VIP programme, Willett Hospital Urgent Care.

Programs: Health promotion programs, projects to support populations that are homeless, city initiatives to create affordable housing, children and youth-specific programs, recreational programs, job placement for the hard-to-employ populations, secondary stroke prevention.

Efforts towards collaboration: Coordinated services for domestic violence, co-operative spirit of agencies, networks of service providers working together to address needs of individuals in need, local recognition of seniors needs, strong volunteerism.

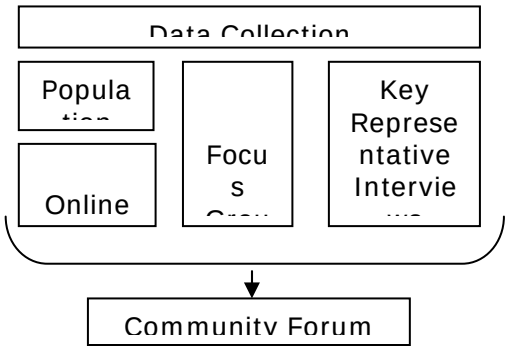
Natural resources: Walking trails and the Grand River.

2. INVOLVING THE COMMUNITY IN DECISION-MAKING

2.1 Describe your community consultation process and any conflicting or different views that have arisen through the process. How did you resolve or address these?

The current community consultation is a multi-faceted process designed to increase awareness and understanding of the CHC model, and encourage both community members and service providers to contribute their input in a variety of ways: in person at focus groups, key representative interviews, partnership consultations, community forum days, and an online service provider survey. As well, research has been conducted into past consultations conducted by other health and social service organisations, which has contributed to the understanding of the health needs of area residents. The community consultation process is depicted in Figure 3 below.

Figure 3 -Pictorial Depiction of the Grand River CHC Community Consultation Process



Arising Issue - Closure of Nurse Practitioner Clinics

Over the last few years, The City of Brantford has had three Nurse Practitioner (NP) clinics close their doors. Two of these clinics were administered by Aberdeen Health and Community Services,

providing primary healthcare services to low income, seniors and mental health populations in the downtown core, East Ward and Slovak Village (Eagle Place). The NP clinic in the downtown core was located in the Ontario Works office. St. Andrew's United Church also housed a Nurse Practitioner clinic to complement their food security, harm reduction and social work programmes for at-risk populations in the downtown core. With the recent closure of the remaining NP clinic in Brantford in early November, the Grand River CHC's Steering Committee has been asked to fill the gap by local organizations, government officials and community members. Local service providers, in particular, have requested that the GRCHC open its doors as soon as possible.

In response to these increasing demands, the GRCHC Steering Committee has made the following steps:

- Requested a meeting with MPP Dave Levac, HNHB LHIN staff and the Association of Ontario Health Centres to discuss the possibility of the GRCHC providing NP services as soon as possible. This conversation could also include former and potential NP employers such as Aberdeen Health and Community Services, St. Andrew's United Church, Ontario Works and John Noble Home for the Aged

- Contacted the Executive Director of Aberdeen Community & Health Services to investigate what lead to the closure of the Slovak Village NP clinic

- Obtained the name of a doctor who is currently accepting new patients (this doctor is Hamilton-based)

- Confirmed that the Medical Officer of Health for Brant County is following up on any test results initiated by the Slovak Village Nurse Practitioner clinic

- Conducted a focus group with local Nurse Practitioners to gather their understanding of the primary healthcare needs in the area (See Appendix B).

Grand River CHC will provide primary healthcare services to residents in the catchment area who do not have access to primary healthcare practitioners with emphasis on the priority populations listed in Section 1.1.

2.2 How does your group encourage participation from a diversity of community members (e.g., through sub-committees, public meetings, diversity of the sponsoring group)? What are the decision-making structures that encourage this participation?

- The Steering Committee / Board is made of up a diverse group of community representatives from organisations in the area such as Adult Recreation Therapy Centre, Brant Community Healthcare System, Brantwood Centre, Canadian Mental Health Association, Dell Pharmacies, Mohawk College, Public Health, Safety and Social Services, Wilfrid Laurier University etc.

- Community forum events were widely advertised in a variety of media and venues.

- During the key representative interviews and focus groups, participants' views on current programmes and services, their experience of the healthcare system, how the GRCHC could fill gaps and improve/enhance services and their recommendations for change were solicited and became the foundation on which this report rests.

- Assistance for individuals with special needs was advertised as being available to community forum participants as needed.

- A listing of individuals interested in volunteering or sitting committees has been maintained throughout the CE process and will be drawn upon during the pre-operational phase.

2.3 How are you keeping a broad range of community members up-to-date on your progress?

Members of the GRCHC Steering Committee / Board participate on other local committees in the area, such as the Brant Mental Health and Addictions Network, Brant Network for Children and Youth and Physician Recruitment Committee, where information is shared broadly. They also actively share information about the CHC community engagement with members of their social, volunteer and work networks.

The community forum days were being widely announced and promoted, through local media across Brant County and Brantford (See Section 1.8).

The Grand River CHC's Community Coordinator has developed a newsletter to update community members on the progress of the new CHC. In January 2008, the first edition if the newsletter was distributed all stakeholders listed in the GRCHC inventory as well as participants in the CE process (See Appendix J). A follow-up edition of the newsletter will be released in April 2008 to advise the broader community of the results of the CE process and next steps in the pre-operational planning.

3. DEVELOPING LINKAGES, PARTNERSHIPS AND SERVICE COORDINATION

3.1 *Identify a list of partner agencies that have agreed to work with your CHC/Satellite CHC and describe the expected nature of your work together.*

The following groups and organizations have expressed an interest in the Grand River CHC and their intentions to support and collaborate with the CHC in a variety of ways, from co-locating services and collaborating on programming, to using programme space and serving as a future volunteer or Board member. Further discussion will be required to formalize these initial partnership ideas. Please see Appendix A for details of these potential partnerships.

1. Aberdeen Health and Community Services
2. Adult Recreation Therapy Centre
3. Alzheimer Society of Brant
4. Beckett Adult Leisure Centre
5. Brant Ambulance Service
6. Brant Community Healthcare System (Diabetes Education Centre, Mental Health Services, the Willett Hospital)
7. Brant Community Social Planning Council
8. Brant County Health Unit
9. Brant Haldimand Norfolk Catholic District School Board
10. Brant Lactation Consultant Working Group
11. Brant Mental Health and Addictions Network
12. Brant United Way
13. Brantford Mosque
14. Brantford Native Housing
15. Brantford Physiotherapy and Sports Medicine Centre
16. Brantford Police Service
17. Brantwood Centre
18. Canadian Council of the Blind, Robert Troughton Memorial Chapter
19. Canadian Diabetes Association, Brantford Branch

20. Canadian Mental Health Association
21. Canadian National Institute for the Blind
22. Canadian Red Cross Society, Brantford Branch
23. Children's Aid Society Brant
24. City of Brantford, Public Health, Safety and Social Services (Ontario Works, Housing Department)
25. Community Advisory Committee for Disability Issues
26. Community Legal Clinic, Brant, Haldimand, Norfolk
27. Community Living Brant
28. Community Resource Service
29. De dwa da dehs nye>s Aboriginal Health Centre
30. Doug Snooks Eagle Place Community Centre
31. Family Counselling Centre of Brant Inc.
32. Grand Erie District School Board
33. Hamilton Niagara Haldimand Brant Community Care Access Centre
34. Hamilton Niagara Haldimand Brant Local Health Integration Network
35. Heritage United Church
36. Immigrant Settlement Services, YMCA of Brantford
37. John Noble Home for the Aged
38. Kids Can Fly Brant
39. Master Aging Plan
40. Mohawk College, Brantford Campus
41. Nipissing University, Faculty of Education, Brantford Campus
42. Ontario Early Years: Brant
43. Ontario Provincial Police, Brant County
44. Operation Lift
45. Paris Transportation Service
46. Park Lane Terrace
47. Pregnancy and Resource Centre
48. Salvation Army, Brantford Family and Community Services
49. Sexual Assault Centre of Brant
50. St. Andrew's Church
51. St. Joseph's Lifecare Centre and Foundation
52. St. Leonard's Community Services
53. Stedman Community Hospice
54. Victim Services of Brant
55. Why Not City Missions
56. Wilfrid Laurier University
57. Wincare Drug Mart
58. YMCA of Brantford

3.2 Describe how potential partner agencies have been involved in the planning for the CHC.

Potential partner agencies have been generous with their time and resource in support of the Grand River CHC. These organizations have been involved in the planning for the Grand River CHC in the following ways:

- Serving on the Grand River CHC Steering Committee / Board
- Participating in community engagement process as key representative interview, focus group, online survey and/or community forum participant
- Provision of local and regional reports regarding the population health

- Advice on area needs and service gaps
- Recruiting participants and/or coordinating of focus groups with priority populations
- Provision of meeting space and refreshments for steering committee meetings
- Supplied refreshments and honorarium for priority population focus groups
- Distribution of questionnaire to community members
- Offers to advertise the community engagement process in local news bulletins
- Development of health human resource strategy in Brant
- Sharing of service coordination resources

3.3 Describe how your CHC fits into the network of health and social services in your community.

The Grand River CHC will both complement and strengthen the current healthcare and social service infrastructure by offering primary healthcare, health promotion, illness prevention and capacity building programs and services via an inter-disciplinary team of practitioners. The Grand River CHC will become known as the hub of community health promotion and chronic illness management. Chronic disease management and health promotion programming will reduce the burden on secondary and tertiary services. Over time, its presence will also reduce the need for travel to healthcare services out of the area, particularly for those most vulnerable populations. Where appropriate, partnerships will be pursued with other service providers in the area. As the Grand River CHC's Board begins to develop its programs and services plan during the pre-operational development phase, they will determine which networks and committees the CHC will sit on.

As with the HNHB LHIN, CHC health providers, patients, board members and all government leaders must use the finances provided to the most effective and efficient use possible. By providing safe and accessible buildings in locations that serve the priority populations, CHCs endeavour to cut costs for those that are accessing care. CHCs intentionally recruit healthcare providers who understand the interdisciplinary team model and are attuned to the challenges and advantages of collaborative practice. Creativity and sustainability are a part of the creation of new programs. By maximizing technology, the patient is served more fully by the entire team, utilizing the strengths and gifts of each provider.

4. ORGANIZATIONAL STRUCTURE

4.1 What is the mission and vision for the CHC?

The Grand River Community Health Centre's **vision** is:

Healthy individuals. Healthy communities. Healthy futures.

The Grand River Community Health Centre's **mission** is:

"The Grand River Community Health Centre empowers the people of Brantford and Brant County to lead healthier lives through collaborative, holistic partnership".

4.2 *How were the mission and vision developed? Who was involved?*

The vision and mission statements were created as part of an orientation session to community governance facilitated by the CE consultants. The Grand River CHC Steering Committee and CE consultants gathered together over three meetings between February and March 2008 to discuss the following themes:

1. Identification and mapping of current and future skills needed for board membership

2. Guidelines for 'good' governance

3. Challenges other CHC boards have encountered

4. Importance of community governance

5. Mission and vision interactive activity

The mission and vision activities divided steering committee members into dyads where they discussed and presented to the larger group their ideas regarding:

Mission

- Why do we exist? What is our purpose?
- What do we produce?
- Whom do we serve?

Vision

- An energising, positive and inspiring statement of where and what we want to be in the future
- A *vision* has dreamlike qualities, future hopes and aspirations, even if they are never quite fully attainable

The group came to consensus deciding on the mission and vision presented in Section 4.1.

4.3 Describe your plans to sign up members for your organization, elect a board of directors, and hold an AGM.

a) Membership enrolment will occur over time and as clients come to the CHC. Membership will become a focus of all Board members and staff of the CHC as they engage with the local community.

b) The Grand River CHC Steering Committee developed a current profile of its knowledge, skills and attributes as part of the governance orientation session facilitated by the CE consultants. Based on the results of the profile, the committee established a set of priorities to ensure that the Board reflects the priority populations that the CHC will serve (once approved by the HNHB LHIN), and embodies the skills and expertise needed for good governance. The Grand River CHC recruiting priorities include: representation from priority populations; accounting, banking, business, law, facilities and real estate expertise; cultural and linguistic diversity, under 35 years and 65+ age groups etc.

c) Six of the twelve GRCHC Steering Committee members indicated an interest in transitioning on to the Board. As such, a sub-committee was struck to review and establish contact with approximately 30 individuals and organizations that expressed interest in sitting on the board during the community engagement process. Five candidates in particular were recommended as new steering committee members based on their community involvement and opportunities for collaboration. The steering committee approved these new members and facilitated their orientation in collaboration with the CE consultants. The potential membership of the Board of Directors is currently being

reviewed by the Nominations Sub-Committee of the GRCHC Steering Committee. The Nominations Sub-Committee will develop recruitment criteria. The Grand River CHC is incorporated.

d) The first AGM will take place by the end of June 2009.

4.4 Do you have a draft set of by-laws?

A sub-committee of the GRCHC Steering Committee was established at the outset of the community engagement process to develop a set of by-laws based on a template used by other Community Health Centres. The by-laws sub-committee met on a regular basis to go through the example by-laws and make recommendations for revisions that were presented to the larger group for approval. The draft by-laws were approved by the steering committee then reviewed by legal counsel. See Appendix K for Grand River CHC's by-laws.

4.5 How do you plan to recruit a broad membership base? What are your criteria for membership?

A broad membership base will be recruited with the assistance of partner organisations and those organisations that work most directly with the defined priority populations.

Criteria for membership will be formulated based on final approval of priority populations by the HNHB LHIN.

4.6 How do you plan to recruit board members that reflect the diversity of skills needed, perspectives related to the priority populations you intend to serve, and the services you plan to offer?

Once priority populations have been approved by the HNHB LHIN, potential Board members will be considered with respect to skill level and their connection to any of these populations.

The Steering Committee, as it currently exists, gathers together a group of people with many of the necessary skills and expertise to do the all-important foundation-laying for a vibrant, strong and sustainable primary healthcare organisation. It is understood by the Steering Committee members that local champions who are 'close to the need' of the community will be essential in defining the CHC's identity in early days and building a strong base for future development.

5. SERVICE PLANNING

5.1 What priority populations have you identified and why?

The Grand River CHC will provide primary healthcare services to residents living within the identified catchment area who are not registered with a primary healthcare practitioner, experiencing poverty and other barriers to accessing primary healthcare, with particular emphasis on:

- *People experiencing homelessness or who are under-housed*
- *Seniors*
- *Off-reserve Aboriginal populations who do not have a status card*
- *People with disabilities, mental health and/or addiction issues*
- *Children and youth*

- *Recent immigrants*

These populations were identified as being in greatest need of primary healthcare services during the extensive community engagement process, in combination with the analysis of local and regional population health data.

5.2 What are the key services your CHC plans to offer and how will these meet the health needs of your priority populations?

See Section 1.5 for a detailed description of the key services Grand River CHC intends to offer and how these will address the health needs of the identified priority populations.

5.3 How were these priority plans and populations approved and by whom?

The process for approval of priority plans and populations occurred as follows:

- Throughout the community engagement process, the CE consultants attended Grand River CHC Steering Committee meetings on a bi-monthly basis, providing updates regarding the priority populations emerging from key representative interviews and focus groups. The group as a whole reviewed and discussed the findings at length to deepen their understanding of the barriers these populations experience when attempting to access primary healthcare services.

- The CE consultants summarized the preliminary results of the community engagement process into a presentation to be delivered to the broader community during the forum events. Members of the Grand River CHC Steering Committee reviewed and provided input towards this presentation which identified potential priority populations and suggestions regarding key staff, services and location.

- After the community forum events, the Grand River Steering Committee went through the interim report on the use of community engagement funds and gave verbal and written feedback to the CE consultants. The report was first approved by the steering committee in December 2007 and then by the HNHB LHIN in January 2008.

- The Grand River CHC board reviewed the final report during the last week of March 2008 then met with the consultants to discuss and make revisions in early April 2008. This report was approved by the board and sent to the LHIN for review on April 4, 2008.