Guelph Community Health Centre

Priority Group Review/Renewal Process

Final Report and Recommendations
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Guelph Community Health Centre

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RECOMMENDATIONS

Recommendation 1 - Development of a Health Equity System for Primary Care Services for the City of Guelph

Recommendation 2 – Maintaining Guelph CHC's Focus on Priority Populations, Health Issues and Neighbourhood Strategies

Recommendation 3 – Addressing Capacity - Development of a Health Equity Assessment and Care Planning Review Process for all Clinical Clients

Recommendation 4 – Development and Implementation of an Inclusion Strategy

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GUELPH COMMUNITY HEALTH CENTRE – PRIORITY GROUP REVIEW/RENEWAL PROCESS

A. INTRODUCTION

This report presents findings and recommendations to the Board of Directors of the Guelph Community Health Centre (Guelph CHC). In the fall of 2010, the board formally initiated a process to "review/renew" the priority populations that were the focus of the programs and services provided by the agency within the city of Guelph. The process was also designed to determine a framework for a transition process for clients to ensure that there was ongoing capacity for the organization to address priority populations and primary health care issues. The review was initiated in recognition that the population of the City of Guelph had been growing rapidly, that the health and community service landscape had changed, and that system-wide planning and coordination were being stressed increasingly in the sector. The CHC was mandated by its status as a CHC and its service agreement with its principal funder, the Waterloo Wellington Local Health Integration Network (WWLHIN) to focus its resources on priority populations. In addition, the Guelph Family Health Team, which had grown to include a majority of the primary care practitioners in the City, with a large team of practitioners of various disciplines, had capacity and an interest in collaboration. This provided further timely impetus for the review.

The board struck a steering committee with board representation, the Executive Director, front-line staff and two partner organizations, the Guelph Family Health Team and Trellis Mental Health and Development Services, to work with a team of consultants in managing the process. Project components included a profile of the population of Guelph, drawing on multiple data sources. This research was designed to identify trends, determine clusters of variables that would reveal the distribution of populations that were most likely to be facing barriers to health and to accessing effective primary health care services and supports. A review of relevant literature was conducted to support this research and an extensive engagement process was undertaken to explore the perspectives of multiple stakeholders, both service providers and a diverse sample of GCHC clients and broader community residents.

As the process moved forward, there was increasing recognition from a number of sources that the research being conducted by Guelph CHC was timely and relevant not only to the CHC itself, but to the entire system of primary health services and the broader community services sector in the city of Guelph. By reviewing the status of primary health care access and identifying priority populations, neighbourhoods and health issues in the city, the review had the potential to provide a more global picture of health equity issues in primary care and therefore identify system-wide collaborative strategies to address them. The distinct role of the Guelph CHC would be determined from within this health equity map.

This expanded scope received endorsement from the Waterloo Wellington Local Health Integration Network as an appropriate approach for the CHC and a potential contributor to addressing LHIN priorities. It was also well received by partner organizations. The Board endorsed the project and extension of the timelines to allow for more detailed research and exploratory meetings with key partners. The expanded scope and reporting process is described below.

Expanded Scope

The expanded scope allows for the gathering and analysis of more detailed information about population groups in Guelph, what their health issues are, and where the greatest need lies in the city for the kinds of expertise and resources that the CHC has to offer. Identifying the health conditions and related issues that lead to preventable visits to the Guelph General Hospital Emergency Department for example, will suggest areas for collaborative primary care intervention, health promotion, chronic disease prevention and management strategies. Similarly, by identifying where the Community Care Access Centre faces barriers to accessing and providing services to specific population groups, it will suggest where collaborative initiatives might be effective. These interventions could come in the form of direct service provision, provision of assistance to other service providers or facilitation of service. Examples include collaboration with the Guelph Family Health Team to offer complementary programming to support GFHT patients; providing interpreters to conduct assessments with CCAC coordinators; facilitating housing access for homeless people in need of care; system navigation and discharge planning initiatives based at the Guelph General Hospital; collaboration with Ontario Works to case conference and link OW clients with community health programming and related supports. They could also include longer-term initiatives such as replicating the Integrated Assisted Living Program, which the Waterloo Wellington CCAC has already piloted with seniors and the Working Centre initiative for homeless/underhoused individuals.

The expanded scope will provide the opportunity for exploration of some of these collaborative responses to priority access and equity issues by bringing together groups of service providers to discuss shared approaches to service and service transitions. A supplementary report will incorporate the additional data that will provide greater detail as to the nature and distribution of health equity priorities, and, based on this data and the dialogue with key stakeholders, suggest a critical path for implementation of the recommendations as adopted.

Additional Research for Expanded Scope May/June 2011

The additional research includes two components: Data analysis and discussion groups.

The data analysis focuses on identifying patterns of health service use. Data on Emergency Department admissions at the Guelph General Hospital, service use at

the CHC, and populations served by the CCAC, the Family Health Team and Guelph's mental health services provide us with tools to assess the way people are using the health care system and ways the system might provide more appropriate care. Data analysis includes identifying which services are being used by particular populations in Guelph and correlating those patterns to identifiable barriers to determine what alternate interventions might serve clients better.

The discussion groups include staff from key health services in Guelph and are designed to identify systems that can improve client access to appropriate care by developing collaborative practice and supporting transitions as needs change. Discussions will involve the Family Health Team, the LHIN, the General hospital, the CHC and the CCAC in adding to the learning to date and in identifying system changes that create a more seamless service infrastructure.

B. THE REVIEW PROCESS

Steering Committee

The steering committee was appointed with two board representatives, one of whom was assigned to chair the committee and to provide progress reports to the board. The committee was charged with the responsibility of engaging consulting support, with managing the implementation of the review, including communications, and with delivering a completed report with recommendations to the board within the agreed timelines. Public Interest Strategy and Communications was engaged in December 2010, charged with the task of delivering a final report in May of 2011. As noted, a separate contract was negotiated to allow for the additional research to continue with reporting at the end of June 2011.

The components of the review process were as follows: -

Environmental Scan

This first phase of the research involved the collection of relevant information to provide a thorough understanding of the context within which the review was being conducted – the history and current mandate, programs, services and resources of the CHC; its client populations; relevant health and community services with a role in primary health care in Guelph; demographic and related data on the population of the city, of trends and indicators of significance; relevant public policy including the priorities and strategic directions of the LHIN. Case studies that indicated the nature of the organization's work with priority groups were also requested, and these were instructive in deepening the research team's contextual understanding.

This was supplemented with a literature review, initially focusing on the CHC model of care, the LHIN directions and on priority-setting processes in the health sector. Early findings suggested an expansion to explore the role of health equity in current primary care service provision. The sourcing of relevant research and case studies was ongoing throughout the review process, and included periodicals, peer-reviewed journals and internet sources.

In addition, 8 interviews were conducted with key informants to provide additional perspective on the current status of existing priority populations, on changes in the health and community services sector, and on emerging trends and issues to consider as the research proceeded.

Analysis of the above information provided initial directions for the review and allowed for determination of the scope and nature of the community engagement process, identifying the critical key informants, population groups to engage with, and issues to explore in those interviews and meetings.

Community Engagement
The community engagement process was designed to maximize inclusion within timelines and the available resources. The approach selected was to engage with a sample of key population groups and service providers in meetings and in focus groups and to provide open opportunities for inclusion through two Town Hall meetings and an open-invitation session for long-time clients of the CHC. The consultants also provided contact information, which allowed for input and in some cases dialogue by email. The list of interviews, meetings and focus groups is included as Appendix 5. Staff from the CHC and from partner organizations participated in the promotion of Town Hall meetings and in recruitment for focus groups. The second Town Hall Meeting was also advertized in the Guelph Mercury.

Detailed notes were taken at each session and in the Town Hall meetings participants worked in table groups where there was a facilitator/note-taker from the consulting team. All notes were collated and themes noted as well as individual comments that were identified as instructive to the process. Some meetings led to follow up email exchanges with staff, with clients and with broader community members. These conversations elaborated on issues raised at the meetings, in some cases offering specific requests re service gaps (hormone treatment and related primary care services for trans people for example). These are noted in the findings section below.

Reporting and Receiving Input
At each stage of the research, all of the data was reviewed, key findings noted, and themes relevant to the objectives of the research identified and "flagged" for further data collection and/or discussion in ensuing interviews and focus groups. At each stage input from the steering committee was used to shape the next phase of the review.

On May 16th 2011, the steering committee reviewed the conclusions and recommendations as presented by the consultants, suggested some amendments and agreed to present the recommendations as amended to the board for review at its May meeting. A presentation was made to the board on May 25th and, based on feedback from that meeting, the consultants were requested to include some additional methodological information and to present a final report to the board by June 15th and to the membership at the Annual General Meeting on June 23rd, 2011.

C. METHODOLOGY

This section outlines the methodology used to define the focus of the research and subsequent analysis. As noted in the introduction, the principal objectives of the process were defined by the organization to review/renew the priority populations and to review processes by which it might "graduate" individuals from the Guelph CHC who no longer belong to priority groups.

Methodology – Environmental Scan

For the environmental scan, the consultants worked with the steering committee to develop a list of materials to define the current context as extensively as possible. This included a review of documents outlining the history and current scope of service of the organization; the CHC model of care; the Integrated Health Services Plan and related Waterloo Wellington LHIN materials; CHC communications materials as well as various sources of data about the population of Guelph, its health and utilization of primary health care and community services. This was supplemented by a search of the literature to identify relevant priority-setting mechanisms and transition models.

Initial meetings were held with both clinical and community health staff teams to engage them in the process, to explore their perceptions of priorities and key issues for the review, and to assist in identifying an appropriate sample for the engagement process. Key themes from these meetings are noted below. The committee also identified a list of key external informants who could act as advisors to shape the focus of the research and the community engagement. This list of informants was supplemented by recommendations from the staff. The questions for those individuals/organizations are included as Appendix 1 and the list of interviewees in Appendix 5. These interviews allowed the consultants to identify some preliminary themes related to the perceptions of the CHC's location in the health and community services sector, about changes in the population, health status (including determinants of health factors), and to identify essential organizations, issues and population groups to link with in the community engagement process. These themes are noted below.

Methodology – Community Engagement

The scope and focus of the engagement process was determined by synthesizing all of the above elements. As noted in Section B, the time frame and resources for the project suggested a combination of focus group sessions by invitation to ensure key stakeholders were given voice, and open, Town Hall type sessions to maximize the opportunity for other interested parties to participate. These were supplemented, in response to specific requests, with drop-in sessions for Neighbourhood Group representatives and for staff to invite additional input.

Methodology – Synthesis, Analysis, Conclusions, Recommendations

Detailed notes were taken in all interviews and focus groups, and in the small group sessions and question and answer sessions at the Town Hall meetings. Notes were collated and reviewed to extract both recurring themes and also individual comments that addressed priority issues. This information was tested against the information from the literature review and data analysis to identify where there was congruence and where there were inconsistencies. Where there were inconsistencies this indicated an anomaly that warranted further exploration.

The conclusions, that is the directions indicated by the data collection and analysis, flowed from this process. For example, the convergence of the data, policy directions, literature review and input from the engagement process suggested that the CHC's neighbourhood based approach was not only valued by staff, partners and community members as one of the cornerstones of its service delivery model, but supported conclusively by data on the concentration of access barriers and compromised health, and by literature on place-based interventions and the CHC model of care. Where there was not a convergence this was also noted and solutions sought from additional research, for example, the debate explored throughout this document about the necessity and the risks of focusing solely on "vulnerable" populations.

Finally, the recommendations were determined by a review of the conclusions, and consideration of the challenges and opportunities of the environment, the resource requirements and degree of change required to achieve the desired outcome. In this way, the recommendations were developed to suggest viable, complementary, incremental implementation strategies.

D. THEMATIC SUMMARY OF FINDINGS

Themes Emerging from the Environmental Scan

Four themes emerged from initial meetings with the steering committee and from the first round of key informant interviews. All four of these themes were tested and explored through the literature review and against the data. The themes were subsequently used as focal points for the community process and for additional research.

Theme 1. Creating and Maintaining Capacity: Not surprisingly, the issue of capacity, as one of the two principal challenges for the CHC, was raised consistently. It was raised in terms of the closed roster of the CHC, the significant capacity of the Family Health Team, and in terms of the challenges of developing a transition system that would maximize continuity, minimize stress and ensure security of service scope for clients.

Theme 2. Guelph CHC's Service Model: The external informants consistently viewed the CHC as being an organization with a valuable role in the sector – an organization that focused on underserved and marginalized populations, with programs, services and a comprehensive model of care that were all designed specifically to engage with and address the needs of these populations and neighbourhoods. There was little mention of the CHC's role in serving the "general" population.

Theme 3. Generic vs. Priority Access: The question of whether the organization should continue to serve a broad client base or to focus all of its resources on priority populations was, of course, a central theme in the review. It was raised as related to capacity to serve priority populations and the resultant pressure to transition "non-priority" populations. However, it was also raised early in the process as a suggestion that there were risks of marginalizing clients further by restricting the diversity of interaction with "the general population." A difference in perspectives amongst staff was also noted. Some clinical practitioners were concerned about the prospect of having to end relationships with long-time clients, and were equally concerned about the stress and intensity of focusing solely on clients whose needs and circumstances were complex. Other clinical staff, and many community health team members were committed to focusing the organization's work with the most vulnerable clients and/or neighbourhoods.

Theme 4. Service Gaps and System Linkages: In the initial interviews, internally and externally, the issue of collaboration arose frequently. The two topics that were most consistent were a) examples of service gaps and of ineffective or non-existent linkages between providers, and b) the widely expressed commitment to improve service integration.

Other Environmental Scan Components

Document and Literature Review

The initial review of relevant policy documents and targeted literature search, as summarized in the Appendix 3, reaffirmed the clear relationship between income, education, immigration status and poorer health. It also supported the approaches already utilized by Guelph CHC for identifying populations and neighbourhoods compromised by determinants of health factors. It provided affirmation of the CHC model of care as one of the most effective models of primary health care for populations facing barriers.

The initial research suggested that Guelph CHC's hybrid service model, which simultaneously emphasized specific priority populations, particular health issues and individual neighbourhoods as three necessary and distinct approaches, was a necessary approach. Where there was a high concentration of social risk indicators, neighbourhood-based approaches stressing engagement, inclusion and a high intensity focus on determinants of health and capacity-building were demonstrably effective. Other indicators of compromised access and health outcomes were distributed more broadly and necessitated population based approaches.

The initial research led persistently to a greater emphasis on health equity, with its focus on access to health systems rather than specific services. This model, explained in detail in section F on page 18, suggests that responsive, accessible, fluid systems can mitigate impacts of inequality and improve outcomes. This suggested the necessity for reorienting the CHC from an emphasis on service delivery to an emphasis promoting on health equity, allowing for a more flexible range of responses to health challenges, and enabling the CHC to build on its role as a system facilitator in addition to provider of direct services. The participation of two key partner organizations in the CHC's review process served to reinforce the organization's orientation towards system-based approaches. The question of "graduation" or transitions across the range of primary care and community services also reinforced the relevance of this approach.

Initial Data Analysis

The preliminary data analysis and demographic profile focused on existing CHC priorities, trends in social risk factors, new priority populations and the dispersal of risk factors and populations in neighbourhoods and across the city (see Appendix 2). It drew on the following sources: -

- 2001 and 2006 census data, with focus on indicators of priority populations and social determinants of health.
- Well-Being of Children Ages Birth to Six.
- Early Development Instrument 2006 and 2009.
- Guelph CHC report to WWLHIN 2009 (SRI/SES).
- Ontario Works Caseloads 2009 and 2010.

- Guelph CHC client data 2008-2010.
- Waterloo-Wellington Local Health Integration Network – Integrated Health Services Plan 2010-2013

Analysis of the data form these sources provided a unique view of the health services and health needs in Guelph. Not surprisingly, the data showed many of the identified health challenges persisting. The existing priority populations had continued to grow and adverse social determinants of health indicators were also increasing.

Immigrants, for example, made up 34% of the population growth between 2001-2006 and only 68-80% of recent immigrants had access to a primary care practitioner, as opposed to 95% of the general population. Children also faced health challenges. The number of children scoring poorly on the Early Development Index for indicators of physical health and well-being increased between 2006 and 2009, more children were born with low birth-weights, and more children were considered vulnerable than the Ontario average. While incomes were increasing in Guelph, and remained higher than the provincial average, many others faced growing poverty. Rents increased by 13% from 2006-2009 without a comparable increase in incomes; there was an increase in the numbers of people living below the Low Income Cutoff, indicating increasing economic polarization. This was substantiated by the almost doubling of food bank usage between 2006 and 2008.

In addition to the established priority populations, other populations and neighbourhoods facing equity and compromised health outcomes were identified through the data and environmental scan and were "flagged" for further exploration in the community engagement process. Only Onward Willow was actually named as a priority in terms of GCHC's role; however supplementary analysis of the Social Risk Indicators suggested that Brant and Two Rivers both met enough clusters of variables to warrant comparable priority status. In terms of population groups, census data indicated a growing youth population facing employment challenges and an increasing number of seniors living alone across the city.

The data suggested that pressures on the health system were growing despite the fact that Guelph had higher than average access to physicians, and over 95% of the population had access to a primary care practitioner. These findings further emphasized the need to address the priority population issue from a system perspective exploring health equity rather than focusing on adding services and reprioritizing populations on a one-time basis.

Exploring the themes – the community engagement process

As noted above, the environmental scan was used to frame the focus of the engagement process – the interview questions and focus group guides were designed to ensure that the four themes were covered, in addition to open dialogue. The summary below is structured under those headings.

Theme 1. Creating and Maintaining Capacity:
Responses regarding the capacity of the CHC and of other primary care and related services were consistent. The CHC clinical roster was full and community health programs and services were stretched to the limit. The only area of capacity identified within the system was the Family Health Team. The question was asked in focus groups and in the Town Hall meetings as to what would assist in managing transition from the CHC to other providers. The most consistent responses were that people wanted information about their options; for example few, if any, clients and other community members were aware of the distinctions between a traditional family practice and the Family Health Team and the scope of services offered. Meeting potential new practitioners, seamless transfer of health records, as were linkages between old and new practitioners were also all mentioned frequently.

For many of the founding members and long time clients there was considerable anxiety about and resistance to the notion of change, both in terms of the prospect of losing the long-term relationship with their existing clinicians and in terms of their concerns about finding comparable alternative practitioners. Some accepted the CHC's rationale for transition and were ready to explore their options to transfer with the kinds of supports noted in the above paragraph. Some were resistant, as noted below and elsewhere, to the notion of being asked to or required to move to other clinicians. A number talked about the fact that they were originally "recruited" to support the formation of the CHC as a Health Services Organization, and therefore should not be required to transfer.

At the focus group with founding members and at the Town Hall meetings these issues were explored in more detail, in particular the fact that the mandate of the organization changed when it became funded as a community health centre under the provincial program, requiring it to focus on priority populations. There was general acceptance of this fact, and increased acceptance of the necessity to prioritize. The concerns for some long-term clients remained in terms of the perception of lack of comparable alternatives to the CHC and the issue of the risks of losing the perceived benefits of a diverse client base. (See "Generic vs. Priority Focus" below).

The other question raised frequently was how the CHC would manage transition as priority populations shifted over time, and as clients' health and circumstances improved so that they no longer warranted "priority group" status.

For newcomers, there was a recurring identification of lack of information about primary health care options and fear or reluctance to access services because of linguistic and cultural barriers. The issue here was more one of initial system access and subsequent system navigation than of transition. Translation of materials about the health care system, broadening the ethnocultural diversity of practitioners and interpreting were the most frequently identified solutions proposed.

One of the significant points that emerged from staff consultations was that in addition to challenges in terms of transitions for clients moving *from* the CHC to other providers, there were also challenges to be addressed in effective transitions *to* the CHC for new clients. The need for new tools, protocols and training to ensure that staff had the competencies to work with all client groups was identified, and provided another indication of the need for an incremental change process.

Theme 2. Guelph CHC's Service Model:
The engagement process demonstrated consistently that other health and community service organizations saw the CHC as having unique expertise in engagement with priority populations and neighbourhoods. As noted in the section above describing the findings of the environmental scan, the three elements of the model – population groups, health issues and neighbourhood strategies – were all validated as effective and necessary and the comprehensive scope of service was also recognized.

Theme 3. Generic vs. Priority Focus
The review process was premised on the necessity for the organization to address its mandate as a CHC and its responsibility to its funder to focus its resources on those "facing barriers to care." This required the review of priorities and the creation of short-term and ongoing capacity, and in the process raised the issue of the impact of narrowing access only to those populations and neighbourhoods that were defined as priorities. In addition to the themes identified in the environmental scan (risk of further marginalizing people and neighbourhoods, pressures on staff of intensive workloads), two other issues were raised.

Firstly, some participants were concerned about a model that actively excluded specific groups from service, and asserted that the goal should be maximum inclusion. This was raised by representatives from the LGBTT communities, and also by community organizers who felt that a principle of inclusion would be lost by restricting service. Other community development workers (and some GCHC staff) advocated strongly for the CHC to put its resources solely into working with priority populations. In exploring this issue, some reconciliation between perspectives was achieved. This was accomplished by acknowledging that positive interaction between all residents and acceptance for all in any setting were goals for a healthy city, but that the urgency of need for many residents of the city, who would not receive service elsewhere, rendered a necessity for prioritizing.

It should also be noted that, as identified by some respondents, some types of services are most effectively delivered when there is appropriate anonymity and other kinds of accommodations are met to facilitate access – sexual health clinics, violence against women programs, for example, benefit from alternative approaches. Additionally, satellite locations are often necessary in priority neighbourhoods – Shelldale staff noted that Onward Willow residents are unlikely to travel to the downtown location for service.

The second, related perspective, raised most frequently by "non-priority group" clients, was that there were benefits for marginalized, priority populations to having regular interaction with people from outside of their networks, in particular from people who were established and effectively engaged socially, economically and civically. Some founding/long-time clients also suggested that, as individuals committed to the comprehensive model of the CHC, their presence as champions for this model would counteract any risks of marginalizing the organization within the system.

This latter point was explored further by the research team, and data provided by the CHC indicated that, other than in generic areas such as Early Years programming, and through the volunteer program, there was no evidence of interaction between clinical and community health clients, and in particular between priority and "non-priority" clients. The exception was through volunteer programming, where the volunteers were mostly university students.

This important theme suggested the need to explore strategies to maintain a breadth of engagement and involvement in the life of the organization, even if direct services were almost entirely restricted to "priority groups." It should be noted that there is, in fact, substantial diversity within and between priority populations, and it would be inaccurate to characterize the client base of the CHC as homogeneous.

Theme 4. Service Gaps and System Linkages:
As noted previously, there were various indications of service gaps or inequitable access. The most consistently identified were as follows: -

- **Lesbian, Gay, Bisexual, Transsexual and Transgendered Communities**: barriers faced by LGBTT community members of all ages; youth reluctant to come out to their primary care practitioners, trans people unable to find practitioners to prescribe hormone treatment and manage their care, seniors finding safe and queer positive retirement homes and long term care facilities. A general challenge in the LGBTT communities was identified as limited access to dental care, people being refused because of their HIV positive status.

- **Youth Services:** access to mental health services, LGBTT supports as noted above, pre and post natal services for young mothers.

- **Mental Health/Addictions:** While there were several services targeted to individuals with concurrent disorders, it was noted that the numbers of people of all ages in this category are growing, and that there is poor coordination between providers.

- **Seniors:** The growing seniors' population, in particular isolated seniors, was raised by several respondents as an area for increased investment and one that is well suited to collaborative interventions.

The engagement process also highlighted, as noted elsewhere, that in addition to the strong drive for system integration by the LHIN, that there was the need for and in some cases immediate potential for concrete collaboration. These included improved collaboration in relation to breastfeeding programs and maternal health; the CHC and other providers working with the CCAC to access "hard to reach " clients, providing interpreters and engagement strategies; mental health services, with specific reference to concurrent disorders; newcomers unaware of their options regarding primary care requesting information and system navigation support; Ontario Works enthusiastic to implement case conferences for complex client situations.

E. CONCLUSIONS

As noted in Section D above, the emerging themes were explored through the community engagement process and referenced against the literature search and related contextual materials. This led to a series of conclusions about both the status of existing priority populations, the CHC's service models, emerging populations and priorities and about how the organization could manage transition for current and future clients. These conclusions are summarized in this section and each is related to at least one of the themes identified above.

In terms of capacity, existing priority populations continued to show evidence of access barriers and compromised health, continued to require additional supports and models of intervention to facilitate access to appropriate services and supports and the Guelph CHC remained the most effective primary health provider to address these populations. The research indicated that both numbers within each priority group and overall economic polarization had been increasing and likely would continue to do so.

The concentration of poverty and other indicators of barriers to health (low socio-economic status and high Social Risk Indices) in Onward Willow (the Shelldale satellite location) remained high, and the research indicated that this neighbourhood, already designated as a priority by the CHC, should remain so. The research also indicated that the Brant and Two Rivers neighbourhoods, both scoring highly on the social risk index and indicated as priorities through the engagement process, should be designated as additional priority neighbourhoods. The CHC was already active in both neighbourhoods.

As noted, additional priority populations and health issues were identified - isolated seniors, youth issues, concurrent disorders and access and appropriate services for the LGBTT communities. It was also evident that as the city will continue to grow new issues will continue to emerge. While additional interventions were indicated for the above priorities, the proposed solutions to improved access and outcomes for all of these groups were not solely related to the capacity of the CHC or any single organization, but rather involved collaboration, partnership and system change.

In terms of the CHC's service models, there was sufficient disjuncture between the distribution of priority populations and the concentration of access and health issues in priority neighbourhoods to indicate the need for a continuation of both neighbourhood based and population/issue-specific interventions. Some examples include: the distribution of newcomers, a priority population, does not match the concentration of social risk indicators in the priority neighbourhoods; isolated seniors are dispersed across the city and across socio-economic circumstance; the homeless population tends to be concentrated in the downtown area. Secondly, in terms of neighbourhoods, the place-based, determinants of health, community

engagement, community development approach that Guelph CHC has taken in partnership with neighbourhood groups and other community organizations is a proven approach to improving health outcomes and building sustainable change.

In terms of service access for priority populations, the volume of most primary care health services in Guelph may be appropriate to the volume of need, but the allocation of services is uneven and priority groups are not achieving adequate access to those services. In addition, needs shift over time – individuals may require different combinations of services from different providers at various points in their lives, emerging issues and priority populations may change the nature of service needs, competencies and service models. Individuals may "start out" as falling under the umbrella of "priority" but cease to be so over time; and vice versa. However, access to appropriate services is not currently equitably distributed or supported. A model that looks at overall equitable access to appropriate care would suit the challenges more appropriately than one that simply adds service to particular groups.

Equitable access to appropriate service includes supporting change and transition as needs change. Currently there are limited supports for patients/clients seeking to change the nature of their care, and transition models that support that change need to be developed. The CHC itself, as evidenced by the need for this priority group review, will need to create capacity within its clinical roster in the short-term and develop a model that allows for "flow through" of clients over time to ensure the flexibility and the ongoing capacity to address existing and emerging priorities. This transition process will need to respond effectively to the concerns of existing clients regarding how transition status will be determined and managed.

Interaction between clinical client populations is limited, as is interaction between clinical and community health clients, and between the CHC's three locations. Providing opportunities for interaction across groups was seen to facilitate social inclusion and to be consistent with the CHC model of care. Additional strategies were therefore indicated to ensure that the organization maximizes its potential to promote social inclusion and civic engagement. See Recommendation 4 below.

Guelph CHC, with its model of care, existing programs, services, reputation and presence in the city is well placed to play a facilitative role in health equity planning and system-wide responses.

F. RECOMMENDATIONS – Preamble: Health Equity

"There is a clear gradient in health in which people with lower income, education or other indicators of social inequality and exclusion tend to have poorer health.

In addition, there are systemic disparities in access to and quality of care within the healthcare system. Health disparities make it more difficult to achieve provincial priorities such as ALCs, ER, diabetes, and contribute to avoidable costs. That's why enhancing health equity has become a clear priority – from the Province to LHINs to many providers."[1]

"Ontario should narrow existing health and health behaviour disparities. Interventions should ensure that people in disadvantaged groups make the first and greatest gains. . .and will likely require additional resources and different or additional programs. . ."[2]

This report provides four overarching recommendations, each with several constituent parts. While there are some components than can be implemented independently, the full impact of the recommendations can only be achieved if they are viewed as an integrated strategy. The overall is based on a health equity framework. The nature of this approach is outlined here.

The research for this priority population review identified a variety of changes recommended for the Guelph CHC, but concludes that a simple catalogue of internal adjustments will not adequately address the issues shaping CHC policies. Consequently, the principal recommendation locates the determination of priorities for the Guelph Community Health Centre in the context of a city-wide systems approach to health equity. The research suggests that there are incentives for all of the key providers, including the hospital, to come to the table to develop this system.

In this model, all health and community services incorporate a commitment to inclusion of populations that are identified as not facing equitable opportunities to service access and to healthy outcomes as the general population. Not only does this improve access and collaboration/integration between services for priority populations, but also it encourages a system that allows for ease of transition across the system for *all* clients, facilitating capacity and maximizing resource efficiencies.

It is proposed that this systems approach is the most effective and viable way for Guelph CHC to fulfill its mission and thereby its accountability to its membership

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[1] Health Equity Into Action: Strategy, Planning and Other Resources for LHINs: Getting Data on Health Disparities; Bob Gardner, The Wellesley Institute, September 2010
[2] MOHLTC 2005 (Ontario's Disease Prevention and Management Framework)

and its objectives as mandated by the Waterloo Wellington LHIN. In light of this, as noted, the review was expanded from the initial mandate to a focus on the nature and distribution of health inequities in the city of Guelph, and the identification of mechanisms to maximize not only the CHC's capacity to address them, but the system over all. In summary, the research indicates the following: -

- Existing priority groups and neighbourhoods continue to face compromised health outcomes and inequitable system access. Demographic trends and the findings from the related research and community engagement process do not indicate any projected decrease in the numbers or health equity status of these populations.

- As outlined in the previous section, there are additional populations and health issues that fall clearly into the domain of health equity and therefore fall under the mandate of the GCHC.

- The GCHC, while having the appropriate model of care and expertise, does not have the capacity to provide direct service, both rostered clinical services and community health programs, to all populations and health issues that fall within its mandate as outlined here.

- Other primary health care stakeholders have the opportunity, some have existing capacity and arguably the responsibility to increase access and effective service for a range of population groups, including vulnerable populations, through collaboration, through implementation of good practices and training and through service model refinements.

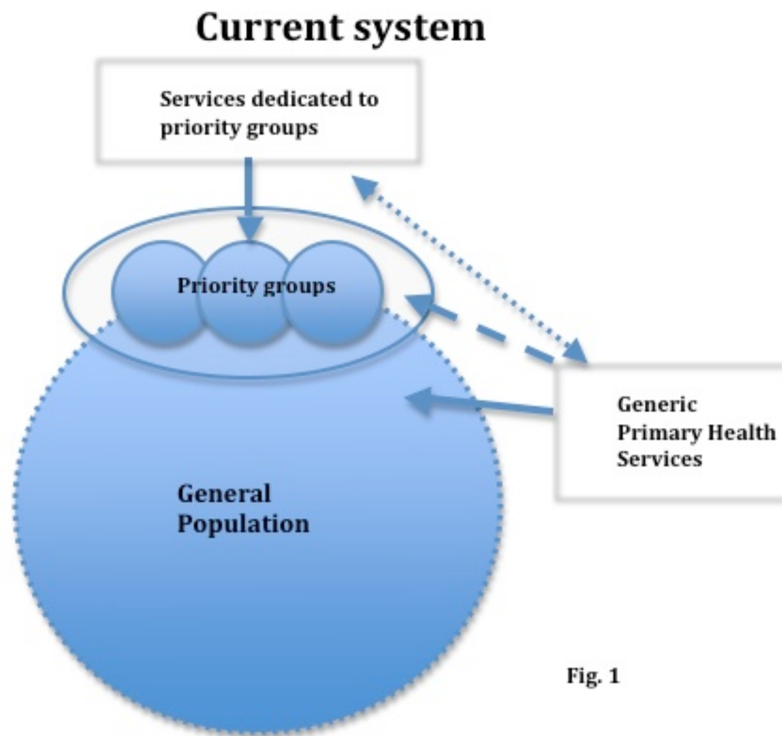
- While there are various effective partnerships and collaborative initiatives, there is no overall system coordination within the City of Guelph to address vulnerable populations. Neither is there system to ensure that *all* clients and patients of the various primary care and community services have access to the range of services and 'level of care' appropriate to their needs and circumstances over time. Without this coordinated approach, there will continue to be service gaps, transition issues and insufficient flexibility to respond to emerging priorities.

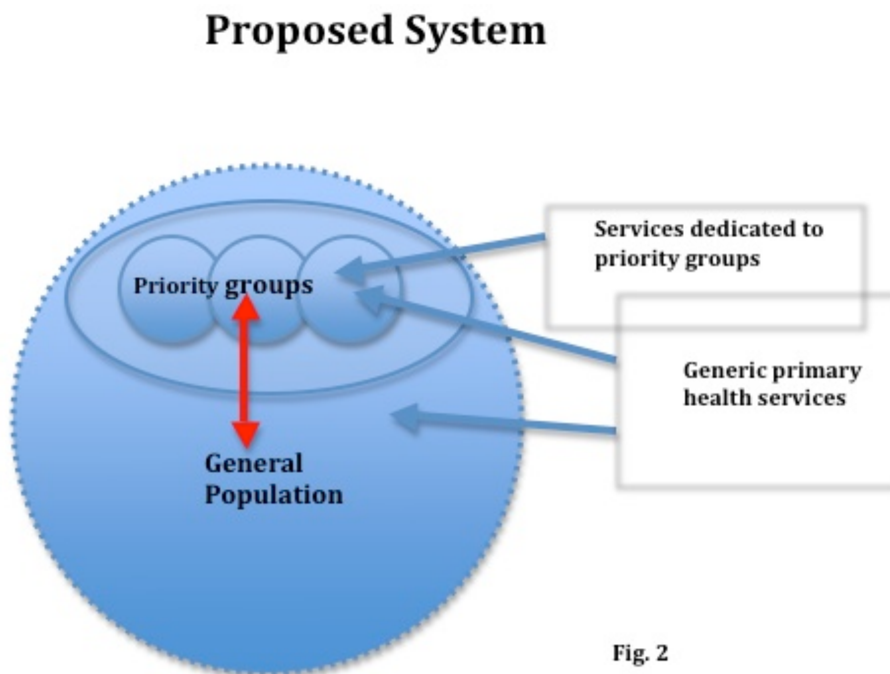
- There is ongoing research to support the positive impacts of health equity models in terms of population health, overall system capacity and effectiveness.

Taken together, these conclusions suggest that the most effective approach to defining and addressing the health needs of priority groups for GCHC and for health care providers across the city is to build a system of health equity planning and intervention that allows for primary care services to increase their ability to serve vulnerable populations, increase complementary service delivery to facilitate improved access, and manage effective transitions between appropriate services for all clients and patients. There is every indication that there is a moment of opportunity to act on this.

Adopting this model, maximizing its role as catalyst for building a more equitable and healthier city, and building mechanisms internally to maintain capacity, as outlined in this report, are suggested as the most effective means of achieving the objectives of the priority group review and indeed the mission of Guelph CHC, and therefore becomes the principal recommendation of the review.

On the next page the current and proposed models are presented graphically to illustrate further the various system changes that would result from the adoption of a health equity framework. These are followed by the concrete recommendations.





In **Figure 1**, priority groups, represented by the three circles at the top of the diagram, are only partially served by general primary health care services, including links with hospitals, leaving the CHC and other organizations that focus on priority groups only partially linked with the broader system, and priority group clients with

limited access to the full scope of primary health care services. In the other direction, priority populations that are "hidden" within general services are not easily linked with priority services appropriate to their needs and circumstances. Links between services to priority groups and general primary health services are characterized by a broken line, as are services from the general system to priority groups.

Figure 2 represents a more integrated model, where priority groups are incorporated more effectively within the generic system. In this model, all primary care and related organizations and institutions are linked, shown by the overlap between priority and generic services. The arrow between priority populations and the general population indicates appropriate access and transition through the system. This does not remove the necessity for the CHC and other services to focus on priority populations, but facilitates access, and therefore transition, across the system and allows "generic" providers to provide services to "priority" populations. All individuals can access services appropriate to their needs as those needs and their circumstances change.

The boundaries between services are more fluid. For example, young mothers living in a priority neighbourhood can receive initial supports through the CHC, and can transition to the Family Health Team or to other practitioners over time as they establish their health and stability of circumstance. Family Health Team patients who are dealing with complex mental health and addiction issues can remain on the roster while accessing in-patient, day programs and groups run by other organizations or, through a case conference, may transfer to the CHC or another provider. Over time, all system components increase their effectiveness and their ability to provide service to anyone who connects with them.

While the full scope of system change would require 3-5 years or longer, there are multiple short-term gains in terms of gap and barrier analysis planning and collaborative initiatives.

The four, interlinked recommendations follow.

Recommendation 1 – Development of a Health Equity System for Primary Care Services for the City of Guelph

It is recommended that Guelph CHC adopt a health equity framework to define its priorities and central focus as an organization. While there are actions that the organization can take internally to move in this direction, the principal task that flows from adopting this approach is for the CHC to take a lead, facilitative role in the development of a city-wide, collaborative planning process. The objective of this planning body is to build effective, system responses to improve access to appropriate health and community services for vulnerable, underserved population groups across the city and transition models to allow all residents, no matter what

their circumstances, to access relevant services appropriate to their circumstances over time - a City of Guelph health equity planning body or working group.

The new body would fulfill the following objectives and develop the appropriate structures and tools:

a. Sustainable mechanisms for identifying and tracking health outcomes for relevant population groups and neighbourhoods – identifying where there are barriers to health equity in the city.
b. Health Equity Assessment and related tools to use with individuals to determine their status on a health equity scale, and their primary health care needs in terms of nature and scope of programs and services. The objective would be a standardized tool that would be used system-wide to facilitate appropriate service access at first point of contact and for ongoing review.
c. Transition systems: related to the above, the model is intended to allow for effective transition across the system. So, as an individual's circumstances and health care needs change, they can transfer to the appropriate 'basket' of services to match those needs.
d. Mechanisms to address access and service barriers for the identified populations and neighbourhoods. Examples include:
    i. Collaboration to address specific access barriers to existing services, such as translation of materials, interpreters, and development of cultural competency skills, LGBT positive approaches, or geographic barriers through itinerant or satellite programs.
    ii. Complementary collaborative services, such as harm reduction programming or group counselling for Family Health Team patients delivered by partner organizations. In this way, existing clients/patients with one provider/practitioner can access additional service and supports while remaining with their primary provider.
    iii. New program initiatives to address specific populations.
    iv. Research to support the development of new models.

There was considerable interest from various key organizations in pursuing this model, which builds on the numerous existing partnerships and collaborative initiatives that have developed in a relatively ad hoc manner in the city, and on existing networks that could be invited to participate in this broader system-wide model. In addition, the Waterloo Wellington LHIN has provided data and other supports to move this process forward, and has endorsed the CHC's conclusions.

It is therefore recommended that the CHC move forward by bringing together a group of partner organizations and other interested stakeholders to develop terms of reference and a logic model. The ability of the CHC to address existing and emerging priority populations and neighbourhoods is contingent on the progress of this model. While there is clearly interest from most of the key stakeholders in moving forward, implementation would benefit from development funding to support the work.

Recommendation 2 – Maintaining Guelph CHC's Focus on Priority Populations, Health Issues and Neighbourhood Strategies

Guelph CHC has developed and sustained three principal approaches to address priority health issues in the city – clinical and community health programs that are targeted at specific populations, at specific health issues, and neighbourhood based strategies. The neighbourhood based strategies go beyond simply satellite locations or itinerant services to promote accessibility. They involve intensive community engagement and community development approaches to maximize impact on individuals, but also on the determinants of health that shape the vitality of the neighbourhood and the health and opportunity of its residents.

As indicated above, the research demonstrates that these approaches are appropriate and necessary to facilitate service access and also to maximize positive, sustainable outcomes. The models, in fact, are not as divergent as may first appear – work with newcomer populations that may be dispersed around the city, for example, requires similar approaches to building networks, addressing barriers, and capacity-building as neighbourhood based initiatives.

As a result, it is recommended that the organization maintain the current model, focusing its efforts on the most effective means of addressing health inequities, which may involve any or all of the existing priority populations, neighbourhoods and health issues (e.g. diabetes and other CDPM initiatives). While the nature of the CHC's role in addressing current priority populations, health issues and neighbourhoods may change over time as other system components are introduced and the health equity model operationalized, it is recommended that the current priorities and range of interventions be continued in the short and mid-term. This allows both for continuity for existing clients and programs, satellite locations and community development initiatives and minimizes organizational disruption to allow for incremental, managed change.

In response to the additional priorities identified in the research, it is recommended that the organization identify opportunities both internally and externally to promote improved service access and health outcomes for those populations and health issues. Again, this should be approached within the realistic boundaries of existing organizational capacity and planning processes. This could include, for example, reporting findings from the review process at existing networks and planning tables, prioritizing participation at relevant tables; review of the findings at team/staff meetings and implementation of manageable initiatives (for example student placements to focus on LGBT inclusion strategies, pursuing specific program/population based partnerships, training/staff development or researching collaborative project funding opportunities, such as system navigation initiatives.) As the health equity model and the related assessment, system navigation and transition tools are implemented, the increased fluidity around the system and

resulting "flow-through" of clients will create additional capacity without significant additional resources.

Recommendation 3 – Addressing Capacity - Development of a Health Equity Assessment and Care Planning Review Process for all Clinical Clients

One of the two main tasks for this study was to explore mechanisms to create capacity for the organization to focus its resources on priority populations. The conclusions of the research, as outlined above, indicate that a sustainable model must involve broader system planning. There are some short-term strategies for the CHC to create capacity, but maintaining the fluidity to address shifting priorities over time requires a system that works collaboratively to manage transitions for individuals into the appropriate level and nature of services for their needs at particular points in their lives. The objective is an integrated system of services that works collectively to provide appropriate services and supports to individuals, groups and neighbourhoods that face health equity challenges. In order to work effectively, however, the model must in addition coordinate transitions for clients to the most appropriate combination of primary care and related services as their needs and circumstances change.

a. **Development of health equity status assessment, care planning tools and transition models:** The development of these tools and the structures to apply them is one of the central tasks of the citywide health equity process. Ideally, the tools should be developed collaboratively. However, the CHC could move forward with an initial pilot of the health equity and care planning tools as the larger process is developed. This would allow for current clinical clients to be introduced to the new model, and to participate in a review that may lead to some opportunities for transition.

   When the model is fully developed, it is recommended that all clinical clients participate in a health equity status and care planning process with their primary provider. The assessment tool will identify the client's health status, service needs and access options, and an appropriate care plan. Those clients whose assessment indicates that they do not fall within priority population groups (or do not meet sufficient health equity criteria) and have viable alternative options will be supported through personal care planning including the transition to alternative primary care and related services.[3] For those who remain as CHC clients the care plan will become an annual, inclusive assessment and planning process. This could, for example involve external partners in a case conference with the client.

[3] As of –May 15th, 2011, approximately 2,000 of the 5011 active clients did not fall within one or more of a range of variables that would indicate priority status – income , housing status, concurrent disorders, social isolation, single parenting, food security, employment security and cultural barriers. As noted, the assessment process may identify additional factors that would indicate that clients should remain with the CHC.

b. **Active links with and directory of primary health care services:** The community engagement process explored what kinds of information and choices would maximize the ease of transition for clients who were moving to other parts of the primary care system. The most frequent responses were that people wanted choice, and wanted to have as much information about these options as possible. For example, existing CHC clients who anticipate moving to other providers wanted to know more about the Guelph Family Health Team – what services it offers, how the model works, and if possible to meet with practitioners. This, and related connections, could be implemented in the short term as ongoing practices. Other suggestions were to ensure efficient transfer of health records, and to allow for direct communication/ consultation between the old and new provider. Maintaining an active physical and (ideally searchable) on-line resource directory of services would be another important component of this model.

c. **Communications strategy – internal and external:** It is recommended that there be an internal communications strategy that allows all staff and volunteers to understand and, where possible, participate in the development of the new model. For example, the Health Equity Assessment and Care Planning tools would benefit from development with input from all teams and disciplines. An external communications strategy must also be implemented with all relevant stakeholders, both current and potential clients and all health and community services. There is, at the time of writing, considerable interest and in many cases anxiety about the outcomes of the review process. Communications that explain the rationale, timelines and concrete outcomes for individual clients will be essential, as well as opportunities for discussion with a trusted staff person or volunteer. This plan should include translation into all relevant languages and related approaches to maximize accessibility and clarity of message.

d. **Transition planning for clients who reside outside of the City of Guelph:** It is recommended that a mandatory transition plan be adopted with all current clients who reside outside of the Guelph CHC catchment. Appropriate communications with and supports for all clients who fall within this category should be provided. As of May 15th, 2011 this totaled 573 of the 5,011 active clients.

e. **Health equity/care planning review with all clinical clients:** As outlined in 'a' above, all clinical clients will be required to have an assessment and care planning review. In addition to those who are determined to be priority clients for the CHC within the health equity model, some may be determined to fall within priority categories (which could, for example, include avoiding "fragmenting" a family where all are clients and one member fits with priority criteria). As a short-term measure, and as part of the communications strategy, existing clients who are in agreement that they have limited use of the CHC's scope of services and have viable alternative primary care options will be encouraged to self-identify as willing to transfer and will be supported to do so. This, in conjunction with 'd' above, will create some short-term capacity within the clinical roster.

f. **Service agreement with new clinical clients:** As outlined above, all new clinical clients should have a clear understanding of the new model and, once developed, be required to sign a service agreement that incorporates the components of assessment/care review and the potential for transition to other providers.

Recommendation 4 – Development and Implementation of an Inclusion Strategy

The CHC model of care supports the concept that social and economic inclusion are integral components in determining health – for individuals, communities and neighbourhoods. The populations and neighbourhoods that are priorities for a health equity strategy are generally marginalized in some way – newcomers unable to find the networks and pathways to employment, isolated seniors with no opportunity to engage with the world around them and therefore "invisible", neighbourhoods marginalized by stigma, people with mental health challenges facing barriers to employment, youth excluded from decision-making that impacts their lives etc.

It is recommended that the Guelph CHC integrate inclusion as a driving principle in all of its activities, identifying opportunities for people to engage in social networks, their communities, in civic life and addressing the related barriers. The more informed and engaged hitherto excluded groups are in municipal decision-making, in service planning, in economic development, in governance and advisory capacities, the more informed, effective and reflective the decisions are likely to become.

In addition, in the research, there were concerns raised, primarily by "non-priority group" clients that, by focusing solely on "priority groups" the CHC would lose the benefits of broad diversity in its client base, and might risk marginalizing the organization and "re-marginalizing" its clients. As noted in the conclusions, there was little evidence of interaction between the "generic" population of clinical clients and "priority groups" and a broader inclusion strategy was indicated. It is recommended, as part of the inclusion strategy, that the organization promote opportunities to build as broad a base of participation in its activities. The health equity framework, as illustrated in figure 2 on page 20, integrates services and clients in a model that facilitates engagement and inclusion between organizations and their clients.

Recommended actions, both retention and expansion of existing activities, and the addition of new ones, include the following: -

- Continue to build a volunteer program, both program and governance, that builds a broad base, both to reflect the client population, to offer work experience and capacity-building opportunities for newcomers, youth and others, and to draw on individuals who have skills and resources and commitment to champion the CHC model.
- Maintain focus on community development, capacity building, leadership development and civic engagement in neighbourhood based work, but also within other priority populations (e.g. newcomers – strengthening informal

networks, linkages with municipal and community services and health sector planning and decision-making).

- Maintain and expand communications that promote public awareness of the socio-economic, ethnocultural diversity of the city's population, of the challenges and barriers that many face, and the assets, resources and opportunities that such diversity brings.
- Maximize the interaction of Guelph CHC and its client populations in civic life.

G. IMPLEMENTATION

The recommended process outlined here requires significant change for an organization that is already working to capacity, and relies on participation from stakeholders that are equally stretched. The recommendations are structured to recognize the challenges of managing that change. In addition, the nature and sequencing of the change management process will in part be contingent on the participants and the resources available to the citywide health equity planning body. As noted in the introduction, the additional research will allow not only for a more accurate projection of priority populations and health issues, but also an indication of the likely participation and timelines for the development and implementation of the key components of the health equity plan. The supplementary report will provide a more detailed implementation pathway. However, there are two initial steps that are recommended:

1. **Striking of an Internal Guelph CHC Working Group:**
   That the board strike an internal working group to assess and develop a work plan for the organization. Tasks include: -
   a. A communications strategy – internal and external to inform all stakeholders of the conclusions of the study and the resulting directions.
   b. Identify viable short-term activities to support the model – out-of-catchment transition planning; response to the additional priorities identified in the research; drafting and piloting components of the health-equity assessment and care-planning tools. See 3 (a) – (e) above.

2. **Convening of Stakeholder Health Equity Working Group:**
   That the board charges the working group with the responsibility of bringing together key partners to begin to build the health equity body. Suggested tasks include: -
   a. Dialogue with the LHIN regarding the convening of the planning body and the LHIN's role in facilitating this.
   b. Once convened, the priority tasks for the planning body are suggested as:
      i. Visioning health equity and primary health care for the City of Guelph.
      ii. Terms of reference that define objectives, membership, operational process.
      iii. Determine resource requirements to design and implement the model and pursue funding and related resources.
      iv. Identify "quick wins" in terms of viable short-term initiatives that will demonstrate the effectiveness of collaboration for health equity.

The items noted in points 1(a) and (b) above should be addressed as short-term priorities. Given the broad awareness and interest in the results of the review, the communications strategy and initial distribution of key messages should be completed as soon as possible after the Annual General Meeting, ideally within one month.

Appendix 1 – Environmental Scan Questions

Environmental Scan December 2010 – External Interviews

Questions:

1. What is your organization's role in health services in Guelph? What populations do you serve and what is your scope of service?

2. What is your connection with Guelph Community Health Centre?

3. What is your understanding of the mandate of the CHC and the populations it serves? What distinct role does the CHC currently play?

4. What are the significant changes, both positive and negative, past, present and projected, that you would identify in the health and community services sector in Guelph.

5. What shifts have you seen in the populations that you work with, and in the population of Guelph over all in recent years? Are there trends that you think are important to consider in planning for health care? How is your organization responding?

6. Who would you say is well served by health services in Guelph, and who would you see as the priority population groups that may be facing barriers to accessing effective health related interventions?

7. For each population group that you identified as underserved, who currently provides services to these populations and who would you say are the key individuals and organizations that we should connect with to further our understanding of and to access these populations? How does your organization currently or plan to serve these populations?

8. What information do you have that you could share that would assist in building a solid picture of the people, trends, health status etc in Guelph? (*Demographic data, health status and trends, service inventories, informal structures and access points to population groups that you would identify as priorities?)*

9. What role could you see your organization playing in this process of building a complementary and seamlessly accessible scope of services for the residents of Guelph? How would this support the identified service gaps/priority populations? What concerns, if any, do you have about efforts to coordinate/integrate services?

10. Do you have any questions for me at this time?

Appendix 2 – Phase 1 Data Summary

As part of the environmental scan, the research team collected and analyzed data in order to understand the general demographic characteristics of populations in Guelph with specific attention to those facing challenges in relation to the social determinants of health. As well as identification of population groups and health issues generally in the city, the data was used to understand if there are neighbourhoods in which risk factors are concentrated.

The data highlights included are based on the following:

- 2001 Census, 2006 Census (CD),
- The Well-being of Children Ages Birth to Six (2009) (WB),
- Ontario Works numbers for 2009-2010 (OW),
- Early Development Instrument Results 2006-2009 (EDI),
- Guelph CHC client numbers for active clients (last 3 years) (GCHC),
- Guelph Health Priorities (still in draft form) (HP),
- Waterloo-Wellington Local Health Integration Network – Integrated Health Services Plan 2010-2013 (WWLHIN)

These are initial findings, prior to the identification of the rich data sources being provided by the LHIN, the CCAC, the FHT and others that will provide a deeper analysis of areas for more effective primary care intervention. However, the data presented here is at a sufficient level of detail to frame the conclusions and recommendations of the study.

According to the WWLHIN, over 95% of Guelph residents have access to a family doctor, and there are an average of over 100 physicians per 100,000 people. The recommended number of physicians per 100,000 is 72. This indicates that residents of Guelph have higher than average access to doctors.

Priority Populations
Most priority populations continue to grow as the population of Guelph grows.

Children under 6

- Number of Children under 6 increased by 100 from 8,130 to 8,230 between 2001 and 2006. (CD)
- The average number of children per family is decreasing slightly from 1.2 in 2001 to 1.1 in 2006. (CD)
- 13% of children under 6 are living below the Low Income Cut-Off (LICO). In raw numbers this comprises 1,242 children under 6 years old. (WB)
- EDI numbers: overall, EDI scores are lower than the Ontario average and have dropped between 2006 and 2009. Guelph has a higher proportion of children who are considered vulnerable in 2 or more categories (14.3% in 2009 compared to 13.8% for Ontario, and 13.5% in Guelph in 2006). (EDI)

- Guelph children scored best for language abilities with only 86 (6.8%) children deemed vulnerable – an improvement over 91 children in 2006. However in 2009, another 18% of children were deemed at risk in the language category (one step better than vulnerable). (EDI)
- The largest drop in EDI scores was for Physical health and Well-being where 14.7% of children were vulnerable and numbers of vulnerable children increased from 151 children to 187 children. (EDI)
- The proportion of children with low birth rates is increasing in Guelph from 4% of babies in 2004 to nearly 6% in 2007. (WB)
- A 2006 survey showed that nearly 9% of 5-year-old children in Guelph had speech impairment, nearly 8% had asthma, and over 6% had allergies. (WB)
- Some children face issues of domestic abuse in the home. In 2007, there were nearly 1,300 Protection Investigations Opened by Family and Children Services in Guelph and Wellington County – this shows a slight decrease in investigations from 2005 (WB).

Underhoused

- The WWLHIN identified through consultation that homeless and street-involved individuals were less likely to have access to a physician. (WWLHIN)
- Rentals: The number of people renting apartments increased by only 135 people between 2001 and 2006 representing a low number of new rental units. Conversely, there was an increase in the number of homeowners by over 7,800. This is an indication of a small rental market. (CD)
- Rental cost: Average rent paid in 2006 was $821 per month. Average rent increased by 13% (nearly $100) from $729 per month in 2001. (CD)
- Housing affordability: along with the increase in rental costs, rentals are becoming less affordable. While the number of renters increased by 135, the number of renters that pay more than 30% of their income on housing increased by 545 people to a total of 5,670 people. (CD)
- In 2008, there were 1,099 subsidized units for families in Guelph (WB), 869 people were on the housing waiting list in 2006, and the wait time is expected to be 6 years.
- Multifamily households: can be an indication of underhousing. The proportion of multifamily households is low compared to the CMA at 1.7% of the population, however the number of people has increased by 175 from 590 to 765 between 2001 and 2006. (CD)
- Major repairs: the number of people living in homes needing major repair has decreased between 2001 and 2006 from 2620 to 2330. (CD)
- Homelessness numbers: The homeless population was estimated in 2007 at 1,282 for Guelph and Wellington County. (WB)

New immigrants

- The WWLHIN identified that between 68% and 80% of immigrants who have been in Canada less than 10 years have access to a doctor (compared to 95% of Canadian-born residents).

- The number of immigrants is on the rise with an increase of 2700 immigrants between 2001 and 2006. While immigrants make up 21% of the total Guelph population, immigration populations accounted for 34% of all population growth in Guelph over the same 5-year period. (CD)
- Recent immigrants: The number of recent immigrants increased by 735 between 2001 and 2006 from 3,085 to 3,820. (CD)
- Recent immigrants are coming from China, India, and Philippines while immigrants more likely to be from Italy, British Isles and Vietnam. (CD)
- Language Barriers: 1.2% of the population is not able to speak English. This population increased slightly by 65 between 2001 and 2006 to 1,320. (CD)
- Movers: In 2006, 18,720 people moved to Guelph within a year. (CD)

Individuals with other barriers to health (Low income, isolation, single parents, unemployment)

- Median Incomes: incomes are higher than average and improving in Guelph from $54,500 to $66,300 (22% increase) for median household incomes between 2001 and 2006. (CD)
- In 2001, 2,985 people claimed they had no income (this data is not available for 2006. (CD)
- LICO general: Despite the increase in income, there are higher proportions and more people living below LICO. The number of families living below LICO increased by 502 from 2,100 to 2,602 between 2001 and 2006. (CD)
- Use of food banks by children and youth under 18 years old increased in Guelph between 2006 and 2008 from approximately 5.3% of that age group in 2006 to nearly 9.0% in 2008
- Ontario Works numbers: the average monthly caseload of Ontario Works has been increasingly annually since 2004. By December 2010, the average monthly caseload was 1,459 people up from 1,345 in 2009, 1,005 in 2008, and 943 in 2007. (OW)
- Despite the annual increases, monthly OW caseloads have decreased in recent months. In December 2010, the number of caseloads was 1,393, down from a year high of 1,507 caseloads in April 2010. However December showed a slight increase in caseloads over November with 1,382. (OW)
- Unemployment rates/numbers: in 2006, 3,505 over 15 years old were unemployed (5.2% of population). The number of unemployed increase by 320 from 2001 levels. (CD)
- Manufacturing industries: largest industry in Guelph in 2006 at 24% of all occupations, however this is the industry hardest hit by the recent recession. (CD)
- EI numbers: EI claims increased significantly with the economic recession in Guelph. EI rates were at 3.1% of the workforce in November 2008 and triple to over 9.3% in May of 2009. (WB)
- Single parent families: 16% of Guelph families in 2006 were single parents. The number of single parent families increased from 4,250 in 2001 to 5,010 in 2006. Single parent families also represent 27% of all new families in Guelph over the same 5-year period.

- Single parent families tend to live with lower incomes – approximately 1,202 single parents in Guelph are living below LICO. (CD)
- Living alone: The number of people living alone increased by 1,440 between 2001 and 2006 to 11,310. These populations are more likely to be facing isolation issues. (CD)

Other Potential Priorities
The data also points towards some other potential priority issues and populations:

Youth
- 16,672 youth in Guelph, an increase of 1,527 between 2001 and 2006 (CD)
- Unemployment rates for youth are higher than average at 10.8% to 5.2%. (CD)

Seniors
- 14,160 seniors in Guelph, an increase of 1,005 between 2001 and 2006 (CD)
- Seniors face more significant isolation issues with 28.8% of seniors in 2006 living alone – a total of 3,475. (CD)

Substance Abuse and Addiction
- Higher proportion of Guelph Residents than Ontario residents consume 5 or more drinks on one occasion at least once a month at 22% of the population (HP)
- 22% of Guelph homes has smokers in them according to a 2006 survey (WB)

LGBTQ
- The WWLHIN identified through consultation that this population is less likely than the average resident to have access to a physician.

Geographic Variations/Highlights
Census data was used to look at clusters of variables in different neighbourhoods. The clusters included variables on household composition (i.e. single parent families, people living alone), income and unemployment, immigration and visible minorities and housing.

Findings are reported by neighbourhoods and census tract. The research team built on the preliminary work conducted by Guelph CHC utilizing the Social Risk Index as a tool for identifying neighbourhoods with high concentrations of key factors impacting health status (social determinants of health).[4]

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[4] Guelph CHC Priority Group Review; Information Meeting with WWLHIN, and Guelph FHT; PowerPoint Presentation; June 16, 2010

The neighbourhoods identified as priorities using this methodology share high Social Risk Indices, but do not necessarily share the same risk factors.

Onward Willow (Census tracts10.01 and 10.02)
SRI 9 out of 9; 8% of neighbourhood are clinical clients

- The priority neighbourhood in Guelph, one of the better served by CHC satellite office
- Above average numbers across three sets of variables (income, immigration, family composition) – one exception is housing.
- 10.02 had the highest number of single parent families.
- Low median income, and low median household income.
- 10.01 had the highest unemployment rate.
- 10.02 second highest proportion of immigrants, very high proportion of recent immigrants (16.1% - compared to 3.4% in the entire city), highest percentage of people with no knowledge of English or French, second highest proportion of visible minorities.
- Both tracts have relatively low number of renters paying more than 30% of household income on rent.

Downtown neighbourhoods (census tracts 6.00, 7.00, and 8.00) – Downtown, Sunny Acres, Old University
SRI 6, 5, and 6; 6% of neighbourhood are clinical clients

- Heavy renting communities with single parents and people living alone. Housing affordability and income are issues though people are generally working.
- All tracts have higher than average number of single parent families, number of people living alone and seniors living alone.
- 6.00: lowest median and household median income, yet it has a relatively low unemployment rate. 7.00: similar trend with slightly higher incomes. Could indicate high presence of working poor.
- All have high number of rentals.
- All have high proportion of renters paying more than 30% of household income on rent.
- 6.00 Low immigration numbers.

Brant and Two Rivers 12.00, 13.01, 13.02, and 3.00
SRI 3, 2, and 6; 2% of neighbourhoods are clinical clients

- Low incomes.
- Low immigration, low language barriers - predominantly Canadian-born.
- Higher than average proportion of single parent families; people living alone including seniors.
- Lower than average median and median household incomes.

- Higher than average proportion of renters, renters and owners paying more than 30% of household income on rent or payments.

West Willow Woods and Parkwood Gardens 9.03, 9.04, 9.05, and 9.06
SRI 5, 3, 3, and 3; 4% of neighbourhoods are clinical clients

- Some emerging employment and income issues, but generally high incomes along with high immigration – could be 2nd community that recent immigrants move to after they've lived in Guelph for a while.
- 9.03 and 9.04: higher than average number of single parent families
- 9.03 and 9.04: slightly higher unemployment rate than the average, but higher median and higher median income than average.
- 9.05 and 9.06 have high income as well, but lower unemployment rates.
- 9.06 has low individual income, but high household income.
- High proportions of immigrants.
- High proportions of recent immigrants.
- High proportions of visible minorities.
- Only 9.03 has high number of people with language barriers.

Neighbourhoods with the fewest proportions who are clinical clients

- 14.00, Commercial Area (0.5% of the population uses CHC), SRI 4
- 15.00, North, outside of Guelph (0.7%), SRI 1
- 1.07 and 1.08, Hanlon Creek/Clairfields (0.9%), SRI 1

Appendix 3 – Literature Review Summary

Role of the CHC

Within the health system and among various health service organizations, Community Health Centres are found to be distinct in a number of ways including their structure, focus and roles. The Ministry of Long-Term Health defines CHCs as "non-profit organizations that provide primary health and health promotion programs for individuals, families and communities. A health centre is established and governed by a community-elected board of directors."[i] CHCs offer numerous services under one roof including health promotion, illness prevention and treatment, chronic disease management and individual and community capacity-building.[ii] CHCs deliver these through one-to-one services, personal development groups and community-level interventions. CHCs also work with community partners.

CHCs have articulated a model of care that applies to all CHCs including the Guelph CHC and helps to further define the role and mandates of these organizations. The eight attributes of the CHC model of care are:

1. Comprehensive;
2. Accessible;
3. Client – and community-centered;
4. Interprofessional;
5. Integrated;
6. Community-governed;
7. Inclusive of the social determinants of health;
8. Grounded in a community development approach.

CHCs are intended, through their design and structure, to address barriers to health care being experienced by some groups. Some examples of barriers to health care include income, racism, ageism, and language.[iii] Not surprisingly, CHC clients tend to be diverse and face complexities in terms of their health and life circumstances.

In terms of this review, a key question is: how should CHCs identify which groups are experiencing barriers to health care? In terms of these groups and addressing barriers, what might the role of the CHC be in the context of a broader health system that includes hospitals, family health teams and other health and community service organizations?

To help answer this question, we begin by discussing four attributes of the model of care that speak directly to the way CHCs determine priority populations. The Association of Ontario Health Centres' Model of Care manual is drawn upon in this discussion. Following this, we look at the concept of health equity. A growing number of policy makers and researchers have found health equity to be a useful lens for understanding and evaluating barriers to health care systems.

CHC Model of Care Attributes

Accessible

According to the AOHC manual, "CHCs are designed to improve access, participation, equity, inclusiveness and social justice by eliminating systemic barriers to full participation. CHCs have expertise in ensuring access for people who encounter a diverse range of social, cultural, economic, legal or geographic barriers which contribute to the risk of developing health problems."[iv] As part of their work to eliminate barriers and improve accessibility, CHCs prioritize offering their services to clients who face challenges accessing mainstream health-care system.

Client- and Community-Centered

The third attribute of the CHC model of care is that CHCs are client- and community centred. In terms of being client-centered, CHCs not only provide access to care, but they also respect their clients' values and preferences. Under this model, clients are seen as partners in their own care – not just passive recipients of expert knowledge.

Being community-centered means that CHCs are also responsive to population health needs. In order to be responsive to these needs, CHCs plan their services based on those needs. CHCs conduct community health needs assessments, which include both quantitative data (statistics, reports, research) and qualitative data (community engagement, interviews, focus groups). These assessments are used to:

- Define priority populations,
- Determine what programs and services should be offered,
- Determine what staff are needed and
- Determine what partnerships with other organizations should be developed.

Community-governed

The sixth attribute of CHCs is that they are community-governed. CHCs have locally-elected boards made up of community members. This governance structure helps to ensure that CHCs are responsive to the needs of the community. As well, community participation in decision-making can help to improve health outcomes by leveraging local knowledge and expertise. When discussing this attribute the AOHC stresses the importance of community participation in determining priority populations.

Inclusive of Social Determinants of Health

As CHCs plan and develop their programs and services they take into account social determinants of health. The social determinants of health focus on features of the social context in which people live and that affect their health.[v] Research has shown that people's ability to access these determinants can affect their health. In fact, research into social determinants of health at York University has found that these

effects are actually stronger than the effects of specific behaviours and risk factors we normally associated with poor health, i.e. diet or tobacco use.[vi]

Health Canada lists 12 determinants of health:

1. Income
2. Social support
3. Education and literacy
4. Employment and working conditions
5. Social environments
6. Physical environments
7. Personal health practices and coping skills
8. Healthy child development
9. Biology and genetic endowment
10. Health services
11. Gender
12. Culture

CHC's work to address social determinants of health in a number of ways – through programs, services, health policy and partnerships with other organizations. The Guelph CHC has a number of programs and services that address social determinants of health. For example, the Guelph CHC's early years programs work to address early childhood development. *Maybe throw in some more examples?*

In Sum

In sum, the CHC model of care helps to define the role and expectations of CHCs and offer guidance as to how CHCs should plan services and determine primary populations. As comprehensive primary health care providers – CHCs are community-based organizations that work to understand and respond to the needs of the community. CHCs plan and prioritize their services by paying attention to the broader health needs of the community and the various conditions (including socio-economic ones) that can impact health.

Health Equity

Social determinants of health offer a framework for understanding why some groups consistently experience poorer health than others. The question is, how can health organizations address these determinants? To help answer this question, we turn to the concept of health equity. A growing number of health organizations and policy makers have begun to use this concept to encourage planning and service delivery that acknowledges and addresses differential access to some of the social determinants of health.

In explaining the concept of health equity, Margaret Lettner writes, "there are many definitions of health disparities or inequities but, simply put disparities are

differences in health outcomes that are avoidable, unfair and systematically related to social inequality and disadvantage. Health equity, then, works to reduce or eliminate socially structured inequalities and differential outcomes. It is linked with broader ideas about fairness, social justice, and civil society. Or, put simply, health equity means equal opportunities for good health."[vii]

It is important to note that a health equity lens would not look at all social determinants of health. Instead it would focus on those that stem from avoidable and unfair social inequality and disadvantage such as income and education.

This section reviews the research into health equity and pays particular attention to recommendations the research makes about how health organizations can plan services in ways that take into account health equity.

The Role of the Health System in Promoting Health Equity

Not surprisingly, one of the social determinants of health is access to quality health care. Access to health care can be influenced by a number of factors. Barriers to health care may be related to income, gender, sexual orientation, language, or where people live. Health organizations are encouraged (and in some cases required) to plan and evaluate their services in ways that work towards ensuring that various groups are able to access them.

For example, the Ontario Health Quality Council stresses the importance of accessibility as a key indicator of success and argues that the health care system can take a number of steps to reduce health disparities including:

1. Improving the accessibility of the health system through outreach, location, physical design, opening hours, and other policies.
2. Improving the patient-centredness of the system by providing culturally competent care, interpretation services, and assisting patients and families to surmount social and economic barriers to care.
3. Cooperating with other sectors to improve population health.[viii]

Planning Services from a Health Equity Perspective

At a 2010 Association of Ontario Health Centres conference, Bob Gardner, a researcher with the Wellesley Institute presented research into how health care organizations can move towards health equity.[ix] The presentation included recommendations for how health organizations can plan and deliver services in ways that address equity. These recommendations can be applied to CHCs as well.

In addressing disparities, Gardner recommends that services be targeted to specific populations and/or service areas that are facing the worst disparities and greatest needs. He also stresses the importance of customizing and concentrating health programs for the most disadvantaged as well as the need for health organizations to explore cross-sectoral partnerships. Gardner cites two examples of innovative

programs that integrate services. These include hub-style multi-service centres and satellite CHCs being developed in high-needs areas in Toronto that also bring in other social service agencies. These approaches, focus on neighbourhoods in which social disadvantage is concentrated. In recent years, researchers and policy advocates have begun to stress the importance of 'place-based' interventions for addressing the multiple and overlapping challenges concentrated in a number of Canadian communities. This approach and strategy, and its relevance to health equity are discussed in greater detail below.

As a starting point to addressing health equity, organizations need to have a solid understanding of:

- Key barriers to equitable access to high quality care;
- The specific needs of health-disadvantaged populations;
- Gaps in available services for the populations.

Health organizations also need to understand the roots of disparities. For instance, what are the factors that are preventing people from accessing health care? Are there language barriers, a lack of services in some areas, or something else that prevents people from getting the care they require?

Uncovering Health Inequities in a Community

For health organizations attempting to address health inequities, one of the first steps usually involves conducting an assessment or review that provides evidence and information about different populations and their health outcomes. In Ontario, there is some information and guidance about how to do this. Ontario boards of health are required to identify, report and use information about social determinants of health in planning and program delivery with the aim of reducing health inequities.[x] These inequities include "increased burden of illness; or increased risk of adverse health outcome(s); and/or those who may experience barriers in accessing public health or other health services or who would benefit from public health action."[xi]

The Population Health Assessment and Surveillance Protocol outlines the elements of population health assessment and surveillance. As well, Dianne Patychuk and Daniela Seskar-Hencic developed a document that provides further guidance around identifying health inequities.[xii] Both documents are drawn upon here to provide an overview of how a health organization could undertake a health equity assessment.

Patychuk and Seskar-Hencic identify four steps that can be used to identify health inequities:

1. Assessment and Surveillance
2. Research
3. Knowledge Exchange
4. Program Evaluation

1. Assessment and Surveillance

In the assessment and surveillance step, health organizations collect and analyze data in an attempt to understand general demographic characteristics of a community and the relationships between various populations and social determinants of health. The goal here is to try to start defining which groups are experiencing poorer health outcomes and/or access barriers.

This data can include[xiii]:

- Socio-demographic data including age, sex, education and employment
- Mortality and morbidity
- Reproductive outcomes
- Growth and development
- Risk factors
- Preventive health practices
- Physical environment factors
- Other relevant data

Data sources include both qualitative and quantitative sources such as public health information systems, administrative databases, surveys, grey and peer-reviewed literature, policy and program documentation and other primary data sources.

After acquiring the necessary data, the Protocol tells boards to interpret the data and information to describe relationships between access to social determinants of health and health outcomes. For example, a board might analyze the relationship between recent immigrants and tobacco use, or age and reproductive outcomes.[xiv]

2. Research

In some cases, the data alone may not necessarily reveal relationships between access to social determinants of health and health outcomes, or the picture it does reveal may be too broad and general. Patychuk and Seskar-Hensic suggest that in order to obtain more in-depth understandings of these relationships, health organizations can also undertake qualitative and quantitative research. Methods could include surveys tailored to populations identified as having low access to social determinants of health, case studies, talking to the community. One of the goals of this step may be to uncover the specific needs and populations that are experiencing poor health outcomes.

3. Knowledge Mobilization

In this step, the health organization mobilizes the knowledge it has attained to develop goals linked to the local setting. This involves engaging with the community

around the research steps, findings and the actions to be taken. Patychuk and Seskar-Hensic recommend that community engagement occur throughout the entire process.

4. Equity-based Evaluation

The Protocol recommends that boards also use program evaluation data to identify program benefits and gaps for diverse populations. For Patychuk and Seskar-Hensic this involves examining success and challenges in working with priority populations. Among the question organizations may ask in this step:

- Who is currently being reached?
- Who is being included/excluded?
- Where are the populations we are concerned about?
- How can we reach them?

The Role of CHCs in Working with Other Organizations

CHCs, through their model of care, are at the forefront of addressing health equity and often have expertise around the issues that are preventing people from accessing care. CHCs alone cannot address all the barriers to care in their communities, but they are able to share their expertise with other organizations that may be trying to reduce barriers among specific groups. CHCs can also work in partnership with other organizations including health care organizations, as well organizations in other sectors to address barriers.

Place-based Strategies for Addressing Health Equity

As recommended by Gardner, strategies for addressing health equity should target specific populations and/or service areas that are facing the highest degree of disparities and the greatest needs. In this section we discuss strategies that target neighbourhoods. Commonly called ‘place-based’, these approaches emerged from the recognition that in many of Canada’s cities, poverty and social disadvantage are increasingly concentrated in specific neighbourhoods.

From a health equity perspective, many of the factors that contribute to concentrated social disadvantage also directly and indirectly impact health in multiple, compounding and overlapping ways. Some of the ways that health is impacted by where people live include:

- Lack of access to social networks,
- Limited role models to integrate residents into the ‘appropriate’ behaviours of wider society,
- Prejudice and stigma associated with residing in areas that are perceived as negative and undesirable places,
- Decreased access to a range of health, education and community services.[xv]

Place-based strategies have taken a number of forms. Initially, when place-based strategies were first used, the emphasis was on 'urban regeneration' and improving the physical environment. Increasingly, though, there is a growing realization that the issues being faced in these communities are so complex and multi-faceted that they require integrated approaches.[xvi] Thus, researchers have begun to emphasize the importance of tailoring strategies to local conditions. This involves the full participation and inclusion of community members and can include community development and capacity building. As well, the complex nature of issues requires that various agencies and levels of government work together. Place-based approaches are asset-based in that they identify and build on local strengths.[xvii] These aspects of place-based strategies align well with the CHC Model of Care, in particular its emphasis on community development.

In fact, place-based approaches may be particularly appropriate for health service organizations such as CHCs. Evidence from Australia suggests that "people who are socioeconomically disadvantaged are more likely to need, but are less likely to access health care, especially preventive health services."[xviii] Within Canada, researchers have also found that in a system of national health insurance, people tend to use whatever services are available even if they are not appropriate.[xix] Gina Browne et al's research into the cost effectiveness of different approaches to improving health for vulnerable populations found that the most successful strategies are those that are:

- Cooperative and cross-sectoral, linking physical health care to social services, mental health services, and other services;
- Comprehensive and holistic, treating the whole family in context;
- Proactive, reaching out to those who are unlikely to find the help they need on their own.

All of these elements could be met through a place-based approach. For example, the co-location of health and social services may be one strategy used to increase access to appropriate care in a particular neighbourhood.

In her review of the literature on the health impacts of place-based interventions, Karen Larsen[xx] found that positive impacts in health and social determinants of health in place-based programs were related to:

- Integrated and holistic approaches
- Interventions that are fully implemented i.e. no premature discontinuation
- Use of community engagement, participation, and ownership
- Focus on long term and sustainable benefits
- The assumed benefits are based on empirical evidence
- A good understanding of the community (the type and causes of disadvantage, the needs, the resources available)
- Investment in early intervention and prevention.

In conclusion, the literature review, while not identifying replicable priority-setting models for the Guelph CHC context, reaffirmed the CHC's hybrid service model with

its focus on populations, health issues and place-based intervention; reaffirmed the CHC model of care as effective in improving outcomes for vulnerable populations, and pointed the research towards system-wide health equity planning.

Appendix 4
Guelph Community Health Centre Priority Group Review
(Background document distributed at Town Hall meetings and focus groups)

- **ORIGINS:** Guelph Community Health Centre was founded in 1984 as a health co-operative and sought funding and was approved in the early stages as a Health Service Organization (HSO).
- **THE HSO MODEL:** The HSO model was designed for the general population – a rostered model – had to recruit people to make up the numbers to make the HSO financially viable. It drew on the people already involved, and on the general population. Guelph CHC opened its doors in 1988 at 89 Wyndham Street.
- **THE SHIFT TO A COMMUNITY HEALTH CENTRE:** When the board sought and was awarded funding as a community health centre in 1992 it (bringing all of the additional staffing, the mandate of the organization by necessity changed.
- **THE CHC MODEL OF CARE** (as currently defined) -
    - CHCs offer a range of comprehensive primary care, health promotion, individual and community capacity building and service integration activities in diverse communities across Ontario with an emphasis on priority populations identified by geography and/or population groupings.
    - A priority population has one or both of the following characteristics:
        - Face barriers to accessing an appropriate range of primary care services (e.g. geographic isolation, or cultural or language barriers); and/or
        - A higher burden or risk of ill health due to social determinants of health, such as socio-economic status, age, environmental factors, social isolation, mental health issues, gender, sexual orientation or other health determinants (e.g. chronic disease).
- **PRIORITY POPULATIONS:** In 1997, as part of its requirements to the funder, the organization revised its mission statement and defined its priority populations as
    - *Children, prenatal to 6 years of age and their families;*
    - *Homeless/underhoused and downtown vulnerable adults;*
    - *New immigrants;*
    - *Individuals with barriers to good health, including*
        - *Low income*
        - *Disability (physically or mentally)*
        - *Isolation*
        - *Single parents*
        - *Unemployment.*
- Managed for a number of years to maintain services to existing populations as well as develop expertise, staffing and programming to reach and work on improving the health of the priority populations.
- Increasingly, this became a challenge – clinical services reached capacity, shortage of family physicians. No increased funding or other resources.

- **THE REVIEW:** This brings us to 2010, when the board embarked on this review – circumstances required this – it is also a time of opportunity: -
  - Funder expectations and support– the CHC model of care is an attachment to the annual submission (Community Annual Planning Submission) to the Waterloo Wellington Local Health Integration Network (WWLHIN) and WWLHIN has endorsed this review.
  - There is increased demand for GCHC expertise for underserved populations and neighbourhoods.
  - The Guelph Family Health Team is interested in collaborating and has capacity – this is a new circumstance – capacity for up to 5000 new patients.
  - Other primary care and community organizations are interested in collaborating to improve access to and the coordination of health services in Guelph.

Prepared by Public Interest Strategy and Communications for the Guelph CHC Priority Population Review March 2011

Appendix 5 – List of Key Informant Interviews and Focus Groups

Key Informant Interviews - Environmental Scan	
Valerie Sauer	Ontario Works – Division of Wellington county
Amenda Ng	Immigrant Services Guelph
Fred Wagner	Trellis
Gayle Valeriote	Volunteer Guelph
Margaret Sherratt	Family Birthing Unit – Guelph General Hospital
Lorna Schwartzentruber	Onward Willow Better Beginnings
Eileen Bain	Guelph General Hospital
Ross Kirkconnell	Guelph Family Health Team
Key Informant Interviews – Community Engagement	
Bruce Lauckner, Toni Lemon, Gloria Whitson-Shea	Waterloo Wellington Local Health Integration Network
Andrea Roberts Jennifer McCorrister	City Guelph Public Health
Lisa Grosicki	TAPPS
Lynne Briggs	Evergreen Seniors Centre
Heather Field	Women in Crisis
Adam Rutherford	Guelph Youth Council
Patrick Seliske	Public Health, University of Waterloo
B. J. Caldwell	AIDS Committee of Guelph
Ines Sousa-Batista	Local Immigration Partnership
Kate Bishop	Neighbourhood Support Coalition
Meetings and Drop-Ins	
Clinical Team Meeting (CHC)	
Community Health Team (CHC)	

Staff Drop-In (Downtown CHC)
Neighbourhood Group Drop-In
Focus Groups
Primary Care Practitioners and CCAC
Peer Leaders/Health Advisory
Newcomers (conducted in Spanish, Farsi/Dari, Hindi/Urdu, Vietnamese, Cantonese/Mandarin)
Mental Health/Addiction Service Providers
Underhoused Service Providers
GCHC Clients (Shelldale)
GCHC Clients (Brant)
GCHC Clients (Founding Members)
Town Halls
First Town Hall - March 31
Second Town Hall – May 12

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