



Ontario's Community
Health Centres

Les centres de santé
communautaire en Ontario

Final Report on the Use of Community Engagement Funds

Greater St. Catharines Community Health Centre

Submitted by the Greater St. Catharines CHC Steering Committee
to the Hamilton Niagara Haldimand Brant
Local Health Integration Network

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

April 2008

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Vision: Health, community and a sense of value.

Mission: Greater St. Catharines CHC enables all of our citizens to achieve health, community and a sense of value.

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Final Report on the Use of Community Engagement Funds Greater St. Catharines Community Health Centre

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 Greater St. Catharines Community Health Centre (GSCCHC) between October 2007 and March 2008.

In November 2005, the Ministry of Health and Long-Term Care (MOHLTC) announced that the City of St. Catharines was designated to receive a Community Health Centre (CHC), tentatively scheduled to open in 2006-07. 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 health needs assessment in 2007.

During the first phase of community engagement, stakeholders indicated that the City of Thorold was also in need of primary healthcare services. As such, this second segment of community engagement has focussed on engaging the municipalities of St. Catharines and Thorold. (Together, these two communities will be referred to as the Greater St. Catharines area throughout this report). It was a multi-faceted process, 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 Greater St. Catharines residents, increase awareness of the Greater St. Catharines 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 Greater St. Catharines CHC.

The key recommendations that have emerged from the CE process include identification of the Greater St. Catharines CHC's:

- **Catchment area**, encompassing the municipalities of St. Catharines and Thorold
- **Priority populations**, are those residents living within the identified catchment area, who are not registered with a primary healthcare practitioner and also experience other barriers to accessing primary healthcare, with emphasis on populations that are: street-involved (e.g., homeless, under-housed, sex trade workers), isolated seniors, people with mental health and/or addiction issues, at-risk children and youth, newcomers to Canada and people with disabilities (e.g., physical, developmental). The priority populations will also include sexually and gender diverse residents from across the Region of Niagara (e.g., lesbian, gay, bisexual, transgender or LGBT)
- **Programmes, services and staff**, with a focus on: addressing primary healthcare needs; health promotion programming; chronic disease prevention and management;

transportation barriers; mental health and addictions issues; system navigation and the integration of services across the continuum of care; the social determinants of health; accessible and culturally-competent healthcare

- **Locations**, with the primary location in the downtown core of St. Catharines, and a point of access in Thorold.

The process also resulted in the development of the Greater St. Catharines CHC Board's draft by-laws, mission and vision statements.

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 Greater St. Catharines CHC.

1. UNDERSTANDING THE COMMUNITY

The Cities of St. Catharines and Thorold are part of the Regional Municipality of Niagara, a land mass that covers 1,854.17 square kilometres and encompasses twelve municipalities - namely the Towns of Grimsby, Lincoln, Pelham, Fort Erie and Niagara-on-the-Lake; Townships of West Lincoln and Wainfleet; and the Cities of Niagara Falls, Welland and Port Colborne (Statistics Canada, 2007). Embraced by the Niagara Escarpment to the south and Lake Ontario to the north, the Queen Elizabeth Way connects several of the Niagara Region's municipalities as it rounds the Golden Horseshoe and meets the US border. With a 2006 Census population of 427,421 residents, the Region (4.1%) has grown at a slower rate as compared to the province (6.6%) since 2001 (Statistics Canada, 2007). The Ministry of Finance's *Ontario Population Projections Update* estimates that Niagara's population will grow to 489,500 by the year 2031.

Figure 1: Regional Municipality of Niagara



(Regional Niagara website, 2007)

St. Catharines is the sixth largest urban area in Ontario and the largest city in the Niagara Region, occupying a land mass of 96.11 square kilometres (Statistics Canada, 2007). According to the 2006 Census, St. Catharines has 131,989 residents, representing an increase of 2.2% between 2001 and 2006 (Statistics Canada, 2007). St. Catharines carries the official nickname 'The Garden City' due to its 1,000 acres of parks, gardens and trails. Relative to the province, St. Catharines:

has a **higher**

- proportion of seniors (age 60 years and older);
- rate of unemployment;
- percentage of income from government transfers;
- number of rented private dwellings;
- percentage of lone parent families;

and a **lower**

- proportion of residents age 59 years and younger;
- proportion of residents who report French or other languages as their mother tongue;
- proportion of residents who identify as Aboriginal;
- proportion of immigrants and members of racialised communities;
- percentage of residents without a high school certificate or university degree;
- participation and employment rates;

- average individual earnings, median family and lone parent family incomes;
- number of owned private dwellings.

Located directly south of St. Catharines, the City of Thorold grew at a rate of 1.0% since the 2001 Census with a 2006 population of 18,224 residents (Statistics Canada, 2007). Thorold's land area covers 83 square kilometres, is home to Niagara's largest inland lake, Lake Gibson, and has one of the remaining canal downtown areas in Canada (City of Thorold website, 2007). Relative to the province, Thorold:

has a **higher**

- proportion of residents age 40 years and older);
- participation and employment rates;
- percentage of income from government transfers;
- number of owned private dwellings;

and a **lower**

- proportion of residents age 39 years and younger;
- unemployment rate;
- proportion of residents who report French or other languages as their mother tongue;
- proportion of residents who identify as Aboriginal
- proportion of immigrants and members of racialised communities;
- percentage of residents without a high school certificate or university degree;
- average individual earnings, median family and lone parent family income;
- number of rented private dwellings.

1.1 What are your proposed catchment area and priority populations?

Catchment Area

Through the CE process, the Greater St. Catharines CHC Steering Committee has heard from community members that additional health and social services are greatly needed in both St. Catharines and Thorold.

It is the intention of the Greater St. Catharines CHC to make a range of primary healthcare services available to residents of St. Catharines and Thorold with emphasis on those identified as priority populations.

Proposed Priority Populations

The Greater St. Catharines CHC will provide primary healthcare to residents living within the identified catchment area who are not registered with a primary health care practitioner and experience other barriers to accessing primary healthcare, with emphasis on:

- ❑ *Street-involved populations (e.g., homeless, under-housed, sex trade workers)*
- ❑ *Isolated seniors*
- ❑ *At-risk children and youth*
- ❑ *People with disabilities (e.g., physical, developmental)*
- ❑ *People who experience mental health and/or addiction issues*
- ❑ *Newcomers to Canada*

- *Sexually and gender diverse populations across the Region of Niagara (e.g., lesbian, gay, bisexual and transgender)*

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

The following population health profile provides an overview the Greater St. Catharines area, 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)

Note:

- **Statistics Canada data:** Niagara refers to the entire Regional Municipality of Niagara. The St. Catharines-Niagara census metropolitan area (CMA) includes the following municipalities: Fort Erie, Lincoln, Niagara Falls, Niagara-on-the-Lake, Pelham, Port Colborne, St. Catharines, Thorold, Wainfleet and Welland.
- **HNHB LHIN data:** The LHIN area extends from Fort Erie to Turkey Point and Paris to Lowville, covering an estimated 7,000 square kilometres. It includes Brant, Burlington, Haldimand, Hamilton, Niagara and Norfolk. Thirty-two percent (32%) of the HNHB LHIN's population lives in the Regional Municipality of Niagara (HNHB LHIN, 2006).

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A. Socio-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 (Regional Niagara Public Health Department, 2006).

Table 1 – Population Size and Growth Rate, Ontario, Niagara, St. Catharines and Thorold, 2001 to 2006

Location	Population Size (2001)	Population Size (2006)	2001 to 2006 population change (%)
Ontario	11,410,046	12,160,282	6.6
Niagara	410,574	427,421	4.1
St. Catharines	129,170	131,989	2.2
Thorold	18,048	18,224	1.0

(Statistics Canada, 2007)

Highlights

- Between 2001 and 2006, St. Catharines and Thorold grew at a slower rate than both the region and the province.
- According to the Ministry of Finance's *Ontario Population Projections Update*, the population of St. Catharines is expected to reach between 136,000 and 149,000 residents by 2011 and 137,000 and 151,000 residents by 2016. The regional population is projected to reach between 440,100 and 481,300 inhabitants by 2011 and 443,300 and 498,200 by 2016 (Ministry of Finance, 2006). Data are not available for Thorold.

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) (Regional Niagara Public Health Department, 2006).

Table 2 – Percentage of Population by Age, Ontario, Niagara, St. Catharines, Thorold, 2006

Location	0 – 19 yrs	20 – 39 yrs	40 – 59 yrs	60+ yrs
Ontario	25.0	26.5	30.2	18.3
Niagara	23.7	23.4	30.0	22.9
St. Catharines	22.7	24.8	29.0	23.6
Thorold	24.5	25.8	30.8	19.0

(Statistics Canada, 2007)

Highlights

- Relative to province, St. Catharines had a higher proportion of residents age 40 years and older and a lower proportion of residents age 39 and younger.

- Thorold had a higher proportion of residents age 40 and older; lower proportion age 39 and younger as compared to Ontario.
- The 2006 median age of the population in St. Catharines (41.7 years) and Thorold (39.8 years), is slightly higher than that of Ontario (39 years). (Niagara = 41.9 years) (Statistics Canada, 2007).
- Seniors over the age of 75 made up the fastest growing group across the Niagara Region, increasing by 23.3% between 1996 and 2001. Adults ages 45 to 64 years also increased in numbers (10.7%) during the same time period (Niagara Region Public Health Department, 2006).
- Regionally, there was a decrease in the number of children ages 0 to 14 (-6.8%), youth ages 15 to 24 (-5.5%), adults ages 25 to 44 (-8.7%) and 65 to 74 (-2.5%) between 1996 and 2001 (Niagara Region Public Health Department, 2006).
- The HNHB LHIN area is home to more than 200,000 seniors aged 65+; it is the largest number of seniors of all 14 LHIN populations in Ontario, representing 15.1% of the total HNHB LHIN population, compared to the all provincial rate of 12.9% (HNHB LHIN, 2006).

iii. Population by Gender

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 (Federal, Provincial and Territorial Advisory Committee on Population Health, 1999).

Table 3 – Percentage of Population by Gender, Ontario, Niagara, St. Catharines and Thorold, 2006

Location	Female	Male
Ontario	51.2	48.8
Niagara	51.6	48.4
St. Catharines	52.2	47.8
Thorold	50.3	49.7

(Statistics Canada, 2008)

Highlights

- There were proportionally more women than men in St. Catharines and Thorold in 2006. This is similar to the region and province.
- By 2011, there will be an estimated 226,677 female residents in the Region compared to 218,661 males. The female population is expected to reach 231,012 residents by 2016, while males are projected to grow to 224,102.

iv. 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 (HNHB LHIN, 2006).

**Table 4 – Mother Tongue,
Ontario, Niagara, St. Catharines and Thorold, 2006**

Location	English Only (%)	French Only (%)	Other language(s) (%)
Ontario	68.4	4.1	27.2
Niagara	80.4	3.3	16.1
St. Catharines	78.7	2.3	18.9
Thorold	82.8	2.0	15.0

(Statistics Canada, 2008)

Highlights

- Compared to the province, St. Catharines and Thorold had higher percentages of residents who reported 'English only' as their mother tongue and a lower proportion of residents whose mother tongue is 'French only' or other languages.
- Less than one percent of the residents in St. Catharines (0.7%) and Thorold (0.9%) had no knowledge of English or French. These rates were lower than the province (2.2%) and higher than the region (0.6%) (Statistics Canada, 2007)
- The Cities of Welland and Port Colborne are designated to provide French language services under the French Language Services Act.

Population by home language refers to the number of people who report speaking a given language at home per 100 population speaking only one language in a given year. The proportion of the population speaking a given language most often at home provides a measure of the relative size of communities that may have a different culture. Community members who do not speak English or French (i.e. the official languages of Canada) may have been least affected by the process of acculturation. Those who speak non-official languages at home may have demographic, social, economic and health characteristics that differ from those of Anglophones or Francophones (Regional Niagara Public Health Department, 2006).

**Table 5 – Population by Home Language
Ontario, Niagara, St. Catharines and Thorold, 2001
Percentage Reporting Single Language**

Location	English	French	Italian	Polish	German	Ukrainian	Other
Ontario	88.8	1.7	0.7	0.4	0.2	0.1	8.1
Niagara	96.8	0.6	0.7	0.2	0.2	0.1	1.4
St. Catharines	95.9	0.5	0.6	0.4	0.2	0.1	2.3
Thorold	97.5	0.1	1.6	0.5	0.0	0.1	0.2

(Statistics Canada, 2001)

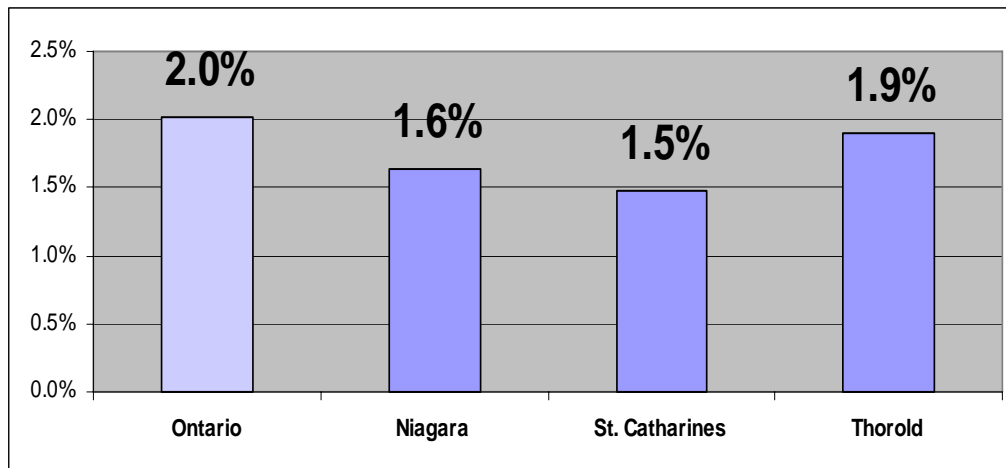
Highlights:

- A higher proportion of Niagara residents reported speaking English most often at home compared to the province. Relative to the province, a lower proportion of Niagara residents spoke French most often at home.
- A higher proportion of Thorold residents spoke Italian or Polish at home compared to the province overall.

v. 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 (HNHB LHIN, 2006).

Graph 1 – Aboriginal Identity Population, Ontario, Niagara, St. Catharines and Thorold, 2006



(Statistics Canada, 2008)

Highlights:

- Compared to the province, Thorold and St. Catharines had a slightly lower proportion of residents who identified as Aboriginal.
- 98.0% of the provincial population was Non-Aboriginal; 98.4% in Niagara, 98.5% in St. Catharines and 98.1% in Thorold (Statistics Canada, 2007)
- It is important to note that the First Nations communities in the Hamilton Niagara Haldimand Brant LHIN area are underestimated in the census data due to incomplete enumeration. Band registry lists with Indian and Northern Affairs Canada show the total registered Aboriginal population in Hamilton Niagara Haldimand Brant LHIN as of August, 2006 was 24,263 (HNHB LHIN, 2006).

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 (Women's Health in Women's Hands, 2003).

Definition:

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 (Ontario Human Rights Commission, 2007).

- In 2001, Thorold (2.5%), St. Catharines (6.6%), the Niagara Region (4.2%) and the HNHB LHIN (7.0%) had substantially fewer residents who were from racialised groups than the province (19.1%). (Statistics Canada, 2001; HNHB LHIN, Spring 2006).
- Niagara’s racialised community status – top five groups:

Population size: 17,355

1. Black: 3,960
2. Chinese: 2,780
3. South Asian: 2,585
4. Latin American: 1,570
5. Southeast Asian: 1,325 (Niagara Training and Adjustment Board, 2007).

vii. Immigration

While being an immigrant itself is not related to socioeconomic status (SES), time since immigration is, with more recent arrivals having substantially lower income than non-immigrants, and higher rates of unemployment (HNHB LHIN, 2006).

**Table 6 – Percentage of Population
by Immigrant Status and Period of Immigration,
Ontario, Niagara, St. Catharines and Thorold, 2006**

	Non-immigrant population	Immigrant population	Recent immigrants (2001-2006)	Non-permanent residents
Ontario	70.8	28.3	4.8	1.0
Niagara	81.2	18.0	1.9	0.8
St. Catharines	77.8	21.1	2.7	1.1
Thorold	85.6	14.2	0.6	0.2

(Statistics Canada, 2008)

Highlights

- Relative to the province, St. Catharines and Thorold had a higher proportion of non-immigrants and lower percentage of immigrants in 2006. The greatest numbers of immigrants in Niagara reside in St. Catharines, followed by Niagara Falls. St. Catharines is home to 36% of Niagara’s immigrants, and receives 42% of the most recent immigrants (Niagara Training and Adjustment Board, 2007).
- One in ten or 13,030 people in St. Catharines identified themselves as a visible minority in the 2006 Census. The City’s visible minority population jumped by 56% between 2001 and 2006, nearly three times the previous increase of 19%. St. Catharines is home to half of Niagara’s 25,470 visible minorities, which make up 6.6% of the Region’s population. According to the Folks Arts Council of St. Catharines, more immigrants are coming to the City from Asia, Latin America, Africa and the Middle East. One of the biggest increases has been the Latin American population in St. Catharines. In 2006, 2,310 people identified themselves as Latin American or nearly three times the 2001 population of 785. Immigrants from Colombia drove the change. Between 2001 and 2006, 1,080 Colombians landed in Niagara. Nationally, 16.2% of people are visible minorities (The St. Catharines Standard, April 3, 2008).

- The most recent group of immigrants to Niagara (those arriving between 2001 and 2006) constitute 1.9% of the Region's population, an increase from 2001 (1% between 1991 and 2000). The provincial percentage of the total recent immigration population decreased from 2001 (5% to 4.8%) (Statistics Canada, 2007).
- Niagara is a major receiver of refugees due to its proximity to the United States border. The size of refugee population, however, is not likely captured by Census enumeration. Similarly, seasonal migrant workers are also not included in official population statistics. This population tends to locate in Niagara for temporary agricultural and tourism employment.
- Recent migration patterns show an increased number of refugee claimants at the Fort Erie point of entry into Canada. Within the past three years, Fort Erie has become the busiest Canadian point of entry for refugees (Region of Niagara, Department of Community and Social Services, 2007).
- In 2001, the overall, percentage of recent immigrants in the HNHB LHIN was 2.1%, less than the province as a whole (4.8%). The highest concentrations of recent immigrants in the LHIN were found in the more urban centres of Hamilton (3.3%), St. Catharines (2.1%) and Niagara Falls (2.0%) (HNHB, 2006).
- Citizenship of International Students, Brock University (2007-08):
 - Asia 62%
 - Europe 13%
 - Central and South America, Caribbean 9%
 - Africa 8%
 - North America 5%
 - Oceania 1%
 - Other 1%

viii. Sexual and gender diversity

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.

- According to the CCHS (2003), 1.5% of Ontario's total population identified as gay, lesbian or bisexual as compared to the national rate of 1.7% (Canadian Community Health Survey, 2003).

ix. Faith and Spirituality

Table 7 – Most Prevalent Religious Groups, Ontario, Niagara, St. Catharines and Thorold, 2001

	Religion	% of Total Population	Religion	% of Total Population	Religion	% of Total Population
Ontario	Protestant	34.9	Roman Catholic	34.3	Muslim	8.7
Niagara	Protestant	43.3	Roman Catholic	36.4	Christian (no denominational or other religious affiliation)	2.4
St. Catharines	Protestant	42.9	Roman Catholic	34.2	Christian (no denominational or other religious affiliation)	2.5
Thorold	Roman Catholic	47.4	Protestant	34.3	Christian (no denominational attachment)	1.8

(Statistics Canada, 2001)

Highlights:

- Protestants make up the largest faith group in Ontario, Niagara and St. Catharines; Roman Catholics in Thorold.

x. 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-headed lone parent families, each was included separately rather than combining genders into a single lone parent category (HNHB LHIN, 2006).

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 (Statistics Canada, 2006).

Table 8 – Selected Family Characteristics, Ontario, Niagara, St. Catharines and Thorold, 2006

Location	Total # of Census Families	Married Couple Families (%)	Common-Law Couple Families (%)	Lone parent Families (%)
Ontario	3,422,315	73.9	10.3	15.8
Niagara	123,365	73.3	10.3	16.4
St. Catharines	37,150	71.1	10.6	18.3
Thorold	5,250	72.7	10.9	16.4

(Statistics Canada, 2008)

Highlights:

- Compared to the province, St. Catharines and Thorold had a lower percentage of married couple families and a higher proportion of lone parent families.
- Female-headed lone parent families constituted 14.9% of all census families in St. Catharines and 12.7% in Thorold (Ontario = 12.9%; Niagara = 13.1%). Rates for male-headed lone parent families were higher in St. Catharines (3.4%) and Thorold (3.7%) than the province (2.9%). (Niagara = 3.2%). (Statistics Canada, 2007).
- In 2001, 19.8% of families in the HNHB LHIN area were led by a female lone parent. This rate was similar to the rate for Ontario (HNHB LHIN, 2006).
- Throughout 2006-07, Family and Children's Services Niagara (FACS) responded to 5,842 child protection concerns and conducted 3,594 investigations, slightly less than in the previous year. Ongoing protection service was provided to 1,422 families during the same time period (Family and Children's Services Niagara, 2006).
- In 2006-07, the average number of children in foster care was 613 and the number of active and approved homes available to care for them was 234. More than 200 children were placed in Kinship Placements with family and community members. There is still a need for homes for teens and homes of all cultural backgrounds (Family and Children's Services Niagara, 2006).

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 (HNHB LHIN, 2006).

i. Education

Education is a core marker of SES. Although highly correlated with income and age, education also encompasses other health-related dimensions (HNHB LHIN, 2006).

**Table 9 – Percentage of Population by
Level of Educational Attainment, Ages 35 to 64,
Ontario, Niagara, St. Catharines and Thorold, 2006**

Location	No certificate; diploma or degree	High school certificate or equivalent	Apprenticeship or trades certificate or diploma	College; CEGEP or other non-university certificate or diploma	University certificate or diploma below the bachelor level	University certificate; diploma or degree
Ontario	15.0	25.4	9.6	21.3	4.7	24.0
Niagara	15.3	30.1	11.8	24.6	3.2	15.1
St. Catharines	15.5	28.9	11.4	23.0	3.3	17.9
Thorold	17.4	30.9	14.2	23.2	3.1	11.2

(Statistics Canada, 2008)

Highlights

- A higher proportion of St. Catharines and Thorold residents between the ages of 35 and 64 had less than a high school education or university degree compared to the province as a whole.
- In the same age group, St. Catharines and Thorold had higher proportions of residents who completed high school, apprenticeship/trades certificates and college diplomas compared to the province.
- Between November 1, 2004, and October 31, 2005, 6% of District School Board of Niagara students left school for a variety of reasons (Pennisi, 2006).
- Located in St. Catharines, Brock University has a student population of more than 17,000 (Brock University, 2006).

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 (Federal, Provincial and Territorial Advisory Committee on Population Health, 1999).

Definitions:

Participation rate – Refers to the available 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.

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.

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) (Statistics Canada, 2007).

**Table 10 – Proportion of Population Aged 15 years and over
by Labour Force Activity,
Ontario, Niagara, St. Catharines and Thorold, 2006**

Location	Participation rate	Employment rate	Unemployment rate
Ontario	67.1	62.8	6.4
Niagara	64.6	60.7	6.1
St. Catharines	63.5	59.3	6.6
Thorold	67.3	63.6	5.4

(Statistics Canada, 2008)

Highlights:

- Relative to the province, St. Catharines had lower participation and employment rates and a higher unemployment rate in 2006.
- Thorold's 2006 unemployment rate was lower than the province as a whole; participation and employment rates were higher than the rest of Ontario.
- According to the Niagara Training and Adjustment Board, Niagara's labour market has made a significant shift from manufacturing to sales and service, which made up the largest segment of the labour force in 2006. The sales and service sectors are generally lower paying sectors (Niagara Training and Adjustment Board, 2007).
- Women in Niagara, make up a large proportion of the sales and service, clerical, skilled administrative and business sector positions (Niagara Training and Adjustment Board, 2007).
- Niagara's racialised communities are over-represented in the sales and service, natural applied science and health sectors. (Niagara Training and Adjustment Board, 2007).
- The unemployment rate of Niagara's most recent immigrants is 12% which is double that of the region's unemployment rate for the non-immigrant population. Thirteen percent (13%) of recent immigrants across Ontario experience unemployment. Among Niagara's recent immigrant population, the greatest unemployment rates are experienced by professionals in Social Science, Education, Government Services and Religion, and Sales (Niagara Training and Adjustment Board, 2007).
- Nationally, unemployment among persons living with serious mental illness is estimated to be as high as 90% (Standing Committee on Social Affairs, Science and Technology, 2006).
- Unemployment rates among people with disabilities in general are at least 50% both nationally and provincially (Ontario Association of Food Banks, 2006).
- In 2001, the HNHB LHIN rate of adult (age 15+) unemployment was 5.8%; the youth (15 to 24 years) unemployment rate was 12.2%. These rates were lower than the province as a whole (6.1% and 12.9% respectively) (HNHB LHIN, 2006).

iii. Income

Poverty is often identified as the most important determinant of health, as it is highly associated with diminished access to the other determinants of health (e.g., housing, education, social supports) (Region of Niagara, Department of Community and Social Services, 2007).

Table 11 – Income Levels, Ontario, Niagara, St. Catharines and Thorold, 2006

Location	Average earnings from full-time employment (\$)	Median family income (\$)	Median income for lone parent families	Proportion of income derived from government transfer payments
Ontario	47,299	61,024	33,724	9.8
Niagara	42,126	56,787	32,334	13.2
St. Catharines	42,941	54,775	32,479	13.8
Thorold	40,282	57,433	31,525	12.5

(Statistics Canada, 2008)

Definitions:

Government transfers: Monies coming from all levels of government, including Old Age Security, Guaranteed Income Supplement, CPP, QPP, Employment Insurance, Canada Child Tax benefits and any other income from government sources.

Highlights

- Relative to the province, St. Catharines and Thorold had lower than average earnings, median family and lone parent family incomes, and a higher percentage of income derived from government transfers in 2006.
- There were a total of 192,000 workers in Niagara Region in 2005; 15,091 of them made under \$8/hour representing 7.86% of the workers. Families with incomes totaling less than \$20,000 year make up 15% of the workforce in Niagara. In Canada, one in every four jobs pays less than \$10/hour (Arai and Burke, 2007).
- In Niagara (2006) there are 6,582 people receiving Ontario Works (OW) assistance and 9,608 people with support from the Ontario Disability Support Program (ODSP). The majority of people on OW and ODSP in the Niagara Region are single adults (approximately 50% and 76% respectively). According to regional Social Service Statistics, 39% of the OW caseload are sole support parents and 9% of the ODSP caseload are sole support parents (Arai and Burke, 2007)
- In a report regarding the Income Replacement and Employment Supports System, the Regional Community Services Department (2007) noted that:
 - *In recent years, the Ministry of Community and Social Services (MCSS) has reviewed the OW program and worked to eliminate disincentives to exit social assistance. As well, since 2004 MCSS has implemented a 5% increase in social assistance rates. However, as noted in COM 22-2007, OW rates for an individual would need to increase by about 15% in order to meet actual costs in Niagara for healthy eating and shelter alone. Currently, a single OW participant would need to find full-time employment earning \$11.43 per hour in order to exit OW. In Niagara, the majority of exits from OW to employment are to the service sector where average earnings are \$10.16. Niagara's average monthly earnings for OW participants who exit OW are \$1,051.37 (Pennisi, 2007).*
- Nationally, children and their families constitute approximately 52% of the people receiving social assistance. In March 2003, there were more than 544,000 Canadian children who relied on social assistance. Children under 18 years comprise 42% of the OW caseload and 32% of

the ODSP caseload in Niagara. In Niagara Region, the number of children relying on OW payments was 2% higher than the provincial average. The number of children relying on ODSP was 12% more than the provincial average (Arai and Burke, 2007).

- In 2005, Niagara experienced a 1.7% increase from 2004 in the number of youth in receipt of Ontario Works (OW). When compared against provincial data, there were fewer young people in receipt of OW in Niagara in 2005 (Pennisi, 2006).
- According to the Niagara Mental Health Housing Study (2002), *“Typically individuals with a serious mental illness qualify for the Ontario Disability Support Program (ODSP) or are currently on Ontario Works (OW) as their main source of income. ODSP provides an average individual with \$930.00 monthly including a \$414.00 maximum shelter allowance and OW provides an average individual with \$520.00 monthly, including a \$325.00 maximum shelter allowance. The majority of clients of Housing Help Centres earn less than \$10,000 per year.”* (p. ii).
- The total social assistance caseload for March 2006 was 7,315, of which the newcomer caseload consisted of 792 cases (or approximately 10% of the total cases). In the first quarter of 2005, 4.5% of new applications for assistance were newcomers to Canada (Watson, 2006).
- In 2001, a higher proportion of HNHB LHIN residents (11.7%) received income government transfer payments than the province (9.8%) (HNHB LHIN, 2006).
- The percentage of households spending 30% or more of their income on housing in the HNHB LHIN (24.4%) was similar to the province as a whole (25.2%). The highest percentages in this LHIN were found in Hamilton (26.8%), St. Catharines (26.1%) Niagara Falls (25.7%) and Brantford (25.5%) (HNHB LHIN, 2006).

Low Income Cut-Offs (LICO) are set at after-tax levels differentiated by size of family and area of residence. LICO refers to income levels at which families or unattached individuals spend 20% more than average on food, shelter and clothing (Statistics Canada, 2006).

Table 12 – Low income cut-offs (1992 base) after tax, Ontario, Niagara, St. Catharines and Thorold, 2004 and 2006

Community of Residence	2004		2006	
	One person family	Four person family	One person family	Four person family
Ontario	\$20,337	\$37,791	\$21,202	\$39,399
Niagara	\$17,515	\$32,546	\$18,260	\$33,930
St. Catharines	\$17,515	\$32,546	\$18,260	\$33,930
Thorold	\$15,928	\$29,596	\$16,605	\$30,855

(Canadian Council on Social Development, 2008).

- The average female-headed lone parent family income is \$9,400 below LICO. The income of two-parent families experiencing poverty is approximately \$9,900 below the LICO (Region of Niagara, Department of Community and Social Services, 2007).
- Men and women who have recently immigrated to Canada (since 1991) experience a higher degree of poverty, with 35% of new-immigrant men and women living below the LICO. According to 2001 census data, 49% of children in recent immigrant families were low income. The factors that contribute to this trend include low wages, barriers to employment (such as for foreign trained professionals not having training or credentials recognized), and reduced opportunities to enter the labour market (Arai and Burke, 2007).

*See Appendices A and B for maps of 2001 LICO percentages in St. Catharines and Thorold.

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 (HNHB LHIN, 2006).

Table 13 – Occupied Private Dwelling Characteristics, Ontario, Niagara, St. Catharines and Thorold, 2006

Location	Owned Dwellings (%)	Rented Dwellings (%)
Ontario	71.0	28.8
Niagara	75.6	24.4
St. Catharines	69.1	30.9
Thorold	80.3	19.8

(Statistics Canada, 2008)

Highlights

- A lower proportion of occupied private dwellings in St. Catharines were owned compared to the rest of the province; a higher proportion of private dwellings in the City were rented.
- At 80.3%, Thorold's percentage of owned dwellings was higher than that of the province overall (71.0%). A lower proportion of private dwellings in Thorold were rented compared to Ontario.
- Rental housing in the Niagara housing market provided accommodation for about 42,000 households – 26% of all households in the region in 2001. 56.8% of renter households had incomes below \$30,000 in 2001. As of 2001, some 45.2% of all tenants (approximately 19,000 households) were paying more than 30% of their income on housing, with 21.2% (approximately 9,000 households) paying more than 50% (Social Housing Strategists, 2004).
- The 2003 rental housing vacancy rate was 2.7%, below the 3.0% level which the Canadian Mortgage and Housing Corporation generally identifies as a market in balance (Social Housing Strategists, 2004).
- Niagara currently has a broad range of housing, including homeless shelters, transitional housing, supportive housing and permanent housing. As part of this continuum of housing, Niagara Regional Housing and 68 non-profit and co-operative housing corporations provide affordable housing in over 7,000 units across the region (approximately 20 in St. Catharines and five in Thorold). However, some of the housing infrastructure is over 30 years old and there is not enough of it to keep pace with the demand for affordable housing. Currently, the central waiting list for rent-geared-to-income housing is approximately 4,000 households, or almost 8,000 people (Hutchings, 2005). In St. Catharines, an individual or family can expect to wait between 2.5 to 6.25 years for affordable housing through Niagara Regional Housing. In Thorold, the estimated wait time is 2.5 to 7 years (Niagara Regional Housing website, 2008).

- Niagara Regional Housing was the system manager for 5,501 subsidised housing units as of December 31, 2006; of which 2,200 are occupied by families, whose average family income is \$15,680.
- The Niagara Region Mental Health Housing Study (2001) reported that:
 - *“The overall housing vacancy rate in St. Catharines-Niagara Census Metropolitan Area dropped from 3.2% in 1999 to 2.6% in 2000. With the expectation of little or no additional rental stock, the supply of rental units is expected to remain almost the same. Thus as a consequence of higher demand and unchanged supply, vacancy rate in St. Catharines-Niagara Census Metropolitan Area is expected to decline further to 2.3% in 2001 and is expected to further decline to 2% in 2002. Both number of apartments vacant and the universe, or total rental stock of buildings in the survey area fell between 1999 and 2000 causing the vacancy rate to drop. In October 2000, 419 rental apartments were vacant, down from 529 in October 1999. During the same period, the universe also declined to 16,311 from 16,433 apartments.”*(p. ii).
 - *“The average apartment rental rates for Niagara region were \$405.00 for a bachelor unit, \$545.00 for a 1-bedroom unit and \$653.00 for a 2-bedroom unit in 2000. In Niagara Falls, average rents ranged from \$537.00 for a 1-bedroom unit to \$639.00 for a 2-bedroom unit. In St. Catharines, average rent ranged from \$412.00 for a bachelor unit to \$776.00 for a 3-bedroom unit. Due to anticipated job growth in St. Catharines-Niagara Census Metropolitan Area, demand for rental units is expected to increase. This along with virtually non-existent new rental construction tightens the rental market. Therefore, average rents are expected to increase by 2.5% in 2001.”*(p. ii).
- In 2003, Niagara’s hostel system faced pressures such as: a high degree of hostel use during the summer months due to seasonal closures of the Out of the Cold programs; a large number of refugee arrivals in Fort Erie requiring emergency shelter services; high rent and utility costs; lack of affordable housing, delayed exit from shelters due to low rental vacancy rates and high shelter costs; the lack of an integrated public transit system. As a result, Niagara saw a 7.4% increase in bed use in the formal hostels and a 56.3% increase in use of hotels and motels in 2003. The sharp growth in hotel and motel use has identified the need for additional beds within the Niagara emergency shelter system. Hotel and motel use accounted for 20% of the \$650,000 hostel budget in 2003 (Pelette, 2004).
- Data on shelter usage show that it has increased substantially since 2001. The total number of clients has increased by some 144.4% since 2001 (from 1,278 to 3,123 in 2003). The largest increase is noted for females, increasing from 178 in 2001 to 572 in 2003, a 221.3% increase. A major contributor to this increase has been a large upswing in the number of refugees arriving in Niagara region with very limited financial resources (Social Housing Strategists, 2004).
- In response to growing need, the number of emergency hostel beds available to youth has increased from 10 beds in 2001 to 12 beds in 2005. The RAFT and Nightlight reported an occupancy rate of 82% in 2005 (Pennisi, 2006).

v. 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 (Davis and Tarasuk, 1994).

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 (Campbell, 1991; Travers, 1996).

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 (Tarasuk, 2002).

- In 2006, just over 4,000 households utilized 13 food banks across the Niagara Region. Approximately one-third of visits to food banks in Niagara are made by children (Region of Niagara, Department of Community and Social Services, 2007).
- In a recent survey, Community Care St. Catharines Thorold, an organization that distributes clothing, household articles and food to residents living below the LICO, found the following proportions of people utilizing their services:
 - 35.1% single men
 - 2.2% single-parent males
 - 22% single women
 - 18.7 single-parent females.
- Data collected by the Nutritious Food Basket (NFB), showed that the cost of a healthy diet in Niagara had increased from \$102.49 per week in 1999 to \$126.78 per week in 2006, a 23.7% increase in seven years, compared to a 5.0% increase in social assistance rates (Ontario Works or Ontario Disability Support Program) and a 13.2% increase in the general minimum wage during the same period. The NFB is a food-costing tool used to measure the cost of healthy eating in Board of Health jurisdictions within Ontario (Hopkins, McCallum and Stevenson, 2007).

vi. 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 (Federal, Provincial and Territorial Advisory Committee on Population Health, 1999).

- At 27.8%, the percentage of seniors in the Region of Niagara living alone was higher than that of the province as a whole (25.1%) (Ontario Trillium Foundation, 2004).

vii. Transportation

The Region of Niagara's Inter-Municipal Transit Study was aimed at identifying the role of the Region in meeting or coordinating the provision of traditional and special needs transit services between municipalities, and to develop a long-term strategy to guide the implementation of inter-city transit services in Niagara. The study reviewed the extent of the existing systems and services, plans to improve existing systems; forecasted the need for additional services between municipalities, and identified alternative ways to provide those services. This study was one in a number of sub-studies that would implement the Region of Niagara's Transportation Strategy.

The first public meeting was held on February 5, 2002 with the purpose of generating general public awareness of the study and providing an opportunity for input on transit concerns and priorities:

- The primary concerns were the lack of adequate inter-city service, including specialized service for disabled persons and the current high fares.
- Priorities for improvement are increased regular inter-municipal transit, service for disabled and elderly persons, basic service throughout the Region, reduced fares. Also, there was some interest in future rail service.
- Almost all participants (10 of 11) indicated that the Region should play a role regarding inter-municipal transit service. This role was most commonly identified as coordinating and facilitating services, as well as participating in the funding of services (Region of Niagara website, 2008).

**Table 14 – Mode of Transportation to Work,
by Proportion of Total Employed Labour Force 15 years and over,
Ontario, Niagara, St. Catharines and Thorold, 2006**

Location	Car, truck, van; as driver	Car, truck, van; as passenger	Public transit	Walked or bicycled	All other modes
Ontario	71.0	8.3	12.9	6.8	1.0
Niagara	81.4	8.7	2.4	6.4	1.1
St. Catharines	78.2	9.3	4.3	7.0	1.2
Thorold	84.0	8.8	1.6	4.6	1.0

(Statistics Canada, 2008)

Highlights:

- Relative to the province, a higher proportion of the St. Catharines labour force, age 15 years and over, drove or were passengers in a vehicle as their mode of transportation to work; less used public transit. Compared to the province, St. Catharines had a higher proportion of residents in the same grouping that walked, cycled or used other modes of transportation to travel to work.
- Thorold also had higher rates of residents driving or being passengers in a vehicle as their mode of transportation to work as compared to the province as a whole. A lower proportion of Thorold residents used public transit and other modes of transportation.

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.

C. Health Status

i. Births

Infant mortality is a long-established measure, not only of child health, but also of the well-being of a society. It reflects the level of mortality, health status, and health care of a population, and the effectiveness of preventive care and the attention paid to maternal and child health (HNHB LHIN, 2006).

- As of 2001, Niagara's infant mortality rate was approximately 5.1 per 1,000 live births compared to 5.8 per 1,000 across the LHIN area and 5.4 per 1,000 throughout the province as a whole (HNHB LHIN, 2006).

Low birth weight (LBW) 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 (HNHB LHIN, 2006).

- In 2003, 6% of babies born in Niagara were considered to be low birth weight (weighing less than 2,500 grams or 5.5 lbs). This was similar to the province (Early Years Niagara, 2005).
- In the HNHB LHIN area, 5.3% of infants born in 2001 were of low birth weight, lower than the provincial rate of 5.7% (HNHB LHIN, 2006).
- In Niagara, more than half of the babies born into families with financial difficulties, developmental challenges, and/or parenting issues were considered at risk (Region of Niagara, Department of Community and Social Services, 2007).
- In 2004 in Niagara, Public Health data shows there were 183 teens giving birth aged 15 to 19 years, which is about the same as 2001 when there were 189 births (Pennisi, 2006).

The Parkyn Postpartum Screen, generally applied in hospital by maternity nurses or midwives, consists of a series of questions designed to identify factors associated with risk of parenting problems. Postpartum screening aims to reach all women (consenting) who give birth in Ontario. Families considered 'at-risk' have a score of greater than nine.

- Local data revealed that 65.5% of new parents experiencing mental illness gave birth to a baby with a Parkyn score of greater than nine, compared to 12.5% of those without mental health issues (Region of Niagara, Department of Community and Social Services, 2007).

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, lower than the life expectancy for Ontario males and females (77.5 and 82.1, respectively). (HNHB LHIN, 2006).

iii. Deaths

- The leading causes of death in Niagara are heart disease and cancer.
- Mortality due to heart disease is higher than the rest of Ontario for both males and females (Regional Niagara Public Health Department, 2006).
- Potential Years of Life Lost (PYLL) rates are useful for quantifying the number of years of life "lost" from deaths that occur "prematurely" (i.e., before age 75). Within the HNHB LHIN area, 2001 PYLL rates were significantly higher than the provincial average (from 10 to 20% higher) in the communities of Hamilton, Brant, Haldimand, Norfolk, and Niagara (HNHB LHIN, 2005).

iv. Hospitalisations

Identifying and understanding patterns of hospitalisation are important to health system planners. Patterns of acute inpatient hospitalisation are influenced by hospital system capacity, the availability of physicians and community services, and the age structure, health status and socio-

economic characteristics of the population. Acute inpatient care represents a major component of hospital expenditures and provides a proxy measure of allocation of hospital resources (HNHB LHIN, 2006).

Definitions:

Hospitalisation rate refers to the hospital separation rate for all hospital inpatients excluding newborns and stillbirths. A separation may be due to death, discharge home, or transfer to another facility.

Age-standardized rate: A summary rate which adjusts for variations in population age distributions over time and place.

- The Niagara Health System (NHS) is Ontario's largest multi-site hospital system comprised of six hospital campuses and an ambulatory care centre serving 434,000 residents across the 12 municipalities of the Niagara Region. The NHS consists of three large community hospitals (Greater Niagara General Site in Niagara Falls, St. Catharines General Site and Welland Hospital Site), three smaller hospitals (Douglas Memorial Hospital Site in Fort Erie, Niagara-on-the-Lake Hospital Site and Port Colborne General Site, and an ambulatory care centre known as the Ontario Street Site). Currently, the NHS employs approximately 4,200 employees, of which about 1,800 are nurses. It is supported by a medical staff of 647 physicians and is served by more than 1,100 active volunteers (Niagara Health System, 2006).
- After childbirth and pregnancy, the leading causes of hospitalisation for Niagara residents are diseases of the circulatory system, digestive system and respiratory system (Regional Niagara Public Health Department, 2006).
- In the fiscal year 2004-05, residents of the HNHB LHIN area had a total of 121,769 inpatient separations and 788,290 inpatient days at Ontario acute care hospitals, the highest volume of acute hospitalisations among all 14 LHIN populations. Within the HNHB LHIN area, residents of Hamilton and Niagara were each responsible for just over 35% of total acute inpatient separations by HNHB LHIN residents (HNHB LHIN, 2006).
- In 2004-05, the age-standardized hospitalisation rate for the HNHB LHIN (8,229) exceeded the provincial average (7,747). The region rate (7,261) was lower than the LHIN and provincial averages (HNHB LHIN, 2005).
- Many of the leading causes of hospitalisation among residents of HNHB reflect an older population with a higher prevalence of chronic health conditions. While the HNHB LHIN population's relatively high percentage of seniors contributes to a disproportionately high volume of acute inpatient separations compared to the Ontario rate, an examination of age-standardized rates of utilization shows that other factors are influencing HNHB LHIN residents' relatively high demand for hospital care. The LHIN's higher age-standardized rates of hospitalisation may be attributed to a combination of factors that influence population health status and the demand for health care, (i.e., socio-economic status, personal resources, lifestyle behaviours and the use of preventive health care services). Having regular access to a family physician can reduce the need to access hospital emergency departments for primary care, and reduce the likelihood of admission to hospital (HNHB LHIN, 2006).
- Within the HNHB LHIN area, the largest volumes of day surgery are related to diseases and conditions associated with an aging population (e.g., the removal of neoplasms, cataracts, gall bladders, etc.). The highest age-standardized rates of day surgery utilization are for residents of Brant and Niagara (89/1,000) and the lowest rates for residents of Burlington (69/1,000 population) (HNHB LHIN, 2005).

v. Emergency Room Visits

Improving the effectiveness and efficiency of the health care system is critical to making publicly-funded health care sustainable. Indicators that reflect the appropriateness of the setting in which care is received reflect system effectiveness and efficiency. These include the percent of emergency department visits which might be managed in a primary care setting and hospitalisations for ambulatory care sensitive conditions (HNHB LHIN, 2006).

- In 2005, there were 49,625 emergency department visits in Niagara by children and youth aged 0 to 17 years. The three top reasons for visits to Niagara emergency departments: Falls, asthma and accidental poisoning (Region of Niagara, Department of Community and Social Services, 2007).
- In 2004-05, residents of the HNHB LHIN area accounted for more than 580,000 visits to the emergency department. Fifty-nine percent (59%) of the 580,000 emergency room visits were considered to be 'non-urgent' conditions with potential to be treated in primary care settings, (e.g., minor infections, colds, cysts, etc.). This is higher than the provincial rate of 56% (HNHB LHIN, 2006).

vi. Prevalence of Chronic Disease

Chronic conditions place a high burden on the health care system and reduce the quality of life of those who suffer from chronic conditions (HNHB LHIN, 2006).

- In 2005, Niagara and the HNHB LHIN area had a higher prevalence of arthritis/rheumatism and other chronic conditions including high blood pressure and heart disease as compared to the province. Asthma and diabetes rates in both of these areas were slightly lower than provincial rates (HNHB LHIN, 2005; Niagara Public Health, 2005).
- A total of 2,274 cases of cancer were diagnosed in the Niagara Region in the year 2003.
- The rate of new cancer cases reported among residents of the HNHB LHIN area in 2001 was 397.3/100,000 population (age-standardized rate), similar to the Ontario rate. Within the HNHB LHIN, the lowest rate was in Niagara (388.9/100,000) (HNHB LHIN, 2006).
- In the Niagara Region, breast cancer results in the largest number of new cancer cases in women, in addition to being one of the primary causes of cancer mortality (Niagara Region Public Health Department, October 2007).
- For men and women, three cancers comprised more than half of the registrations:
- 57% of cancer in **men** was attributed to:
 - prostate (28%)
 - lung (15%)
 - colorectal cancers (14%)
- 53% of cancer in women was attributed to:
 - breast (28%)
 - lung (13%)
 - colorectal cancers (12%) (Niagara Region Public Health Department, 2007).

- The study found that gay men and bisexual women tended to report more chronic conditions than did the heterosexual population. They were also more likely to have had at least one disability day due to physical illness in the two weeks prior to the survey (Canadian Community Health Survey, 2003 and 2005).

vii. Mental Health & Addictions

- Mental illness affects approximately 25% of the population at some point in their lives and about 10% of the adult population has a mental health disorder at any given time (Region of Niagara, Department of Community and Social Services, 2007).
- Contact Niagara's 2004 Community Service Plan (the result of a community-wide collaboration that created a shared vision for children's mental health services in Niagara) indicated that 4,117 individuals entered mental health services in 2002-03 and 3,849 received services. The largest age group beginning services was youths aged 16 to 17 years (39.9%), followed by youth aged 13 to 15 years (35%). The wait list as of March 31, 2004, contained a total of 260 referrals; representing 250 unique individuals, 45.8% of whom were waiting for child and family counselling (Contact Brant, Contact Haldimand Norfolk, Contact Hamilton and Contact Niagara, 2004).
- Adolescents and young adults aged between 15 and 24 were more likely to report suffering from mental illnesses and/or substance use disorders than other age groups (Region of Niagara, Department of Community and Social Services, 2007).
- Almost half of the people accessing mental health or addictions services must wait for eight weeks or more – for 18%, the wait can be a year or longer (Region of Niagara, Department of Community and Social Services, 2007).
- Canadian Mental Health Association (CMHA) serves more than 3,800 clients across Niagara. Programmes and services include mental health counselling, employment services, housing support, and crisis services. Average wait time for the following CMHA programmes and services include (2008):

<u>Program</u>	<u>Average wait time</u>
▪ Community support (<i>e.g., case management for people with moderate mental health needs</i>)	82 days
▪ Phase II housing (<i>e.g., intensive case management support for homeless populations with mental health needs</i>)	48 days
▪ Lodging	25 days
▪ Employment supports	5 to 10 days

(Canadian Mental Health Association Niagara, 2008)

- Acute mental health separations accounted for 5.5% of all inpatient separations (6,722) and 10.3% of total inpatient days (81,279) attributed to HNHB LHIN residents at Ontario acute care hospitals (HNHB LHIN, 2006).
- In April 2003, the Ministry of Health and Long-Term Care (MOHLTC) asked District Health Councils (DHCs) across the province to review the 2003-2004 operating plans of community

mental health programmes and addictions service providers. This review identified the following major issues for existing mental health and addictions programmes:

- No increase to base budgets (*this has increased up to 6.5% since 2004*)
- Reductions in critical mental health & addiction services and staff
- Growing waiting lists for services
- Case loads of existing services are resulting in staff burnout and turnover
- Inability to discharge clients from costly inpatient care due to the unavailability of community services
- An increase in ethnically diverse individuals requiring services unique to their cultural awareness and interpretation of addiction & mental health

A study based on 2003 and 2005 data from the CCHS for adults aged 18 to 59 found that:

- 8% of gay men consulted a psychologist; nearly triple the proportion of 3% among their heterosexual counterparts. About 7% of gay men consulted social workers or counsellors, compared with 4% of heterosexual men. Ten percent of lesbians consulted a psychologist, as did 11% of bisexual women, well above the proportion of only 4% among heterosexual women (Canadian Community Health Survey, 2003 and 2005).
 - 7% of lesbians and 9% of bisexual women attended a self-help group, while only 3% of their heterosexual counterparts did so (Canadian Community Health Survey, 2003 and 2005).
 - Bisexual men and women were more likely than heterosexual men and women to perceive their mental health as fair or poor (Canadian Community Health Survey, 2003 and 2005).
 - All sexual minority groups reported levels of mood or anxiety disorders above those for the heterosexual population (Canadian Community Health Survey, 2003 and 2005).
- The Niagara Region experienced 805 known suicides from 1986 to 2004. The ratio of male to female deaths was 3.5 to 1 which is consistent with national estimates. The highest numbers for men were in the age range of 25 to 44 years, and for women in the age range 25 to 54 years. There were approximately 3,374 admissions to hospitals due to a non-fatal attempt from 1996 to 2001. Each year, approximately 4,000 Canadians die by suicide. Across Canada, suicide is the second leading cause of death among youth age ten to 24 years. Each suicide directly impacts six to ten others, often referred to as survivors (those bereaved by suicide). It is estimated that for each suicide, there are another 100 non-fatal attempts. Suicide affects one in 13 Canadians, taking into consideration reports regarding serious ideation, non-fatal attempts and deaths (Niagara Region Suicide Prevention Strategy, 2006).

D. Health Practices

i. Use of preventive care

The use of preventive healthcare services can lead to early detection of disease, which ultimately results in reduced morbidity and mortality (HNHB LHIN, 2005)

- In 2003, 68.7% of women in the HNHB LHIN area ages 50 to 69 had a mammogram within the last two years compared to 70.6% of females across the province.

- The proportions of lesbian and heterosexual women aged 50 to 59 who had had a mammogram in the two years prior to the survey did not differ significantly. However, bisexual women were less likely to have had a mammogram in that period (Canadian Community Health Survey, 2003 and 2005).
- According to the CCHS (2003), just over two-thirds of women in the HNHB LHIN area had a Pap smear test for cervical cancer screening, compared to 69.2% of females in Ontario.
- Less than two-thirds of lesbians reported having had a Pap test within three years of the survey, well below the more than three-quarters of heterosexual and bisexual women who had done so (Canadian Community Health Survey, 2003 and 2005).
- Rates of flu shots in the HNHB LHIN were similar to those of the province (35.1% of the 12+ population had a flu shot in the past year compared to 34.2% of Ontarians) (HNHB LHIN, 2005).

ii. Health Practices

Poor health practices are known to be related to increased risk of chronic disease, mortality and disability (HNHB LHIN, 2006).

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) (Canadian Community Health Survey, 2004).

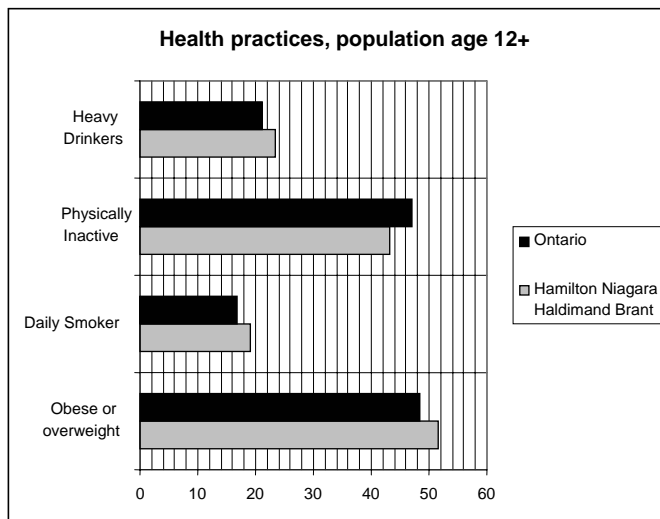
Physically Inactive: The Physical Activity Index is an index that represents the average daily energy an individual would expend on leisure time physical activity. Respondents aged 12 or above were asked about leisure time physical activity during the past 3 months. In addition to the above questions on physical activity, respondents between 12 and 17 years of age were asked about the amount of leisure time they spent on a computer, playing video games, watching TV or videos, and reading (Canadian Community Health Survey, 2004).

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 (Canadian Community Health Survey, 2004).

Obese or Overweight: Data on height and weight were used to calculate Body Mass Index (BMI; weight in kilograms divided by height in metres squared, and BMI was subsequently classified as *underweight*, *normal weight*, *overweight*, or *obese* (HNHB LHIN, 2005).

The following data regarding health practices was collected by the CCHS (2003) and presented in the HNHB LHIN Population Health Profile (2005).

Graph 2 – Health Practices, Population Age 12+, Ontario and Hamilton Niagara Haldimand Brant LHIN, 2003



Highlights:

- According to 2003 CCHS data, the HNHB LHIN area exhibited higher rates of heavy drinking, daily smoking and obesity as compared to the province. There were fewer physically inactive residents in HNHB LHIN area than the province as a whole.
- The overall rate of physical activity in the HNHB LHIN area (51.5%) was higher than the Ontario average rate (51.3%).
- A significantly higher proportion of HNHB LHIN residents (34.2%) reported being limited in their activities due to a physical or mental condition, compared to the Ontario rate (29.4%).
- For the years 2001 to 2005 combined, 54.7% of respondents in Niagara reported a BMI in the overweight or obese range. 1.9% of respondents in Niagara identified as underweight, leaving less than half of Niagara’s population with a BMI in the healthy range. Respondents aged 55 to 64 had the highest rates of overweight and obesity. In 2005, 21.7% of 12 to 17 year olds in Niagara were overweight or obese as compared to the provincial rate of 19.7% (Niagara Public Health, 2007).
- A higher percentage of males have a BMI in the overweight category than females in Niagara (48% versus 30%, respectively) (Niagara Public Health, 2007).

Perceived Health Status: Studies have shown that individuals who perceive their health to be poor have higher mortality rates than those who rate their health as good or excellent:

- Compared to the province (57.4%), fewer Niagara residents (56.8%) rated their health as excellent (Niagara Public Health, 2007).
- An estimated 65% of gay men and 63% of lesbians reported their health as excellent or very good, virtually identical to rates among the heterosexual population (Canadian Community Health Survey, 2003 and 2005).
- However, 12% of bisexual men and 16% of bisexual women reported fair or poor health. These levels were significantly higher than the roughly 8% of men and women in the heterosexual population who reported the same health status (Canadian Community Health Survey, 2003 and 2005).

iii. Access to Primary Healthcare

As of October 2006, with the exception of Hamilton, communities within the HNHB LHIN were designated as having family physician vacancies by the Under-Serviced Area Program (UAP) of the Ontario Ministry of Health and Long-Term Care.

The following table provides an up-to-date overview of the number of designated complements and vacancies for General/Family Practitioners as presented in the List of Areas Under-Serviced (April to June 2008):

**Table 15 – Designated Complement and Vacancy,
Ontario, Niagara, St. Catharines and Thorold, April to June 2008**

Location	Designated Complement	Vacancy
Ontario	2,620	654
Niagara	299	95
St. Catharines	95	20
Thorold	35	13

(Ministry of Health and Long-Term Care, 2008)

A November 2007 article in *Niagara This Week*, "Niagara in ongoing battle for doctors," noted that:

- One in three Niagara residents does not have a family doctor.
- For nearly every doctor coming into Niagara (between 10 and 15 per year) another is retiring or dying (Bowes, 2007).
- Statistically similar proportions of gay, bisexual and heterosexual men reported that they did not have a regular doctor. Among women, 19% of lesbians and 24% of bisexuals did not have a regular doctor, as opposed to only 12% of heterosexuals (Canadian Community Health Survey, 2003 and 2005).
- About 29% of gay men consulted a medical specialist in the 12 months before the survey, compared with 19% of heterosexual men (Canadian Community Health Survey, 2003 and 2005).
- Among women, 77% of lesbians had seen a family doctor in the 12 months before the survey, compared with 83% of heterosexual women (Canadian Community Health Survey, 2003 and 2005).

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 (HNHB LHIN, 2006).

- 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. Within the HNHB LHIN area the rate of family physicians/100,000 population varies, from a low of 57/100,000 in Haldimand and Norfolk to a high of 84/100,000 in Hamilton (HNHB LHIN, 2006).

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 Greater St. Catharines CHC Steering Committee struck a task group to provide local advice and support to the AOHC throughout the CE phase. The primary task of the CE task group was to develop a list of local stakeholders with knowledge and expertise regarding the primary healthcare needs of Greater St. Catharines area residents to be engaged during the community consultation. AOHC further expanded the CE sub-task group’s list by conducting an online environmental scan of organizations from a variety of sectors, and met with the CE task group to prioritize the key organizations to be consulted. This collaborative process resulted in the development of the Greater St. Catharines CHC stakeholder list (see Appendix B) which contains more than 130 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 St. Catharines and Thorold, 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 GSCCHC;
- d. Assists the GSCCHC 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 130 organizations listed in the inventory, more than 65 were consulted during the CE process via *key representative interviews, focus groups* and/or *online survey* noted in the following table:

Table 16 – Organizations consulted, by Method of Consultation

Key Representative Interviews	Focus Groups	Online Survey
1. Addictions Ontario	1. Brock University (3 participants)	1. Montebello Place
2. AIDS Niagara	2. Canadian Mental Health Association (3 participants)	2. Niagara German-Canadian Club
3. Alzheimer Society of Niagara	3. Niagara Health System (6 participants)	3. Niagara Nutritional Partners
4. Associate Medical Officer of Health, Regional Niagara Public Health Department	4. Niagara North Community Legal Assistance (6 participants)	4. Niagara Regional Public Health Department, Dental Program
5. Autism Ontario	5. Regional Niagara Public Health Department (3 participants)	5. Ontario March of Dimes
6. Canadian Diabetes Association		
7. Canadian Hearing Society		
8. Canadian National Institute for the Blind		
9. Canadian Red Cross		
10. CAPC Niagara Brighter Futures		
11. Centre de santé communautaire Hamilton /Niagara		
12. Community Care St. Catharines and Thorold		
13. Community Living St.		

<p>Catharines</p> <ol style="list-style-type: none"> 14. Community Support Services of Niagara Region 15. Contact Niagara for Children's and Developmental Services 16. District School Board of Niagara 17. Employment Help Centre 18. Family and Children's Services Niagara 19. Folk Arts Council of St. Catharines 20. French Language Health Services, Central South West Region (2 representatives) 21. Garden City Family Health Team 22. Gateway Residential and Community Support Services 23. Hamilton Niagara Haldimand Brant Community Care Access Centre 24. Hamilton Niagara Haldimand Brant Local Health Integration Network 25. Heart Niagara 26. Hospice Niagara 27. Housing Help Centre of St. Catharines and Thorold 28. Islamic Society of St. Catharines, Masjid Al-Noor Mosque 29. John Howard Society 30. John Howard Society of Niagara 31. Mayor of the City of St. Catharines 32. Meals on Wheels Thorold-St. Catharines 33. Métis Nation of Ontario 34. Niagara Centre for Independent Living 35. Niagara Child and Youth Services 36. Niagara College 37. Niagara Health System (Addiction Services, Patient Services, Maternal Child Department, Emergency) 38. Niagara Homelessness 		
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<p>Initiative Outreach Program</p> <p>39. Niagara Physician Recruitment Program</p> <p>40. Niagara Regional Community Services Department, (Social Assistance and Employment Opportunities, Seniors Services)</p> <p>41. Niagara Regional Housing</p> <p>42. Niagara Regional Native Centre</p> <p>43. Niagara Regional Public Health Department (Community Mental Health Program, Sexual Health Clinic, Youth Connection)</p> <p>44. Niagara Regional Police Service</p> <p>45. Niagara Specialised Transit</p> <p>46. Niagara Support Services</p> <p>47. Niagara Training and Adjustment Board</p> <p>48. Out of the Cold Niagara</p> <p>49. Ozanam Centre</p> <p>50. Rainbow Youth Niagara</p> <p>51. Salvation Army Community Services Ministry</p> <p>52. Start Me Up Niagara</p> <p>53. Terry's Evergreen Addiction Recovery Services (<i>2 participants</i>)</p> <p>54. The Niagara Peninsula Children's Centre</p> <p>55. The Raft</p> <p>56. Welland Heritage Council</p> <p>57. Wellspring Niagara Cancer Support Foundation</p> <p>58. YMCA of Niagara</p>		
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Key representative interviews: This method involves individual interviews being conducted with community representatives who have a broad understanding of the community and its health care needs, using the same schedule of questions.

Fifty-eight agencies (totalling more than 65 participants) responded to the following questions in writing, by phone or in-person:

1. What is the current mandate of your organization? What programmes /services do you offer? Who are your clients? (See Appendix C).

2. In your experience, what groups of people are facing barriers to accessing primary healthcare services in St. Catharines and Thorold? What types of barriers are these? (See Appendices D and E).
3. Where do these populations reside? Can you pinpoint specific neighbourhoods where it is likely that these individuals reside? (See Appendices A, B and E).
4. Which specific programmes, services and staff do you think the Greater St. Catharines CHC should offer? (See Section 1.5).
5. Where do you think the CHC should be located? (See Section 1.1).
6. What potential partnerships may exist between your organization and the Greater St. Catharines CHC? (See Section 3).
7. Are there particular individuals or organizations that you feel we need to engage? (See Appendix E).
8. Are there focus groups with particular populations you think we should hold? (See Appendix E).
9. Are you aware of any recent studies/needs assessments that have been done on the region, specific populations, age groups etc? (See Appendix E and Section 1.2)
10. Would you be interested in volunteering as a Board member, committee member, volunteer at the Greater St. Catharines CHC?

A summary of the feedback collected from key representative interviews was presented during the community forum events and can be found in Appendix D.

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.

Five organizations participated in service provider focus groups (totalling more than 21 participants). 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 health care services;
2. Specific programmes, services and staff should the Greater St. Catharines 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 GSCCHC or alternate points of access; and,
5. Future involvement with GSCCHC 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 service provider focus groups is presented in Appendix E.

Online survey: Local service providers were invited to participate in an online survey as another means for providing input towards the development of the Greater St. Catharines 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 GSCCHC;
- 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 GSCCHC.

Survey participants responded to the following questions:

- Which geographic location(s) does your organization serve?
- Which age groups does your organization deliver services to?
- What are the specific gender groups that your agency serves?
- What types of demographic populations do you cater to?
- What types of health services do you offer?
- What types of social services do you provide?
- In what capacity could your organization collaborate with the Greater St. Catharines CHC?
- How would you like to be involved with the Greater St. Catharines CHC?
- Would you like to stay informed about the development of the GSCCHC?

Approximately eight organizations participated in the online survey. A summary of the feedback gleaned from these agencies is included in Appendix F.

A number of other service providers and organizations were not consulted, primarily due to scheduling challenges or time limitations of the CE process. These service providers and organizations are included in Appendix C.

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

The following table identifies gaps in service in the Greater St. Catharines CHC's catchment area, and the potential programmes and staffing complement needed to address these gaps, as identified through the CE process:

Table 17 - Planning for Gaps in Service

Gaps in Service	How the gap will be addressed
<i>Planning for...</i>	
<p>Access to primary healthcare practitioners</p> <p>Basic primary healthcare needs for those residents living in the designated catchment area who are without access to the full range of primary health care with an emphasis on:</p>	<p>The main priority of the Greater St. Catharines CHC in the first year of operation will be the delivery of primary health care services to the identified priority populations. These services will be provided by a culturally-competent, collaborative, interdisciplinary team experienced with expertise in working with the noted groups. Primary healthcare needs will be met through staffing positions such as:</p> <ul style="list-style-type: none"> • Clinical Programme Manager • Community outreach workers

- ❑ Street-involved populations
- ❑ Isolated seniors
- ❑ At-risk children and youth
- ❑ People with disabilities
- ❑ People who experience mental health and/or addiction issues
- ❑ Newcomers to Canada
- ❑ Sexually and gender diverse populations across Niagara

More Specialist Services Locally

Some specialist services appropriate to the needs of the CHC's designated priority populations that are available on-site offer significant advantages particularly in the areas of pharmacy, physiotherapy and pain management.

- Nurse Practitioners
- Pharmacist (consulting)
- Physicians

and through:

- ❑ A non-invasive intake process
- ❑ Home visits and street outreach
- ❑ Laboratory services

and...

- ❑ Advanced access;
- ❑ Collaboration with regional and municipal health human resources recruitment strategies to attract primary healthcare practitioners and specialists on an ongoing basis;
- ❑ Incorporation of the Tele-health Advisory Service and educate/inform clients that this service is available after hours;
- ❑ Providing 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.

<p>Illness prevention and health promotion programming focussed on:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Healthy eating <input type="checkbox"/> Oral care <input type="checkbox"/> Physical activity <input type="checkbox"/> Smoking cessation <input type="checkbox"/> Stress management <p>...across the lifespan.</p>	<p>Health promotion programming needs will be delivered by staffing positions such as:</p> <ul style="list-style-type: none"> • Community Outreach Workers • Dental hygienist • Dentist • Dietitians • Health Promoters • Health Promotion and Chronic Disease Programme Manager • Nurse Practitioners • Recreational Therapist • Registered Nurses <p>and through Personal Development Groups in the following related areas:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Nutrition (e.g., community kitchens) <input type="checkbox"/> Parenting skills <input type="checkbox"/> Physical fitness <input type="checkbox"/> Social and recreational activities <input type="checkbox"/> Weight management <p>and through educational/coordinated events on:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Free or affordable alternative medicine (e.g., registered massage therapy, acupuncture, naturopathy) <input type="checkbox"/> Injury/falls prevention <input type="checkbox"/> High blood pressure <p>and through partnerships with local and regional organizations such as the Niagara Centre for Independent Living and the Regional Niagara Public Health Department.</p>
<p>Chronic disease prevention and management</p> <p>Programming focussed on those living with:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cancer <input type="checkbox"/> Chronic pain <input type="checkbox"/> Diabetes <input type="checkbox"/> Disabilities (e.g. physical, developmental) <input type="checkbox"/> Heart disease <input type="checkbox"/> Disability <input type="checkbox"/> HIV-AIDS <input type="checkbox"/> Mental health and/or addiction issues <input type="checkbox"/> Obesity 	<p>Chronic disease management programming needs will be met through staffing positions such as:</p> <ul style="list-style-type: none"> • Chiropodist • Diabetic Nurse Educator • Dietitians • Health Promoters • Nurse Practitioners • Physicians • Recreational Therapist • Seniors' Care Coordinator • Social Workers <p>and through clinics and educational/coordinated events on:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain management, heart health, cancer prevention, ear and eye health, tuberculosis, etc., <p>and through partnerships with local and regional organizations such as AIDS Niagara, Alzheimer Society of Niagara, Canadian Diabetes Association, Heart Niagara, Niagara Health System, Wellspring Niagara Cancer Support Foundation.</p>

<p>Addressing transportation barriers</p> <p>Developing a plan to address this barrier is critical for those seeking access to primary health care, and should include:</p> <ul style="list-style-type: none"> ❑ Transit subsidies ❑ Strategies for ensuring accessible transportation to and from the CHC in collaboration with local and regional transportation providers ❑ Equipping and implementing a strategy for mobile health care and outreach in collaboration with local and regional initiatives (enabling staff to support clients outside of the CHC and where they are – e.g., in their homes, at school, on the street) ❑ A point of access in the City of Thorold 	<p>To address transportation barriers, the Greater St. Catharines CHC will:</p> <ul style="list-style-type: none"> ❑ Be accessible by public transportation and located in close proximity to other service providers; ❑ Provide ample free and accessible parking; ❑ 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; ❑ Work with municipalities, local health and social service organizations to identify community space where primary healthcare services could be offered in the City of Thorold. <p>through positions such as:</p> <ul style="list-style-type: none"> • Community Development Workers • Community Outreach Workers • Volunteers
<p>Mental health and addiction services</p> <ul style="list-style-type: none"> ❑ Case management ❑ Crisis response ❑ Drop-in services ❑ Individual and group therapy ❑ Medication education and management ❑ Outreach 	<p>Comprehensive mental health and addictions services will be delivered to priority populations experiencing mild to complex concerns, and their support networks, through the following staffing positions:</p> <ul style="list-style-type: none"> • Community Mental Health Nurses • Community Outreach Workers • Mental Health and Addictions counsellors • Pharmacist (consulting) • Psychiatrist (consulting) • Social Workers <p>and through age-specific Personal Development Groups in the following related areas:</p> <ul style="list-style-type: none"> ❑ Anger management ❑ Life skills ❑ Peer-led, self-help support groups for individuals and their support networks ❑ Social and recreational activities for isolated individuals (e.g., seniors, at-risk youth, street-involved men)

and ...

- ❑ Assistance with completing forms (e.g., Ontario Disability Support Plan application)
- ❑ Collaboration with local mental health and addiction agencies (e.g., Canadian Mental Health Association, Family and Children's Services Niagara, Gateway Residential and Community Support Services, Niagara Child and Youth Services, YMCA of Niagara) to identify gaps, develop and enhance programme delivery
- ❑ Community education to reduce stigma associated with mental health and addictions issues
- ❑ Needle exchange services

<p>System navigation and integration of services across the continuum of care</p> <p>The Greater St. Catharines CHC needs to be a resource for the greater community for:</p> <ul style="list-style-type: none"> ❑ System navigation and coordination ❑ Patient advocacy ❑ Information and resource library ❑ Education and community-capacity building ❑ Outreach and communications 	<p>The Greater St. Catharines CHC will integrate and coordinate services to assist clients to move seamlessly across the continuum of care through the following activities:</p> <ul style="list-style-type: none"> ❑ Raise awareness, through the community-governed Board of Directors and on an ongoing basis, 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 partners and 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., paperless record keeping; ❑ Connect clients to other available services in the community through referrals, and to health information through an information and resource library. <p>The needs for navigation, collaboration, education, and outreach will be met with through staff members such as:</p> <ul style="list-style-type: none"> • Community Development Workers • Social Workers
<p>Addressing the social determinants of health</p> <p>Programming focussed on addressing the following social determinants of health:</p> <ul style="list-style-type: none"> ❑ Employment ❑ Food security ❑ Housing ❑ Income 	<p>All members of the inter-disciplinary team will work to address the broader determinants of health and foster social cohesion through:</p> <p>Personal Development Groups in the following related areas:</p> <ul style="list-style-type: none"> ❑ Community kitchens ❑ Employment counselling ❑ Financial counselling ❑ Housing support ❑ Settlement services <p>Partnerships with local and regional organizations such as Folk Arts Council of St. Catharines, Niagara Homelessness Initiative Outreach Program, The Raft and YMCA of Niagara</p> <p>and the following mechanisms:</p> <ul style="list-style-type: none"> ❑ Advocacy and community-led initiatives; ❑ 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.

Lack of accessible and 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 the identified priority populations

Accessible and culturally-competent services will be provided by the entire primary healthcare team through the following mechanisms:

- ❑ Partnerships with community partners such as the Niagara Centre for Independent Living to ensure that GSCCHC is fully accessible for a variety of abilities (e.g., wide doorways, hydraulic lifts);
- ❑ Recruitment of culturally- and linguistically-appropriate staff such as an Aboriginal Health Nurse and French language primary health care providers;
- ❑ Partnership development with organizations such as the Canadian Hearing Society to provide qualified translation and interpretation services, including sign language;
- ❑ Tools and resources that are relevant to the priority populations served such as TTY, visual and auditory appointment indicators; clearly visible, plain language signage, rainbow flag;
- ❑ Programme 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;
- ❑ Collaboration with local and regional organizations to raise awareness about accessibility and cultural competence.

To foster an environment of cultural appropriateness and competency, staff and volunteers will receive regular and ongoing training in:

- ❑ Anti-oppression;
- ❑ The use of tools such as TTY and hydraulic lifts.

<p>Programming to meet the needs of sexually and gender diverse populations across Niagara</p> <ul style="list-style-type: none"> ❑ Lack of primary healthcare services that address the specific needs of sexually and gender diverse residents across the Region of Niagara ❑ Stigma associated with identifying as LGBT 	<p>The primary healthcare needs of sexually and gender diverse populations will be met through staffing positions such as:</p> <ul style="list-style-type: none"> • Community Outreach Workers • Health Promoters • Nurse Practitioners • Social Workers <p>who are part of the culturally-competent team of providers working in a LGBT 'positive' space that offers:</p> <p>Personal Development Groups in the following related area:</p> <ul style="list-style-type: none"> ❑ Social support for sexually and gender diverse populations and their support networks; <p>And collaborates with community-based organizations such as Rainbow Youth Niagara to coordinate educational events regarding:</p> <ul style="list-style-type: none"> ❑ Anti-oppression.
<p>Administration that facilitates and supports the work and collaboration of the clinical and social services team</p>	<p>The administrative, information technology and management needs of the CHC will be addressed through the hiring of staff such as:</p> <ul style="list-style-type: none"> • Accounting and payroll staff by contract • Data Management Coordinator • Executive Director • Facilities Manager • Finance Manager • Human Resources Manager • Programme Developer • Receptionists and medical secretaries • Volunteer Manager <p>The Greater St. Catharines CHC will explore opportunities for consolidating back office functions with organizations such as the emerging Niagara Falls CHC.</p>

Overall, the Greater St. Catharines CHC will provide accessible and culturally-competent primary healthcare, health promotion and community development services focussed on addressing and raising awareness of the broader determinants of health. The staffing complement may be comprised of but not be limited to:

Primary healthcare staff

Chiropodist
Clinical Programme Manager
Community Development Workers
Community Outreach Workers
Dental hygienist
Dentist
Dietitians

Administrative staff

Accounting and payroll staff by contract
Data Management Coordinator
Executive Director
Facilities Manager
Finance Manager
Human Resources Manager
Programme Developer

Health Promoters
 Health Promotion and Chronic Disease
 Programme Manager
 Mental health and addictions counsellors
 Nurse Practitioners
 Pharmacist (consulting)
 Physicians
 Psychiatrist (consulting)
 Recreation Therapist
 Registered Nurses
 Social Workers

Receptionists and medical secretaries
 Volunteer Manager

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 informally consulted through local meetings and presentations. Members of the GSCCHC Steering Committee and AOHC's Centre Development Team attended various local and regional events to network, gather resources, share and learn more about the CHC sector. During presentations, the Chair of the Greater St. Catharines CHC Steering Committee introduced attendees to the CHC Model of Care and provided an overview of the progress of GSCCHC to date. The Communications Task Group, with the assistance of the GSCCHC Community Coordinator, developed a PowerPoint presentation to supplement these community presentations (See Appendix E). The following table reflects the meetings and presentations that were conducted:

Table 18 – CE Presentations and Meetings

Date	Presentations	Date	Meetings
November 8, 2007	National Council of Women*	November 26, 2007	Second Annual Youth Forum on Sexuality
February 4, 2008	St. Catharines City Council	November 28, 2007	The Early Years Niagara Story
February 5, 2008	Thorold City Council	December 18, 2007	CHC Fest
		March 18, 2008	Every One Matters Campaign

*This was a joint presentation between GSCCHC, AOHC and the Board of the emerging Niagara Falls CHC. Approximately 20 people were in attendance at the St. Catharines Public Library, including representation from the HNHB LHIN, the newly-opened Bridges CHC (Fort Erie-Port Colborne) and local media.

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 groups?

Potential users of CHC services were consulted through *focus groups* and *community forum events*. Participants in each of these methods of consultation were asked to identify:

- What are the health and/or social service programmes that are currently working well in St. Catharines and Thorold? (See Section 1.9 for community assets identified by stakeholders during CE process).
- What health and/or social programmes and services do you think are currently missing? (See Section 1.5 for existing gaps in services as identified during the CE process)

- What programmes, services and staff should be a part of the Greater St. Catharines CHC? (See Section 1.5 for recommendations regarding potential programmes, services and staff to be offered at GSCCHC).
- How do you see yourself being involved with the new CHC?

Focus Groups: Nine focus groups with potential priority populations were conducted, totalling more than 100 participants. These focus groups were meant to gather a first-hand account of the challenges facing these populations while highlighting recommendations and opportunities for the Greater St. Catharines CHC. Feedback gathered during focus groups with priority populations can be found in Appendix H.

Table 19 – Focus Groups with Potential Priority Populations

Date	Potential Priority Population	Community Group Consulted
December 4, 2007	Lesbian, gay, bisexual, transgender (LGBT) populations	Transgender of Niagara
February 12, 2008	LGBT populations	Parents, Families and Friends of Lesbians and Gays (PFLAG)
February 28, 2008	At-risk youth	Family and Children's Services, Youth Advisory Committee
March 11, 2008	Isolated seniors	Meals on Wheels Thorold-St. Catharines 'lunch out' (St. Catharines)
March 18, 2008	Immigrants and refugees	Folk Arts Council of St. Catharines ESL students
March 20, 2008	Isolated seniors	Meals on Wheels Thorold-St. Catharines 'lunch out' (Thorold)
March 20, 2008	People experiencing low income, unemployment; newcomers	YMCA of Niagara Employment Services
March 26, 2008	People with disabilities	Niagara Centre for Independent Living
March 28, 2008	People experiencing homelessness or who are under-housed; mental health and/or addiction issues	Start Me Up Niagara

Community Forum Events: Service providers and community members were invited to attend four forum events regarding the development of the Greater St. Catharines CHC on February 26 and 27, 2008 from 9:15 to 11:30 a.m. and 6:45 to 9:00 p.m. 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 programmes and staff for the future CHC;
- Invite expressions of interest from community members who would like to participate on the GSCCHC Board of Directors or future committees.

A total of 71 participants attended the sessions. Feedback collected during the community forum events is presented in Appendix I.

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 20 – Strategies to engage hard-to-reach populations

Population	Barriers to Participation In CE Process	Strategies to engage these populations
At-risk youth	<ul style="list-style-type: none"> • Lack of engagement with their health • Distrust of service providers 	<ul style="list-style-type: none"> • Engaged local and regional organizations working with these groups (e.g., The Raft, Family and Children’s Services Niagara, Contact Niagara Children’s for Developmental Services, Rainbow Youth Niagara) • Worked with FACS to facilitate a focus group with youth in foster care
Isolated seniors	<ul style="list-style-type: none"> • Limited access to transportation • Socially isolated 	<ul style="list-style-type: none"> • Engaged community-based organizations working with this population (e.g., Meals on Wheels Thorold-St. Catharines) • Worked with Meals on Wheels to facilitate focus groups with seniors in Thorold and St. Catharines
LGBT populations	<ul style="list-style-type: none"> • Distrust of mainstream health and social service providers 	<ul style="list-style-type: none"> • Engaged local organizations working with and supporting these communities • Facilitated focus groups with Transgender of Niagara and PFLAG
Newcomers	<ul style="list-style-type: none"> • Language and cultural barriers • Limited access to local health and social services 	<ul style="list-style-type: none"> • Engaged service providers working with this population, such as Folk Arts Council of St. Catharines and Welland Heritage Council and Multicultural Centre • Collaborated with Folk Arts Council of St. Catharines to conduct a focus group with ESL students
People with disabilities	<ul style="list-style-type: none"> • Limited access to accessible transportation 	<ul style="list-style-type: none"> • Engaged agencies working with this population (e.g., Canadian Hearing Society, Canadian Institute for the Blind, Community Living St. Catharines, Niagara Centre for Independent Living) • Worked with the Niagara Centre for Independent Living to conduct a focus group with members of the population
Street-involved populations	<ul style="list-style-type: none"> • Limited access to transportation • Socially isolated 	<ul style="list-style-type: none"> • Engaged service providers working with these populations (e.g., Community Care St. Catharines Thorold, St. George’s Anglican

		Church, Salvation Army Community Services Ministry) <ul style="list-style-type: none"> • Partnered with Start Me Up Niagara to facilitate a focus group with populations experiencing poverty • Interviewed two former sex trade workers
Urban Aboriginal & Métis peoples	<ul style="list-style-type: none"> • Distrust of mainstream health and social service providers 	<ul style="list-style-type: none"> • Engaged service providers working with these populations (e.g. Métis Nation of Ontario, Niagara Regional Native Centre)

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 Communications Task Group of the Greater St. Catharines CHC Steering Committee developed a communications plan to identify goals, audiences, key messages and communications tools to ensure that both the GSCCHC and community engagement process were accessible to the broader community. The communications plan is available in Appendix J.

Interviews: The Chair of the GSCCHC Steering Committee participated in interviews to advise the broader community about the new CHC with local media (Cogeco TV, 610 CKTB radio, the St. Catharines Standard, Niagara This Week and SNAP St. Catharines).

Advertising of Community Forum events: Organized by the GSCCHC Community Coordinator, community forum events were advertised in the following media:

- Local Newspapers and magazines:
 - Pulse Niagara
 - The Brock Press
 - Forever Young
 - The St. Catharines Standard
 - Niagara this Week (Thorold and St. Catharines editions)
 - Osprey Media
 - Niagara News
 - CARP News FiftyPlus
- Broadcast fax service through Information Niagara, which provides Niagara residents with free, confidential access to information about the full range of community, social, health and government services.
- TV:
 - Cogeco TV
 - CHTV News Hamilton Niagara
- Radio:
 - 610 CKTB
 - 1220 CHSC
 - 91.7 Spirit FM
 - CFLZ/105.1/Wild 101
 - CRNC Radio (Niagara College)

- Organizations:
 - Hamilton Niagara Haldimand Brant LHIN
 - District School Board of Niagara
 - 14 seniors residences
 - St. Catharines Public Library
 - Canadian Corps
 - 63 spiritual and religious organizations

- As well as local pharmacists, dentists and pharmacists.

Flyers for the community forum events were also distributed through the Steering Committee to their broader networks and to all organizations on the GSCCHC stakeholder list. The GSCCHC community forum flyer is available in Appendix K.

Website: The Communications Task Group is in the process of developing a website for the GSCCHC, <http://greaterstcatharineschc.org/>.

Efforts to ensure accessibility during CE activities:

- Advertisements for the forum identified assistance for those with special needs.
- The venues for the community forum events (Canadian Corps and Westminster United Church) were wheelchair accessible with free and accessible parking. Light refreshments were provided free of charge.
- Community forum events were held in the morning and evening to accommodate a variety of work schedules.

1.9 What strengths, assets and opportunities did you identify?

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:

- AIDS Niagara
- Alzheimer Society of Niagara
- Bethlehem Place
- Breast care clinic
- Brock University
- Canadian Mental Health Association
- Circle of Care
- Contact Niagara for Children's and Developmental Services
- Food banks
- Free healthcare
- Garden City Family Health Team
- Hamilton Niagara Haldimand Brant CCAC
- Hospice Niagara
- Information Niagara
- Meals on Wheels Thorold-St. Catharines
- Mental health outreach

- Methadone clinic
- New young doctors
- Niagara Centre for Independent Living
- Niagara Health System
- Niagara Pride Support Services
- Nurses and Nurse Practitioners
- Out of the Cold Niagara
- Parent, Families and Friends of Lesbians and Gays (PFLAG)
- Regional Public Health Department
- St. Catharines Public Library
- Start Me Up Niagara
- Transgender of Niagara
- TRANSPARENT
- Wellspring Niagara Cancer Support Foundation
- Women's Place
- YMCA and YWCA

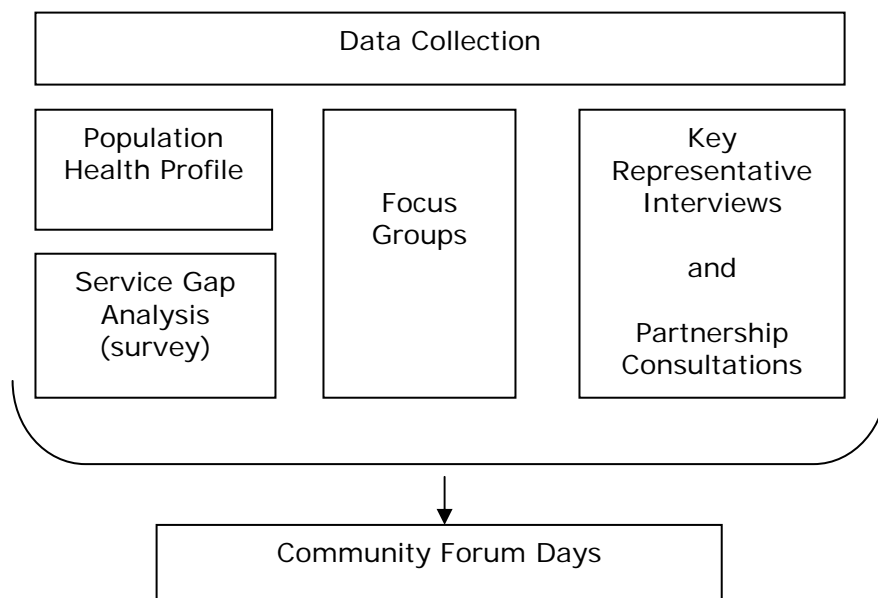
**See Appendices H and I.*

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, in key representative interviews, partnership consultations and the upcoming community forum days, and indirectly through an upcoming online service provider survey. As well, research has been conducted into past consultations conducted by other health and social service organizations, which has contributed to the understanding of the health needs of area residents. The community consultation process is depicted in Figure 2 below.

Figure 2: Pictorial Depiction of the Greater St. Catharines CHC Community Consultation Process



Arising Issue - Location

Throughout the community engagement process, stakeholders were asked to recommend a location for the Greater St. Catharines CHC. The vast majority of respondents indicated that the downtown core of St. Catharines was an ideal location due to its accessibility by public transportation, proximity to other service providers and populations in greatest need of primary healthcare services (e.g., street-involved populations). Stakeholders also noted that while the downtown core is the most central location, GSCCHC would be challenged to find adequate space with ample parking. There was also much discussion about locating GSCCHC on the border of St. Catharines and Thorold (e.g., near Brock University) to facilitate service delivery between the two municipalities. CE participants maintained that public transit between Thorold and St. Catharines was neither consistent nor affordable for populations experiencing poverty or those with disabilities. Stakeholders also discussed the challenges facing rural communities when attempting to access healthcare services. These areas in particular are characterized by a lack of public transportation and limited health and social services.

The Steering Committee reviewed all comments and feedback from the community regarding possible locations for the CHC. Based on this feedback, the catchment area and where populations in greatest need of primary healthcare are congregated, the Steering Committee has identified that:

- the primary location of the Greater St. Catharines CHC should be in the downtown core of St. Catharines with a point of access in Thorold.
- GSCCHC will assess community health needs on an ongoing basis and work with other service providers (e.g., new and emerging CHCs) to identify strategies to address the needs of rural populations.
- Moreover, the Greater St. Catharines CHC will work in conjunction with local and regional organizations to develop strategies to address transportation barriers for those seeking access to primary healthcare (See Section 1.5).

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 Greater St. Catharines CHC Steering Committee is made up of a diverse group of representatives from various communities and service organizations such as the Canadian Mental Health Association, Ministry of Labour, Niagara Physician Recruitment Program, Meals on Wheels Thorold-St. Catharines, Niagara Child and Youth Services, Bayshore Home Health, Rose Cottage (Grimsby), Gateway Residential and Community Support Services, Visiting Angels Inc and the municipalities of St. Catharines and Thorold.
- The flyer for the community forum events advertised that assistance was available for populations with special needs (See Appendix K).
- Community forum events were widely advertised in a variety of local and regional media (See Section 1.8).

- Community engagement events (e.g., forum and focus groups) were held in St. Catharines and Thorold to foster participation by community members throughout the entire research area.
- The GSCCHC Community Coordinator researched the availability and cost of captionist and sign language interpretation services for deaf, hard-of-hearing and deafened individuals in preparation for the community forum events.
- During the key representative interviews and focus groups, participants' views on current programmes and services, their experience of the health care system, how the GSCCHC could fill gaps and improve/enhance services and their recommendations for change were solicited and became the foundation on which this report rests (See Appendices B, C, D, F and G).
- Community members who participated in the community engagement process were asked of their interest to continue to be involved with the Greater St. Catharines CHC, either as a member of a future Board of Directors or Committee, or as a general volunteer with the CHC. Interested parties will be contacted in the pre-operational phase.

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

The Chair of the GSCCHC Steering Committee has conducted a number of interviews and presentations to keep a broad range of community members up-to-date on the progress of the CHC (See Sections 1.6 and 1.8).

Members of the Greater St. Catharines CHC Steering Committee participate on several other committees in the region, where information is shared broadly. They also actively share information about the new CHC with members of their social, volunteer and professional networks.

The community forum days were being widely announced and promoted, through local media across St. Catharines, Thorold and the Region of Niagara (See Section 1.8).

Upon approval of the final report, the Steering Committee intends to inform the public of the findings of the community engagement process and overall progress of the Greater St. Catharines CHC.

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 Greater St. Catharines 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 C for details of these potential partnerships.

1. AIDS Niagara
2. Alzheimer Society of Niagara
3. Brock University
4. Canadian Diabetes Association
5. Canadian Hearing Society
6. Canadian Mental Health Association
7. Canadian National Institute for the Blind

8. Community Living St. Catharines
9. Contact Niagara for Children's and Developmental Services
10. Employment Help Centre
11. Family and Children's Services Niagara
12. Folks Arts Council of St. Catharines
13. French Language Health Services, Central South West Region
14. Gateway Residential and Community Support Services
15. Heart Niagara
16. Hospice Niagara
17. Islamic Society of St. Catharines
18. Montebello Place
19. Niagara Centre for Independent Living
20. Niagara Child and Youth Services
21. Niagara Homeless Initiative Outreach Program
22. Niagara Nutrition Partners
23. Niagara Regional Police Service
24. Niagara Training and Adjustment Board
25. Ontario March of Dimes South
26. Para Med Home Health Care
27. Region of Niagara Public Health Department, Dental Program
28. Salvation Army Community Services Ministry
29. The Raft
30. Victorian Order of Nurses, Niagara Branch
31. Wellspring Niagara Cancer Support Foundation
32. YMCA of Niagara

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 resources in support of the Greater St. Catharines CHC. These organizations have been involved in the planning for the GSCCHC in the following ways:

- Serving on the Greater St. Catharines CHC Steering Committee
- Participating in community engagement process via key representative interviews, focus groups, the online survey and/or community forum events
- 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

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

The Greater St. Catharines CHC will both complement and strengthen the current health care and social service infrastructure by offering primary health care, health promotion, illness prevention and capacity building programmes and services via an inter-disciplinary team of practitioners. The Greater St. Catharines 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 health care 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 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 programmes. 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 Greater St. Catharines Community Health Centre's **vision** is:

Health, community and a sense of value.

The Greater St. Catharines Community Health Centre's **mission** is:

Greater St. Catharines CHC enables all of our citizens to achieve health, community and a sense of value.

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

The Vice Chair of the Greater St. Catharines CHC researched a number of mission and vision statements from other CHCs across the province. A select few were sent out to the larger committee via email and online, the group reached consensus regarding the vision and mission statements reflected in Section 4.1. These statements will be revisited pending approval of the priority populations and instalment of first Board and initial staff.

Prior to the development of the vision and mission statements, the Steering Committee participated in a community governance orientation session facilitated by the CE consultants. The group gathered to discuss the following themes:

1. Characteristics of 'good' governing boards
2. What is Community Governance? What is distinctive about community governance?
3. Review of the social determinants of health
4. Identification of skills needed for future board members
5. What does a Board do? What are its tasks?
6. Mapping the Structure: Having determined function, what might be the form of a community-governed board?

This governance orientation workshop resulted in:

Table 21 – GSCCHC Board member characteristics and task groups

List of priority characteristics for future board members	Three task groups with the following responsibilities:
<ul style="list-style-type: none"> ▪ Academia ▪ Advocacy /social justice ▪ Age ▪ Building management ▪ Community development /investment ▪ Employment /volunteer ▪ Ethnicity ▪ Family status ▪ Finance /fundraising ▪ Gender ▪ Governance experience ▪ Healthcare experience /administration ▪ Legal /insurance ▪ Marketing /communications ▪ Place of residence ▪ Political connectedness ▪ Spirituality ▪ Team building ▪ Varied ability (e.g., physical) ▪ Visionary /long-range planning <p><i>*The Steering Committee recommended diversity of experience in each category.</i></p>	<p>1. Communications</p> <ul style="list-style-type: none"> - Advocacy - Marketing and promotion - Media - Outreach - Two-way communication: projecting vision and environmental scan - Website <p>2. Resource Management</p> <ul style="list-style-type: none"> - Audit - Evaluation - Fiduciary - Health and safety - Human resources - Insurance - Physical assets (e.g. site) - Relationship with Executive Director - Risk management <p>3. Governance</p> <ul style="list-style-type: none"> - Board policies - Board recruitment - Direction - Strategic planning - Vision

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 Greater St. Catharines CHC. Membership will become a focus of all Board members and staff of the CHC as they engage with the local community.
- b) The potential membership of the Board of Directors is being reviewed by the current Steering Committee. The Steering Committee is developing recruitment criteria to ensure that the Board reflects the priority populations that the CHC will serve as well as recruits for the skills and expertise needed to lay the foundation for healthy board and CHC development.
- c) The first AGM will be part of the agenda for the first meeting of the CHC Board.

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

Please see Appendix L for the Greater St. Catharines CHC draft 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 organizations and those agencies 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 organization. It is understood by the GSCCHC 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.

The Steering Committee anticipates that the name of the CHC will change to better reflect the populations to be served.

5. SERVICE PLANNING

5.1 What priority populations have you identified and why?

The Greater St. Catharines CHC will provide primary healthcare to residents living within the identified catchment area who are not registered with a primary health care practitioner and experience other barriers to accessing primary healthcare, with emphasis on:

- Street-involved populations (e.g., homeless, under-housed, sex trade workers)*
- Isolated seniors*
- At-risk children and youth*
- People with disabilities (e.g., physical, developmental)*
- People who experience mental health and/or addiction issues*
- Newcomers to Canada*
- Sexually and gender diverse populations across the Region of Niagara (e.g., lesbian, gay, bisexual and transgender)*

These populations were identified as being in greatest need of primary health care 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 Greater St. Catharines 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 Greater St. Catharines CHC Steering Committee meetings on a 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 health care services.
- In December 2007, the Greater St. Catharines CHC Steering Committee reviewed the interim report on the use of community engagement funds, discussed it at length, made some revisions and approved the report for submission to the HNHB LHIN.
- 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 Greater St. Catharines CHC Steering Committee reviewed and provided input towards this presentation which identified potential priority populations and suggestions regarding key staff, services and location.
- In April 2008, the Greater St. Catharines CHC Steering Committee reviewed the final report on the use of community engagement funds, discussed it at length, made revisions and approved the report for submission to the HNHB LHIN.