Agenda

Health and Social Services
Haldimand and Norfolk

Haldimand-Norfolk
Health and Social Services Advisory Committee

April 24, 2023
9:30 a.m.
Council Chambers

Pages

11.1 HSS-23-027 - Ontario Seniors Dental Care Program Overview and Service Implementation Request
Pursuant to the Municipal Act, 2001 Section 239(2)(k) A position, plan, procedure, criteria or instruction to be applied to any negotiations carried on by or on behalf of the municipality or local board.

12. Next Meeting

12.1 Monday May 22, 2023 - Victoria Day Holiday. Postponing meeting till Monday May 29, 2023 @9:30am

13. Adjournment

Haldimand-Norfolk

Health and Social Services Advisory Committee

March 27, 2023
9:30 a.m.
Virtual Meeting

Present: Chris Van Paassen, Linda Vandendriessche, Alan Duthie, ShelleyAnn Bentley

Absent with Regrets: John Metcalfe

Also Present: Christina Lounsbury, Syed Shah, Stephanie Rice, Jennifer Snell, Lori Friesen

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1. Disclosure of Pecuniary Interest

2. Additions to Agenda

3. Presentations/Deputations

4. Adoption/Correction of Advisory Committee Meeting Minutes

4.1 Health and Social Services Advisory Committee - February 27, 2023

The Minutes of the Health and Social Services Advisory Committee meeting dated February 27, 2023, having been distributed to all Committee Members and there being no errors reported, they were there upon declared adopted and sign by Chair Bentley

Moved By: Chris Van Paassen
Seconded By: Alan Duthie

Carried.

5. Update on Reports

Stephanie Rice, Acting General Manager Health and Social Services advised that all reports from the February 27, 2023 Advisory Committee Meeting were approved at council as presented.

6. Consent Items

7. Staff Reports

7.1 General Manager

7.2 Public Health

7.3 Social Services and Housing

7.3.1 Licensed Home Child Care Service Agreement, HSS-23-009

Moved By: Linda Vandendriessche
Seconded By: Alan Duthie

THAT the report HSS-23-009 regarding the Licensed Home Child Care Service Agreement be received as information;

AND THAT Council authorize staff to proceed with entering into a service agreement with Today's Family, the current Licensed Home Child Care (LHCC) Service Provider, for an additional eighteen (18) months beyond the end of the existing agreement on April 28, 2023;

AND FURTHER THAT Children's Services proceed with securing long-term Licensed Home Child Care Agency services in the fall of 2024, in alignment with Norfolk County Purchasing Policy CS-02, following the Ministry of Education's release of a new funding formula in 2024.

Carried.

8. Sub-Committee Reports

9. Communications

9.1 alPHa's 2023 Annual General Meeting (AGM) and Conference

Moved By: Chris Van Paassen
Seconded By: Alan Duthie

That the following items be received as information.

Carried.

10. Other Business

11. Closed Session

12. Next Meeting

12.1 Monday April 24, 2023

13. Adjournment

Moved By: Chris Van Paassen
Seconded By: Alan Duthie

Carried.

To: Members of Health and Social Services Advisory Committee

From: Dr. Joyce Lock, Acting Medical Officer of Health

Date: April 24, 2023

Re: Acting Medical Officer of Health Update

I am appreciative of the warm welcome received from the staff at the managers' meeting and again at the all-staff meeting, as well as from Dr. Shah, Director of Public Health at our introductory meeting. A special thank you to Christina Lounsbury, administrative coordinator, and the IT staff for patiently walking me through setting up my computer and connectivity to the health unit network.

Presently, I am in the process of meeting with each of the management staff. This provides an opportunity to get to know the staff, learn about their programs, and become familiar with their current challenges. To strengthen the relationship and enhance coordination and cooperation, Dr. Shah and I plan to meet weekly. In my meetings with the managers, I am reviewing the Annual Service Plan to better understand service goals for this year. The Community Needs Assessment provided a comprehensive picture of the health status of our community. Many of the issues impacting our community's well-being are like those impacting health units across the province. The Norfolk 2022-26 Strategic Plan also provided me with a better understanding of the community.

The Council of Medical Officers of Health (COMOH) membership includes Medical Officers of Health and Associates from all provincial health units. COMOH meets monthly in an unstructured forum to provide an opportunity to discuss concerns and challenges common to the group. Some items discussed at the April 5th meeting include the following:

- Developing a Tuberculosis Management Best Practice Working Group
- Growing the relationship with the Office of the Chief Medical Officer of Health to advance population health issues through potential working groups and tables.
- Augmenting coordination of work on matters such as our Information Systems, Public Health Policy, and other specific program areas
- Updates from the National Advisory Committee on Immunizations
- Updates from the COMOH representative to the Ontario Medical Association.

COMOH also meets quarterly as a division of the Association of Local Public Health Agencies (alPHa). The agenda includes updates by representatives from the Office of the Chief Medical Officer of Health (OCMOH), Public Health Ontario, Health Canada's First Nation & Inuit Health Branch (FNIHIB), and the alPHa executive staff. Some of the topics discussed at the April 19th

meeting included:

- Developing a coordinated approach to addressing funding pressures for the 2024 budget
- Plans by the Chief Medical Officer of Health (CMOH) to reinvigorate Public Health, work collaboratively with PHO, Ontario Health (OH), and local public health (PH) to establish priorities, update the public health standards starting with Emergency Preparedness, and review provincial IT assets and needs.

The next meeting of Association of Local Public Health Agencies is in June. Board members are encouraged to participate in the meeting and attend the Board of Health (BOH) section meeting.

COMOH also has several working groups made up of MOHs and AMOHs working on a variety of issue. Reports and updates were provided by group leads. Some of the working groups are as follows

- Opioid and Drug Poisoning Crisis
- Climate Change and Health Impacts
- Council of Directors of Education and the Council of Medical Officers of Health (CODE-COMOH)
- Ontario Health Teams

To ensure local coordination of public health activities, the MOHs and AMOHs of the Central West meet quarterly to discuss local regional issues. Membership of the Central West region includes Niagara, Hamilton, Haldimand-Norfolk, Brant, Waterloo, and Wellington-Dufferin-Guelph health units. A meeting was held on April 21. A key agenda item was addressing and mitigating expected funding reduction in 2023 with the loss of COVID related one-time funding and additional pandemic resources. There are pressures related to catching up on programs and services not attended to during the pandemic as, for example, catching up on childhood immunization rates. These fell significantly during the pandemic due to the loss of in-person visits to primary care.

In April, Niagara Public Health posted a position for an additional Associate Medical Office of Health to complement the current three associates, one of which is working as acting MOH. Niagara has been short-handed for a few years.

Respectfully submitted,

Dr. Joyce Lock

Board of Health Meeting – May 02, 2023

Advisory Committee Meeting – April 24, 2023

Subject:	Environmental Health Emerging Trends 2023
Report Number:	HSS-23-015
Division:	Health and Social Services
Department:	Environmental Health
Purpose:	For Information

Recommendation(s):

THAT Staff Report HSS 23-015, Environmental Health Emerging Trends 2023, be received as information.

Executive Summary:

This report provides information about the emerging trends and issues impacting the Haldimand-Norfolk Health Unit's (HNHU) Environmental Health Team resources. This report highlights new challenges and trends, and public health initiatives required to address them.

Discussion:

The COVID-19 Pandemic impacted, in unprecedented terms, the way people survived and functioned. Remote work became mainstream and there were job losses as companies tried to adapt to our new world, leading people to think outside the box to provide sustenance and opportunities for themselves and their families. New regulations from governing bodies were implemented to improve public health and keep populations healthy. As the world and Haldimand and Norfolk counties opened back up for business, new initiatives to assist our counties and re-invigorate a sense of community, have become a priority to help recover from the Covid-19 Pandemic. New and existing programs that have been impacted as a result of emerging trends include: Home-based food and personal service businesses, Mobile Food Businesses, regulatory changes to drinking water systems, regulatory changes to bunkhouse inspections, and increased demand for Special Events and tourism promotion. This report aims to address these issues in detail to provide a clear picture of how they impact HNHU's Environmental Health Team and our communities.

Home Based Food Businesses and Personal Service Settings

In 2020, the Ontario Food Premises Regulation (O. Reg. 493) was amended to provide exemptions from the requirement to have dedicated handwashing facilities, dishwashing facilities, and Food Handler Certification for premises preparing low risk foods, and in November 2021, the Ministry of Health released *A Guide to Starting a Home-Based Food Business* to support the move towards more Home-based food businesses in Ontario. These amendments effectively removed several of the barriers that made it difficult for an individual to operate a food business from their home.

The Haldimand-Norfolk Health Unit has helped numerous local individuals to start their own Home-Based Food Business. We currently have 25 known and active premises throughout both counties, 17 of them are using their private, residential kitchen to prepare food for sale to the public.

Businesses located in private residences present unique challenges and safety concerns for Regulatory Enforcement Officers. Public Health Inspectors have the right to enter all kitchens, but without a separate entrance, the owner could legally block access to the kitchen by denying access to the rest of the house. The cleanliness and state of the premise and presence of animals adds additional challenges, requiring a more nuanced and collaborative approach when attempting to conduct inspections of these premises.

Personal Service Settings have become more popular in homes as well, where people offer high-risk services such as micro blading, micro shading, as well as eyelash extensions and other beauty treatments.

Many of these business operators are not knowledgeable of the requirements for municipal business licenses and notification to our local Board of Health for health inspections of their facilities, and only advertise online through social media. This makes it difficult to enforce food safety and personal service setting regulations that may pose a health hazard threat in our communities related to food-borne illness and infectious diseases, simply because we may not know they exist and therefore cannot assist them in becoming compliant to ensure they are providing safe products and services.

Mobile Food Premises

One of the unforeseen outcomes of the pandemic was the rise in popularity of Mobile Food Premises. Food Trucks and other mobile units were generally able to continue operating during lockdowns and represented an opportunity for individuals who were out of work due to COVID-19 to earn income with minimal investment.

The Health Unit currently has 49 active mobile food premises that are inspected between one and three times per year. Since 2021, the Health Unit has approved 23 new mobile food premises. This process involves consultation with the business owner,

coordination with other county departments, and a minimum, of two inspections including assessment of their water supply and sample collection. Many mobile food businesses have completed the approval process but since gone out of business or moved to another jurisdiction. Of the 23 approved since 2021, only 8 are still operating today, demonstrating that our current inventory does not accurately reflect the amount of time spent on this program.

Drinking Water Systems

Recent changes to the regulatory definition of a Food Premise have also affected the application of the Small Drinking Water Systems regulation. All fixed food premises, including Home Based Food Businesses are now considered Small Drinking Water Systems and will require the same level of oversight as other drinking water systems. Public Health Inspectors will conduct risk assessments, collect samples, issue directives, review sample results, and respond to adverse water quality incidents for all of these newly identified systems.

Additionally, the Haldimand-Norfolk Health Unit has identified water systems at our Mobile Food Premises as an area that requires further attention. Most of the Mobile Food Premises in Haldimand and Norfolk obtain water by filling holding tanks but are not subject to the same level of oversight as other drinking water systems. Public Health Inspectors have always collected water samples during inspections and followed up with adverse results, however, more attention is required to help ensure operators are knowledgeable and able to institute preventative measures to help ensure their water is safe at all times.

Bunkhouses

Haldimand and Norfolk counties have a long history in agriculture, with Norfolk County being dubbed as “Ontario’s Garden”. Being rural communities with over 28,000 square kilometers shared between the two counties, farming is a large part of everyday life for many of our residents including International Agricultural Workers (IAWs). Every year, the communities of Haldimand and Norfolk welcome over 4500 IAWs, more than almost every other region in the province, increasing our population 5-10% every growing season. As a result, the Haldimand Norfolk Health Unit (HNHU) has one of the largest numbers of seasonal housing units to accommodate IAWs within Ontario. Service Canada requires housing inspections to be included within the Labour Market Impact Assessment (LMIA) that farmers must submit to request workers for all agricultural stream programs where the employer is providing housing for these workers. The Seasonal Housing Program for Migrant Workers continues to grow year after year. The Environmental Health Team has assessed, inspected, and approved 55 new Seasonal Housing facilities since 2021. For each of those new facilities, a Public Health Inspector must conduct at least one site visit, measure each room for floor and air space calculations, collect water samples, and ensure compliance with the Seasonal Housing

Guidelines. Additionally, changes to the Federal Temporary Foreign Worker Program with regard to time between inspections and application submission have caused many Seasonal Housing Units to require two inspections per year rather than one.

The COVID-19 Pandemic has had significant, permanent effects on the Seasonal Housing Program for IAWs. Many of our farm operators have already changed the way they provide housing to workers. Large farm operators are choosing to build numerous smaller units rather than large bunkhouses with shared facilities. In response to the challenges they faced during the pandemic, they are housing fewer workers per unit and incorporating infection control practices such as maintaining a minimum of two meters of space between beds and leaving top bunks vacant. These are positive changes that improve the quality of life for International Agricultural Workers (IAWs), but they are changes that require significantly more time and effort from our Environmental Health Team to inspect, assess, and approve additional units.

The Ministry of Health has announced that new Provincial Seasonal Housing requirements will be coming out soon and will take effect January 2024. While we do not yet know the details, it is expected that occupancy rates will be impacted resulting in renovations and/or new construction for operators to come into compliance. Farm operators will depend on the Environmental Health Team to communicate the changes, educate them on how to come into compliance, and conduct site visits and inspections to ensure they will be approved. Any changes to the Seasonal Housing Program require additional time and effort by our Public Health Inspectors and support staff and these changes are expected to be significant.

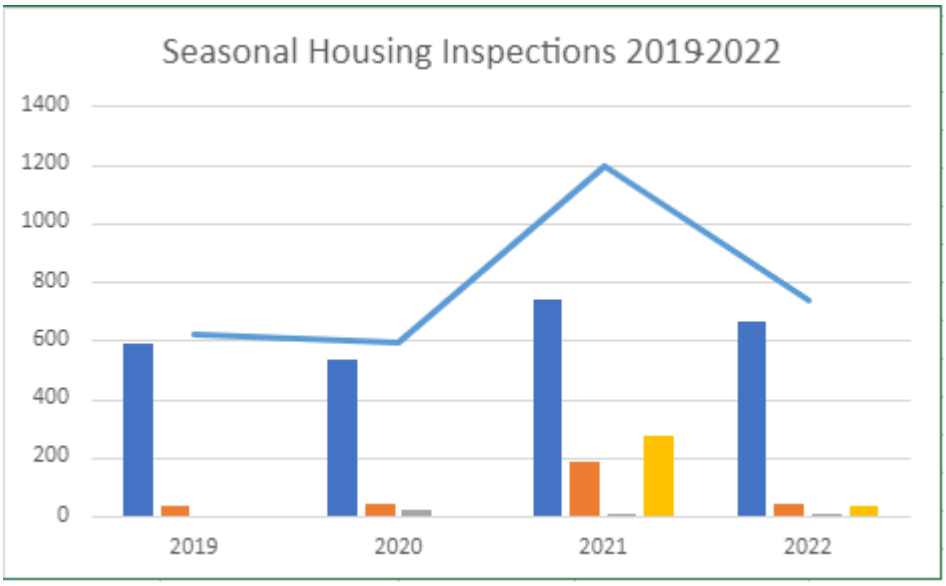
The Seasonal Housing Program poses a significant financial impact on HNHU resources. The bunkhouse inspection fee, which is intended as a cost recovery program is not functioning as such. The same fee is applied per 911 address regardless of whether or not that address has 1 bunkhouse to inspect or 15, giving a financial advantage to larger agri-business operators and increasing the time Public Health Inspectors must dedicate to these inspections.

In 2019, 589 compliance seasonal housing inspections were completed. In addition to this, there were 37 follow-up inspections completed. Total inspections conducted: 626.
In 2020 due to the COVID-19 pandemic and reduced staffing resources due to redeployment, there were 594 inspections.

In 2021, 737 compliance inspections were completed; 182 follow-up inspections were completed (higher due to localized housing changes resulting in additional follow-ups to ensure compliance with these COVID rules); 4 demand inspections were completed; and 2 pre-operational inspections were completed. An additional 273 inspections were done for units that were solely used for the purpose of isolating workers during the mandatory quarantine period upon arrival due to international travel rules for COVID-19 and/or in the event of a COVID-19 outbreak on a farm. Total inspections: 1198.
In 2022, 665 compliance inspections were completed; 41 follow-up inspections were completed; 2 complaint inspections were completed; 1 pre-operational inspection was

completed and 33 inspections were done for units that were solely used in the event of a COVID-19 outbreak on a farm (reduced because mandatory quarantine no longer available). Total inspections: 742.

Year	Compliance Inspections	Follow-up Inspections	Demand/pre-operational	Isolation Unit Inspections	Total
2019	589	37			626
2020	532	42	20		594
2021	737	182	6	273	1198
2022	665	41	3	33	742



Tourism and Special Events

Tourism and Special Events are making a comeback in both counties since their rapid decline during the COVID-19 pandemic. In 2022 the Environmental Health Team reviewed and approved 153 separate events with a total of 477 vendor applications. As of March 16, 2023, the Team has received 53 event applications and 94 vendor applications which is on track to significantly exceed 2022 numbers.

Special Events require Public Health oversight at many levels. Public Health Inspectors review and approve applications from Special Event organizers to ensure the venue is equipped to safely accommodate the expected number of visitors. They ensure the provision of washroom facilities, safe water, and proper waste disposal practices and verify that facilities are in place for any vendors that will be attending. Public Health Inspectors also review and approve food and personal services vendor applications and educate operators about safe practices during events. Special events also require considerable time and effort from our Environmental Health Team support staff. Our Program Assistants process applications, manage organizer and vendor databases, communicate with applicants, and issue permits.

A successful tourism initiative is also expected to lead to an increase in the number of demand calls the Environmental Health Team will receive. Public Health Inspectors respond 24 hours a day to reports and complaints about food premises and foodborne illness, drinking water, recreational water, personal services, and animal bites. An increase in visitors to the area will ultimately lead to an increase in the number of calls received.

The populations of both Haldimand and Norfolk Counties have grown as people from larger centers seek out improved quality of life in smaller communities, something that was not possible before remote work became mainstream. People can now relocate to smaller communities with lower cost of living and still be employed by larger companies in cities.

Since the last census in 2016, the population of Norfolk has increased by 3,446 people, or 5.4 per cent, and Haldimand experienced an increase of 3,608, a 7.9% increase in new residents in the last five years

The increase in our populations have a domino effect on the services available in our community. Despite the staffing and financial resource pressures associated with these new and emerging trends, the HNHU strives to provide excellent service to both communities we serve.

Financial Services Comments:

Norfolk County

There are no direct financial implications within the report as presented. The outlined programs fall under the scope of the Environmental Health Team, and are budgeted in accordance with the Ministry of Health's Mandatory Programs guidelines and requirements.

The Approved 2023 Haldimand-Norfolk Health Unit Operating Budget includes $1,991,900 for the Environmental Health Team, funded in part with Ministry of Health allocation, Haldimand and Norfolk shared levies and user fee recoveries.

Haldimand County

N/A

Interdepartmental Implications:

Norfolk County

N/A

Haldimand County

The positive work conducted by the Environmental Health Team continues to support two of Haldimand's Corporate Strategic Pillars: including *Community Vibrancy and Healthy Community* by ensuring the well-being of communities and *Growing our Local Economy* by supporting positive tourism experiences for local residents and our visitors.

Consultation(s):

N/A

Strategic Plan Linkage:

This report aligns with the 2019-2022 Council Strategic Priorities "Focus on Service"

Explanation: The Environmental Health Team will focus public health services to address emerging trends in the Environmental Health Program. The key is awareness, education of the public, the development of innovative ideas to address providing services, and consultation with the Board of Health to address challenges while providing excellent service to our communities.

Conclusion:

The Environmental Health Team will focus public health services to address emerging trends in the Environmental Health Program. The key is awareness, education of the public, the development of innovative ideas to address providing services, and consultation with the Board of Health to address challenges while providing excellent service to our communities.

Attachment(s):

- N/A

Approval:

Reviewed and submitted by:
Syed Shah
Haldimand Norfolk Health Unit
Director, Public Health

Reviewed by:
Alexis Atkinson
Haldimand Norfolk Health Unit
Program Manager, Environmental Health

Prepared by:
Matthew Harrington
Haldimand Norfolk Health Unit
Senior Public Health Inspector, Environmental Health

Information Memo

Advisory Committee Meeting – April 24, 2023
Board of Health Meeting – May 02, 2023

Division: Health and Social Services
Department: Public Health
Subject: Community Needs Assessment 2022
Report Number HSS-23-020

Recommendation(s):

THAT the Information Memo regarding the Community Needs Assessment 2022 – HSS-23-020 be received as information.

Background

The 2022 Haldimand Norfolk Health and Social Services (HNHSS) Division Community Needs Assessment (CNA) is a follow-up to the 2019 HNHSS CNA. A Community Needs Assessment (CNA) aims to identify and understand the needs of the population within a region and supports the formulation of public health priorities for the population [i]. When used to understand health needs, a CNA should be designed to understand the needs of the population as well as to understand the factors that individuals need to feel healthy, safe, and protected in their community. A CNA typically involves three key steps: (i) assessment; (ii) dissemination; and (iii) implementation.

In 2022 as the Haldimand Norfolk Health Unit (HNHU) started to transition out of COVID-19, the assessment phase (data collection and analysis phase) of a CNA was completed. This involved four components: a community profile, a community survey, focus groups, and interviews. The data has been analyzed and incorporated (Attached as Appendix –A)

This report provides an overview of the CNA findings and marks the beginning of a dissemination phase. The information gained from the CNA will ultimately contribute to future planning of the Health Unit and inform programs and implementation strategies. The CNA informs key public health priorities for action and advocacy.

Discussion:

Methods
The CNA employed a community-based approach that used both quantitative and qualitative methods to gather data. These key elements included: (i) a community profile, (ii) a community survey; (iii) focus groups and (iv) interviews.

Community Profile
The community profile is a method of using previously collected data to describe the overall community and priority populations of Haldimand and Norfolk counties. Typically, this data which is obtained from public sources include indicators (i.e. variables) for demographics, health status, and social services.

Community Survey
The community survey was used to collect data from members of the general population; the goal was to understand the perspectives of residents as well as gain insights into the health and social behaviours of the community. The survey was distributed via online platforms on HNHU social media, and across social media accounts for Haldimand and Norfolk counties. Paper versions were also available at several locations across the two counties, including libraries, churches, hospitals, county fairs, and community agencies.

Focus Groups and Interviews
The focus group sessions and interviews were utilized to elicit the perspectives of experiences of community members. This information may not have been obtained through the community profile and/or survey. A purposive (i.e. targeted) snow-ball (i.e. stepwise) sampling strategy was employed for both focus groups and interviews. Both focus groups and interviews were conducted using a semi-structured approach. Transcripts were analyzed to identify themes or similarities across discussions.

Data Culmination
Following the initial analysis of all of the collected data (i.e. community profile, community survey, focus group discussions and interviews), the data was compared across the different sources for similarities. Major themes emerged as common community needs that the participants in all elements of the CNA prioritized. All of these analyses were done in the context of the rurality of Haldimand and Norfolk Counties.

Findings

Mental Health and Addictions Supports

Mental health and addictions supports were one of the top priorities described by participants in the focus group discussions and interviews. Participants described the need for mental health and addictions supports as being very high, and the availability of services as being very low. Participants stated that supports often had long waitlists that delayed entry into programs, were difficult to travel to, or were expensive.

Physical Health
The data collected as part of this CNA indicate that physical health is a major concern for residents in Haldimand and Norfolk counties. Survey respondents, focus group and interview participants described several local key physical health concerns, most pronounced of all, was a lack of available family physicians in this community.

Poverty
Poverty was described as both a major community issue and a major contributing factor to other local needs. Poverty was seen as a barrier to accessing many of the things that individuals needed to be healthy, such as a safe place to live and healthy food, and as a stressor that exacerbated other needs, such as mental and physical health. Poverty was described as a contributing factor to the high demand for mental health and addictions services, and as a stressor in general life that decreased health of participants. Poverty issues were often described as being worsened by a generational poverty system, relative rurality of the communities, and a lack of available services. Recognition of the role poverty plays in physical and mental health is an important consideration for all program planning at the health unit.

Availability of Products and Services
A lack of access to products and services was discussed frequently. Specifically, issues around transportation, childcare, food, and youth programming abounded in the data. Each of these products or services was discussed in context of their contribution to community members' mental and physical health. These issues were often linked to rurality and the assumption or explanation that services were simply too difficult to provide in a vast geographical area with a relatively low population density. With regards to services, the lived-experiences of poverty were often described as exacerbated because of the lack of transportation to access basic services.

Organizational Systems
Barriers to services in Haldimand and Norfolk frequently involved organizational systems that made it difficult for clients to use or access services. To overcome these barriers the most actionable recommendations made by participants are collaboration, communication, physical access and inclusion. Supportive environments are part of the standards that public health is mandated to meet.

Attachment(s):

Appendix A – Infographic
Appendix B – Community Needs Assessment Report

Conclusion:

Conclusion

Participants in the CNA provided a wealth of information that should be considered when developing recommendations and actions to address the needs of the community.

The findings identify several key areas for the BOH to address in order to meet the needs of residents in Haldimand and Norfolk counties. These key areas will be constructive to develop a new Strategic Plan in 2023 for HNHU.

Approval:

Reviewed and Submitted By:
Syed Shah
Director, Public Health

Reviewed By:
Marcia Annamunthodo
Program Manager, Professional Practice/Quality Assurance and Chief Nursing Officer

Prepared By:
Dr. Katherine Bishop-Williams
Epidemiologist

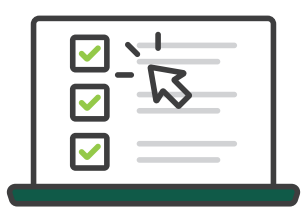
[i] CDC (Centres for Disease Control and Prevention). (2014). Community Health Assessment and Health Improvement Planning

COMMUNITY NEEDS ASSESSMENT 2022

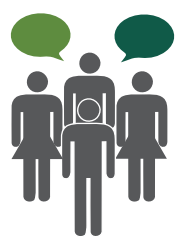
The Haldimand-Norfolk Health and Social Services Community Needs Assessment (CNA) 2022 aimed to identify and understand the needs of the community, and how those have changed since 2019. This will contribute to the planning of HNHSS programs.

Method

community profile



community survey



focus groups

key informant interviews

Key Findings from Community Profile

Population of H-N

116,872

↑ 6.5% since 2019

Median Income

$ 93,000 Haldimand
$ 82,000 Norfolk
$ 91,000 Ontario
↑*

Employment Rate

61.2% Haldimand and Norfolk
59.9% Ontario

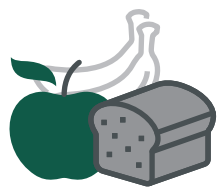
Access to Primary Care

63 physicians per 100,000 in Haldimand and Norfolk
115 physicians per 100,000 in Ontario

Key Findings from Community Survey

1,404
responded to survey
↑ 2.9 times higher participation than in 2019

↑ higher participation among many population groups than in 2019



14.1%
worried they did not have enough money for food in the past month

Self-Identified Substance Use:

↑* **5.5%** alcohol use

↓* **11.9%** tobacco users

↓* **12.3%** cannabis users

3.9% drug users
⇄ similar to 2019

80.3% ↓*
reported that Haldimand Norfolk needs more mental health services locally

81% ↑*
reported Haldimand Norfolk needs more affordable housing

74.5% somewhat or not at all familiar with available programming at HNHSS
⇄ similar to 2019

Key Themes from Interviews and Focus Group Discussions

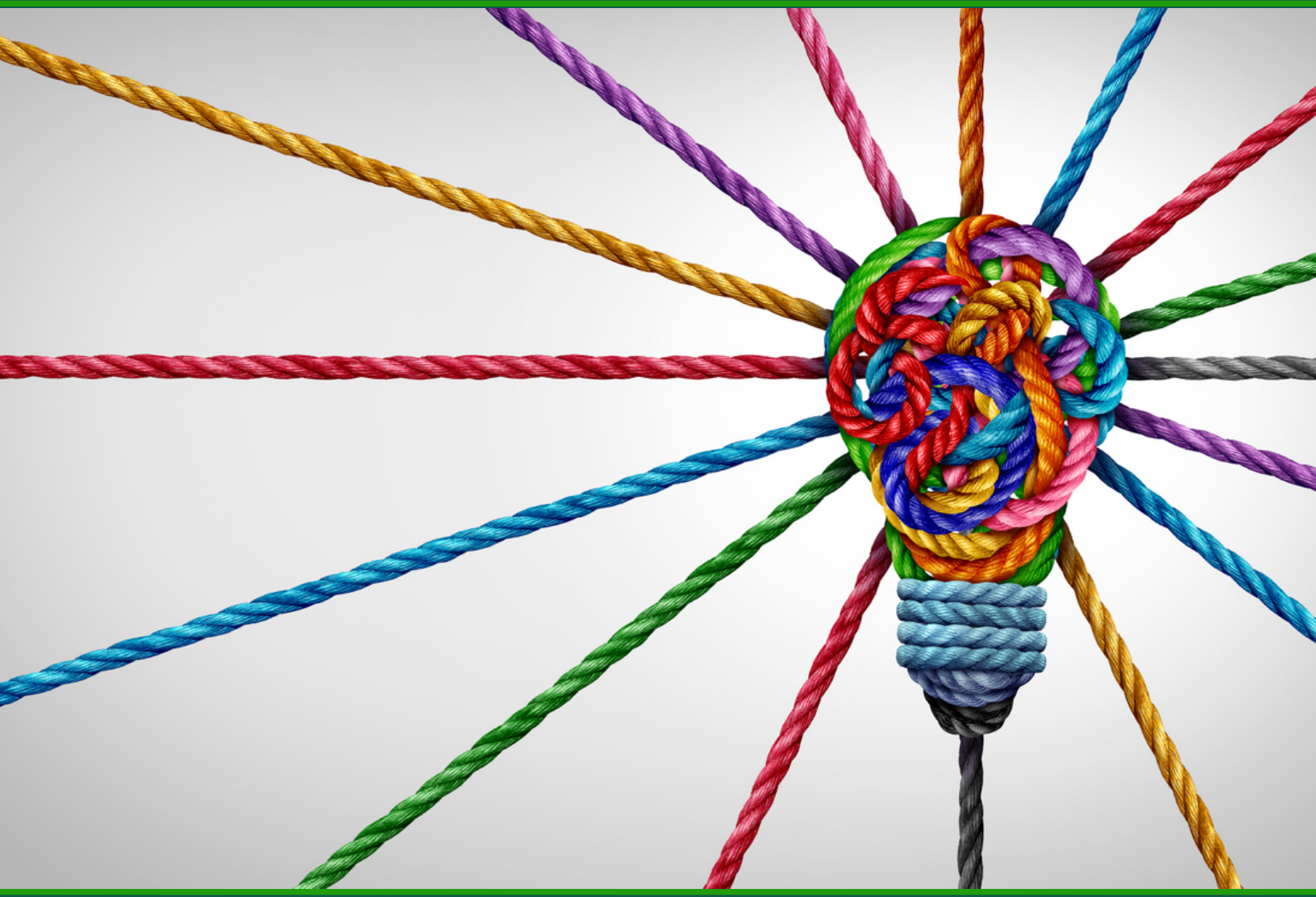
124 participants

- COVID Related Changes
- Barriers to Service
- Health and Social Services Priority Areas
- Health and Social Services Systems
- Leadership

*significant difference since 2019

Health and Social Services Haldimand and Norfolk

COMMUNITY NEEDS ASSESSMENT REPORT 2022



Health and Social Services
Haldimand and Norfolk

Report of Community Needs Assessment 2022 findings.
Haldimand Norfolk Health and Social Services Division, 2022.
Report prepared by Professional Practice, Quality Assurance, Planning & Evaluation Team.

Authorship

Authors:

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Health Promoter

Rupali Krishna
Public Health Nurse

Tamara Robb
Public Health Nurse

Acknowledgements

First and foremost, Haldimand Norfolk Health and Social Services (HNHSS) expresses sincere thanks to the community members across Haldimand and Norfolk counties who participated in the Community Needs Assessment (CNA) 2022. To the individuals who completed surveys, participated in interviews and focus groups, shared social media posts calling for participants, and invited others to have their voice heard, thank you. The CNA is a collaborative project that your support strengthened.

Thank you to the teams at HNHSS's partner organizations for engaging in the research process as participants and liaisons for your clients, including providing time and space for survey pop-up locations, key informant interviews, and focus group discussions.

Thank you to the teams at Haldimand County and Norfolk County for supports with communications, survey distribution, and more.

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Executive Summary

The 2022 Haldimand Norfolk Health and Social Services (HNHSS) Division Community Needs Assessment (CNA) is a follow-up to the HNHSS CNA that was conducted in 2019. The goal of the CNA was to describe the current health and social status of the local community and changes since the 2019 CNA, with the purpose of contributing to future decision-making processes.

The 2022 CNA employed a similar method to the previous assessment, using a multi-pronged approach to data collection and analyses. The CNA was community-based and included both quantitative and qualitative data collection methods, such as a survey, key informant interviews, and focus group discussions. The data for this assessment was analyzed both for numerical trends and thematic trends and cross-validated.

Local community members, partner agencies, and internal staff were highly engaged in the process, resulting in over 1,400 complete survey responses, 80 interviews, and nine focus group sessions. Public engagement also included hundreds of total social media shares and reactions and 11 pop-up survey sites.

The demographic characteristics of the survey participants varied, including participants from across the communities in Haldimand and Norfolk, age brackets, gender identities, and income levels. Experiences related to COVID-19 also varied amongst participants.

Overarching conceptual framing, referred to as frames, to understand the data as it was presented, supported by both quantitative and qualitative information, included “Relationships and Community” and “Health Equity.” These two frames provided insights into the way data themes were interpreted throughout. The five key themes, best understood through the lenses of the two overarching frames, were:

- COVID-Related Changes;
- Barriers to Service;
- Health and Social Services Priority Areas;
- Health and Social Services Systems; and
- Leadership.

The findings contained in this report contribute to ongoing evidence-informed decision-making processes at HNHSS. This report, in conjunction with other critical reports, will serve to support the prioritization of future activities within the community and the HNHSS division.

Introduction

Background

The purpose of a community needs assessment (CNA) is to collect information that describes the population of a community and outlines the needs of that population, aiming to determine what gaps and barriers exist to meet those needs[1,2,3]. Moreover, a CNA should be able to provide local context about the population and their needs and should provide information that helps develop actionable items from the findings. A CNA typically includes three key steps: (i) assessment; (ii) dissemination; and (iii) implementation[4].

The Haldimand Norfolk Health and Social Services (HNHSS) CNA 2022 builds on the methodological design of the HNHSS CNA 2019[3]. Specifically, both CNAs involved four key data collection methods: (i) a community profile consisting of a comprehensive environmental scan of available local data; (ii) a community-based survey; (iii) focus groups with priority population groups with various lived-experiences; and (iv) individual key informant interviews with HNHSS staff, partner agency staff, and individuals with various lived-experiences. These methods constitute the data collection portion of the assessment phase of the CNA.

Rationale for HNHSS CNA 2022

The CNA 2022 serves the immediate need of informing the HNHSS division on the status of community needs in Haldimand and Norfolk counties and will be used by the division's senior leadership, program managers, and program staff to inform future planning, amongst other critical reports. Moreover, the CNA integrates the voices of Haldimand and Norfolk community members into that planning process.

In addition to the ability to include CNA results in planning, the CNA 2022 serves a unique ability to demonstrate how the residents in Haldimand and Norfolk have fared during the COVID-19 pandemic and evaluate how priorities have changed since fall 2019, when the previous CNA was completed[3].

Finally, the CNA 2022 will also provide HNHSS with the information needed to target interventions according to the mandates of the Ontario Ministry of Health (MOH)[5]. This intentionality increases HNHSS's ability to be effective in serving the residents of Haldimand and Norfolk counties and to be resource effective in terms of available funds and time.

Objectives

Building on the success and lessons learned from the HNHSS CNA 2019, and recognizing the changes in the local community since that time, the objectives of the HNHSS CNA 2022 were to:

i. Describe current health, social status, and needs of residents in Haldimand and Norfolk;

ii. Describe the changes in health, social status, and needs of residents in Haldimand and Norfolk from 2019 to 2022, acknowledging the changes experienced as a result of the COVID-19 pandemic;

iii. Identify the needs and gaps in health and social services programming in Haldimand and Norfolk counties and outline changes in programming availability since 2019; and

iv. Support evidence-informed decision-making and program planning for health and social services in the two county service areas.

Methods

Approach

The CNA 2022 used a community-based, participatory, mixed-methods approach throughout. This includes a central focus on engaging the community in all aspects of the CNA 2022, an iterative and semi-structured approach to questions in interviews and focus groups (i.e., not all participants were asked the same questions or in the exact same way), and intentional integration of quantitative (i.e., numeric data) and qualitative (i.e., thoughts, opinions, and feelings) data into a single final product.

The CNA 2022 used a methodological approach that was approved by the HNHSS Research Advisory Council in 2019[3].

Community Profile

The CNA 2022 Community Profile aims to describe the communities of Haldimand and Norfolk counties as fulsomely as possible with available resources, encompassing any relevant data points related to the demographics, health characteristics, or social services behaviours of residents.

Initially, a list of interesting and relevant indicators was developed in 2019. The indicators were identified from the HNHU operational plans, Windsor-Essex County Health Unit 2016 CNA[1], and in discussion with HNHSS staff[3]. Further, an environmental scan was conducted in 2022 to scour available resources that provide additional data or population descriptors for Haldimand and Norfolk counties, such as available COVID-19-related reports.

The Professional Practice, Quality Assurance, Planning & Evaluation Team at HNHSS conducted the Community Profile, including the environmental scan. Data sources for the indicators varied and are presented with each of the relevant parameters in the results section. Each indicator was collected at the most locally-relevant level of data available (e.g., Haldimand County, Norfolk County, Haldimand and Norfolk Census Division, and/or Ontario).

Analysis of Community Profile

The Community Profile is primarily a summary of the available measures from relevant data sources and presents minimal additional statistical analyses. Data were collected in raw or aggregate forms and presented as summary measures, such as medians, means, or ranges. Statistically significant local differences and changes over time were investigated, where possible and appropriate.

Community Survey

The CNA 2022 Community Survey was used to collect quantitative data from as many community members as were willing to participate. The survey used primarily closed-ended questions (e.g., yes or no options or select all that apply) to collect responses. The HNHSS CNA 2022 Community Survey was similar to the Community Survey for the CNA 2019, which was adapted from an existing and validated tool1. Changes to the tool were outlined in the CNA 2019[3], and included appropriate language use (i.e. updating terms to be culturally appropriate), rurally relevant questions, and additions to sections focused on the environment and social services. Similar changes were made for the CNA 2022 Community Survey. The survey included sections for demographics, self-identification, preferences and priorities, health and social behaviours, and COVID-19-related experiences (survey available upon request).

The CNA 2022 Community Survey was primarily administered via the online survey tool Survey Monkey Enterprise™. The online survey was distributed via the HNHSS and Haldimand-Norfolk Health Unit (HNHU) social media accounts, email listservs to internal staff, and communications with external partners.

To ensure representation for all eligible residents in Haldimand and Norfolk communities, the CNA 2022 Community Survey was also available in paper form. Paper surveys could be retrieved and submitted at all three HNHSS offices, six Haldimand County libraries, five Norfolk County libraries, and via 11 survey pop-up events at partner agencies, such as pharmacies and recreation centers, across the two counties.

Survey participation was open to individuals ages 12 of older. The survey was open for online or paper submission from June 6, 2022 to August 2, 2022. Participants were able to choose to enter their name in a draw for one of three grocery store gift cards for completing the survey.

Analysis of Community Survey

The CNA 2022 Community Survey was analyzed primarily via descriptive statistical analyses in Survey Monkey Enterprise™ and Microsoft Excel ©. Descriptive statistical analyses included frequencies, rates, proportions, and cross tabulations for stratification of the data by demographic characteristics, such as town of primary residence, age or age category (i.e. under 18 years, 19-29 years, 30-49 years, 50-69 years, and over 70 years), gender, educational attainment, and income level.

Focus Group Discussions and Key Informant Interviews

Qualitative data collected from focus group discussions and key informant interviews provided a more robust understanding of the community experience. Focus groups and interviews were used to incorporate key informant expertise and lived-experiences into the CNA at large.

Sampling for focus group discussions and key informant interviews employed a purposive sampling technique where individuals working at partner health or social services agencies and individuals with various lived-experiences, such as addictions or homelessness, were directly requested to participate. A snowball sampling technique, which allowed participants to identify additional individuals to invite to contribute, was also used to ensure the voices of the community's most vulnerable groups were identified and included in the CNA. Additionally, community members who engaged in the CNA 2022 Community Survey were offered an opportunity to volunteer to participate in an interview. One attempt each was made by phone and by email to reach every individual who volunteered to participate.

Focus group discussions and key informant interviews were conducted using a semi-structured (i.e., conversational), participatory (i.e., engaging) interview strategy[6], as was done in the CNA 2019[3]. In order to maintain a flexible conversation that allowed for exploration or emerging ideas or tangential ideas, interview guides

focused more on the key ideas to be discussed in an interview or focus group discussion, rather than listing structured questions that must be answered in every session. This semi-structured technique is recognized to generate a more robust dataset that allows for the responsiveness to session topics that might highlight new ideas otherwise missed in a structured interview[6].

Notes taken by the lead researcher while conducting the sessions were used to record focus group discussions and interviews, with the explicit consent of the participants. Audio or video recordings were not used and verbatim transcripts were not recorded.

Analysis of Focus Groups and Key Informant Interviews

Detailed session notes were produced during every focus group discussion and interview. Notes were analyzed via thematic analyses, which aims to parse the data down into bite-sized phrases or ideas and determine an underlying structure for the data[7]. First, notes were uploaded into Dedoose v. 9.0.54 © then coded according to a comprehensive data codebook. The codebook included over 300 codes for all ideas or topics that were covered in the discussions and was applied systematically to the entire dataset. The codebook included data-driven (i.e., emergent) and theory-driven (i.e., supplemental code ideas from previous CNAs, such as the HNHSS CNA 2019) codes. Notes were coded line-by-line to assess the ideas, tone, and priorities of statements. Following the coding of the entire dataset, the key ideas were considered and an emergent data structure was proposed. Theming was conducted iteratively with the participation of the CNA Steering Committee and HNHSS leadership to identify the most reflective thematic structure for the entire dataset.

Comparisons to 2019 CNA Data

The CNA 2022 Community Survey tool was developed from the approved and validated tool for the CNA 2019[3]. In doing so, the 2022 dataset had substantial opportunities for comparison across years. Where the same question was asked in the same way, data points from 2019 were matched to data points for 2022. The direction or magnitude of changes were assessed and compared for statistical significance. Statistical significance was assessed, where appropriate and possible, using a standard Chi-square calculator. Statistical significance was defined as a p-value of alpha <0.05[8] (i.e. a standard definition for statistical significance).

The CNA 2022 Focus Group and Interview Guides were also developed from the approved tools used for the CNA 2019. The qualitative data was compared from 2022 to 2019 at the thematic level, identifying key areas of agreement and difference between the two datasets.

Data Validation

Data validation is a crucial part of qualitative and mixed-methods research that allows for the assessment of data interpretation and determination of fit of findings. Data validation can take many forms and works best when more than one method is used simultaneously[9]. For this project, the data were validated using triangulation, member checking, prolonged engagement, and researcher reflexivity[9] (Table 1).

Table 1. Descriptions of the data validation methods used in the HNHSS CNA 2022.

Data Validation Method	Description
Triangulation	the utilization of various components of the dataset in conjunction with each other to evaluate agreement
Member Checking	collaborative interpretation of preliminary findings between the research team and the participants/ steering committee
Prolonged Engagement	assessment of the findings against what is known about the local community
Researcher Reflexivity	critical assessment of the fit of the data and themes

Community Profile Results

Demographics and Self-Identification

- With over 50% of the population in each county living in rural communities, Haldimand and Norfolk counties are defined as rural areas (i.e., <150 persons per square kilometer)10. Haldimand and Norfolk counties have a population density of 40.5 people per square kilometer compared to 15.9 people per square kilometer in Ontario[10].
- According to the 2020 census, 116,872 residents live in Haldimand and Norfolk counties (42.1% in Haldimand and 57.7% in Norfolk)[10], an increase of 6.5% from the previous census in 2016.
- There is a significantly higher proportion of older adults in Norfolk County: 25.9% of the population in Norfolk County is over the age of 65 years, compared to 20.6% in Haldimand County and 18.5% in Ontario[10].
- Haldimand and Norfolk counties have approximately 4,000 international agriculture workers who come to work on local farms each year[11]. This is more workers per capita than any other area in Ontario. The majority of workers come from Mexico and the Caribbean.
- Approximately 5,000 Low-German Speaking Mennonites reside in Haldimand and Norfolk counties, however, some migrate between Mexico and Norfolk[11].
- 3.6% of residents identify as Indigenous in Haldimand and Norfolk counties compared to 2.8% in Ontario[10]. This proportion is reflective of the population living off-reserve.

Social Services

Income and Poverty

- Haldimand County median total household income was $93,000 compared to $82,000 in Norfolk County. Provincially, the median total household income was $91,000[10].
- 7.9% of Haldimand County residents live in low-income households, compared to 10.0% of Norfolk County residents. Provincially, 10.1% of residents live in low-income households[10]. The proportion of residents living in low-income households varies amongst the towns in the two counties, ranging from 5.0% in Caledonia to 14.7% in Dunnville[10].
- In Haldimand and Norfolk counties, there are approximately 1,099 individuals accessing Ontario Works. This includes 1,864 beneficiaries, household members of a recipient. For 2022 (January to September), the average monthly percent of cases exiting to employment was 20.8%, compared to 23.7% in Ontario[11].
- In 2021, the hourly living wage for Haldimand and Norfolk counties was $17.35, which increased by $0.77 from 2019. In 2021, the minimum wage in Ontario was $14.25/hour; however, it has increased to $15.50/hour[12].
- There are eight food banks in Haldimand County and nine in Norfolk County[11].

Employment and Education

- The employment rate for Haldimand and Norfolk counties is 57.6% compared to 59.9% provincially[13].
- Significantly fewer Haldimand and Norfolk residents (77.2%) have completed a high school diploma (Haldimand County=79.1%, Norfolk = 75.9%), compared to Ontario (82.5%) residents[13].
- Over half (54.7%) of Canadian adults in 2021 score in the lowest two skill levels for numeracy, up from 2003 (49.8%)[14].
- 17% of Canadian adults in 2021 scored in the lowest skill level for reading, higher than the average across other Organization for Economic Co-operation and Development (OECD) countries[14].

Housing and Homelessness

- The 2021 Homelessness Enumeration study for Haldimand and Norfolk was conducted on November 17-18, 2021. At that time, the study identified 117 individuals who were experiencing homelessness[11]. The previous study, conducted in 2018, identified 79 individuals experiencing homelessness[11].
- 62% (n=73) of the individuals identified in the 2021 Homelessness Enumeration Study were identified as “hidden homeless,” which means that they do not have a home but have some sort of provisional accommodation, such as staying with family or friends. Another 20% (n=23) were listed as “fully homeless” and 16% (n=19) were in an emergency shelter on the night of the study[11].

Social Networks

- The Haldimand Norfolk Community Safety and Wellbeing Plan[15] identified mental health and addictions, rurality, and poverty and homelessness as three community-based areas of focus for the next number of years.

Safety

- The rate for all incident-based crimes in Norfolk is 3,417 per 100,000 population compared to 2,856 per 100,000 population in Haldimand. The provincial rate is higher at 4,170 per 100,000 population[16].
- Norfolk County had a crime severity index of 43.8 compared to 34.8 in Haldimand County and 56.2 in Ontario[17].

Childcare

- The Early Development Instrument, a tool that measures children's ability to meet age-appropriate development expectations at school entry, demonstrates that 25% of children in Haldimand and Norfolk are vulnerable on at least one domain compared to 30% of Ontario children. Roughly 10% of Haldimand and Norfolk children were identified to have one or more special concerns.
- There are 19 licensed childcare providers (5 in Haldimand and 14 in Norfolk) and 41 licensed sites (20 in Haldimand and 21 in Norfolk) in Haldimand and Norfolk[11].

Public Health and Wellness

General Health and Wellbeing

- 53.1% of Haldimand and Norfolk residents reported that they were physically active at or above the recommended level compared to 57.7% of Ontario residents[18].
- There are similar rates of self-reported adult obesity for Haldimand and Norfolk and Ontario residents (20.5% and 20.3%, respectively)[16].
- There are 63.3 family physicians per 100,000 population in Haldimand and Norfolk counties compared to 115.1 per 100,000 population in Ontario. As well, there are 17.5 specialist physicians per 100,000 population in Haldimand and Norfolk counties compared to 114.1 per 100,000 population in Ontario[19].

Chronic Disease and Injury

- The rate of hospitalizations for all injuries combined is significantly higher for Haldimand and Norfolk counties compared to Ontario (927 compared to 552 per 100,000 population, respectively)[16].
- Haldimand and Norfolk counties have significantly higher rates for emergency department visits (910 per 100,000 population) and hospitalizations (146 per 100,000 population) for motor vehicle collisions compared to Ontario (415 and 41 per 100,000 population, respectively)[16].
- The rate of hospitalizations for cardiovascular disease for Haldimand and Norfolk residents is 820 per 100,000 population compared to 788 per 100,000 population in Ontario[16].
- The hospitalization rate for chronic obstructive pulmonary disease in Haldimand and Norfolk is significantly higher than the rate for Ontario (139 per 100,000 population compared to 110 per 100,000 population)[16].
- The incidence rate of asthma in Haldimand and Norfolk is significantly lower than the rate for Ontario (160 per 100,000 population compared to 223 per 100,000 population)[18].
- Haldimand and Norfolk has previously reported a significantly higher rate of cancer-related mortality than the rate for Ontario (225 per 100,000 population compared to 190 per 100,000 population)[18]. However, due to the COVID-19 pandemic, provincial comparisons of cancer mortality by region are lagging ; data should be interpreted with caution as trends may have shifted over time.

Mental Health

- The intentional injuries hospitalization rate for Haldimand and Norfolk counties (102 per 100,000 population) is significantly higher than for Ontario (78 per 100,000 population)[18].
- In 2021, 23% of Haldimand and Norfolk residents reported that their life is quite or extremely stressful, compared to 22% in Ontario[15].
- In 2021, 75% (n=172) of Community Safety and Wellbeing Plan[15] survey participants reported feeling anxiety related to contracting COVID-19 and 29% (n=67) reported feeling anxiety about loss of income due to COVID-19.
- Also in 2021, 79% (n=186) of Community Safety and Wellbeing Plan[15] survey participants reported negative mental health impacts due to COVID-19 and 73% (n=171) reported some level of discord in their home due to COVID-19.
- As reported in the Community Safety and Wellbeing Plan15, the Coalition of Ontario Psychiatrists[20] indicated that Ontario is short 200 psychiatrists and the number of psychiatrists per population will decrease by 15% by 2030. As a stark contrast, the average annual number of outpatients seen by psychiatrists in Ontario increased by almost 20% between 2003 and 2013.

Addictions and Substance Use

- For Haldimand and Norfolk residents, the self-reported rate of exceeding the Low-Risk Drinking Guidelines is 52% compared to 44% for Ontario[16].
- There were 67.9 cases per 100,000 population of opioid-related emergency department visits (n=76) in Haldimand and Norfolk counties, compared to 63.4 cases per 100,000 population in Ontario[14].

Maternal and Child Health

- In 2020, approximately 25% of mothers in Haldimand and Norfolk counties were exclusively breastfeeding at 6 months. 66% of mothers were feeding their babies breastmilk in combination with other liquids and/or solids[11].
- 92.1% of mothers in Haldimand and Norfolk counties intend to breastfeed compared to 94.1% provincially[21].
- A significantly higher percentage of mothers smoke during pregnancy in Haldimand and Norfolk counties (7.8%) compared to Ontario (5.6%)[21].
- A significantly higher percentage of mothers in Haldimand and Norfolk counties use folic acid prior to and during pregnancy (37.8%) compared to Ontario (34%)[21].
- The average age of mothers at birth is significantly lower in Haldimand and Norfolk counties (29.4 years) compared to Ontario (31.3 years)[21].

Infectious and Vector-Borne Diseases, including COVID-19

- Haldimand and Norfolk Counties had a total of 9,328 reported cases of COVID-19 to date at the end of data collection, compared to 1,362,341 reported cases in Ontario (up to August 3, 2022[11]). By the end of 2022, the Health Unit had managed 6,194 cases from January 1 to December 31.
- The Health Unit managed 345 COVID-19 outbreaks from January 1, 2020 to December 31, 2022. In the same time, the Health Unit was responsible for managing many COVID-19 suspect outbreaks that did not meet outbreak definition. In 2022 alone, the Health Unit managed 126 confirmed COVID-19 outbreaks.
- The Health Unit managed 14 non-COVID-19 outbreaks in 2022. Outbreaks were caused by Respiratory Syncytial Virus (RSV), Influenza A, Parainfluenza, Norovirus, and Rhinovirus.
- The respiratory virus season that immediately preceded the pandemic (i.e. fall 2019 to winter 2020) included 90 laboratory-confirmed Influenza cases11. In 2022, there were 258 laboratory confirmed Influenza cases.
- The Health Unit is responsible for case management of many infectious diseases, known as Diseases of Public Health Significance. The most commonly reported infectious disease cases in the area in 2022 are presented in Table 2.

Table 2. The ten most commonly reported diseases of public health significance in Haldimand and Norfolk counties in 2022, excluding COVID-19.

Disease Name	Number of Cases Reported to the Haldimand Norfolk Health Unit in 2022
Influenza	258
Chlamydia	186
Lyme Disease	27
Gonorrhea (all types)	26
Pertussis	23
Salmonellosis	19
Campylobacter Enteritis	18
Hepatitis C	16
Group A Streptococcal Disease	15
Giardiasis	11
Total Infectious Disease Cases (all types, includes many not listed above)	**663**

- In 2020, the rate of Lyme disease in Haldimand and Norfolk counties was 5 per 100,000 population compared to 5.7 in Ontario. A total of 27 Lyme cases were reported to the Health Unit in 2022. Overall, since 2015, the number of cases has slowly increased, with 13 cases reported in 2019[23].
- In 2019, the rate of West Nile virus in Haldimand and Norfolk counties was 0.8 cases per 100,000 population compared to 0.2 cases per 100,000 population in Ontario[23].
- 217,693 COVID-19 vaccine doses had been administered to date in Haldimand and Norfolk counties compared to 34,344,783 in Ontario (up to August 3, 2022[11]).
- 82.1% of the Haldimand and Norfolk residents aged 5 years and older had received at least one dose of the COVID-19 vaccine at the end of the data collection period (August 3, 2022[11]).
- Immunization rates among 17-year-olds are presented in Table 3 for quadrivalent meningococcal conjugate (MCV4), human papillomavirus (HPV), and hepatitis B (HB) for Haldimand and Norfolk counties and Ontario, for the 2020-21 school year[22]. Vaccine coverage rates for students in Haldimand and Norfolk is below Ontario averages for most Immunization of School Pupils Act (ISPA) and publicly-funded optional vaccine antigens.

Table 3. Immunization rates among 17-year-olds in Haldimand-Norfolk and Ontario during the 2020-21 school year for the quadrivalent meningococcal conjugate (MCV4), human papillomavirus (HPV), and hepatitis B (HB) antigens[22].

	MCV4: UTD (%)	HPV: Series initiation (%)	HPV: UTD (%)	HB: Series initiation (%)	HB: UTD (%)
Haldimand-Norfolk	86.7	7.6	56.2	7.3	79.1
Ontario	93.8	8.9	63.4	9.2	77.7

Data Note: UTD= up to date

Environment and Health

- Climate change is already negatively affecting the health of Canadians and these impacts will increase as warming and climate uncertainty continues[24]. Impacts will vary across social determinants of health and may increase health inequities in Canada[24].
- In Haldimand and Norfolk, local climate change events, such as flooding in 2019, are already affecting health, safety, and the economy[25].
- In December 2020, Norfolk County Council unanimously voted to approve a local climate change adaptation plan, which includes the Health and Social Services Division[25].
- All cause emergency room visits increase significantly in rural communities in Southern Ontario during extreme heat periods, commonly known as heat waves[26].

Community Survey Results

Reading this section of the report:
The following results include the results of the Community Survey component of the 2022 CNA. To provide context to how community characteristics have changed, "2019=" represents the proportion of survey respondents in 2019 who answered the same question the same way. If an asterisk (i.e. *) follows the data for 2019, there was a significant difference between the findings from 2022 and from 2019. In some cases, the text does not refer to 2019 data. If 2019 is not mentioned, either the question was not asked or was changed from the original survey in 2019. Questions that were changed from 2019 to 2022 are not compared to avoid errors in interpretation of the data.

Survey Respondents

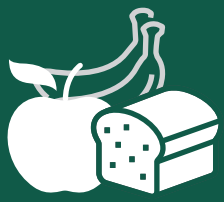
- A total of 2,094 individuals responded to the HNHSS CNA Community Survey in 2022.
- Following the exclusion of incomplete responses, 1,404 survey responses were included in the final analyses. This represents nearly 1% of all residents living in Haldimand and Norfolk counties. This is a significant increase in responses compared to 2019, where 427 useable responses were received. Respondents were able to skip questions if they chose to do so; therefore, the count of responses for each question is presented throughout the results.
- Despite the length of the survey, which took approximately 20-25 minutes to complete, the survey had a completion rate of 67% (2019= <30%).

Demographics and Respondent Representativeness

- Survey respondents were representative of Haldimand and Norfolk county residents based on community of residence, language spoken at home, immigration status, and employment status; however, survey respondents over-represented adults compared to youth, females compared to males and gender non-conforming individuals, higher educational attainment compared to individuals with less than a college diploma, and higher income brackets compared to individuals who lived in households that earned less than $50,000 per year[ii].

Self-identification

- 18.5% (n=312; 2019=23%*) of participants identified that they had a child aged 6-12 years, 16.1% (n=277; 2019=25%*) of participants identified they had a child aged 0-5 years, and 12.8% (n=217; 2019= N/A) of participants identified that they had a child aged 13-17 years. 4.4% (n=75; 2019= N/A) of participants identified as a caregiver for a child or children with a disability.
- 8.4% (n=143; 2019=14%*) of participants identified as a single parent who solely supports their household.
- 15.7% (n=267) of participants identified as a caregiver for an adult, including caring for adult children, parents, or an adult with a disability.
- 1.2% (n=20; 2019= 2%) of participants identified as currently pregnant.
- 6.3% (n=107; 2019= not comparable due to language changes) of participants identified as a person of colour; 6.4% (n=108; 2019= 4%) of participants identified as a visible religious minority ; 6.8% (n=115; 2019= 2%*) of participants identified as an Indigenous person; 6.5% (n=110; 2019= 3%*) of participants identified as LGBTQS2+ or gender non-conforming; and 5.3% (n=89) of participants identified as a seasonal agricultural worker.
- 10.4% (n=176; 2019= 25%*) of participants identified as a person with a disability.



Social Services

Employment and Education

- 68.9% (n=983) of participants agreed or strongly agreed that Haldimand and Norfolk needs more employment services.
- 10.8% (n=181; 2019=11%) of participants stated they are qualified for a better job than they can get.
- 8.2% (n=138; 2019=10%) of participants stated they have been unemployed, not by choice, in the past 12 months.
- 6.2% (n=104; 2019=3%*) of participants identified their job as being dangerous.
- 3.9% (n=66; 2019=8%*) of participants struggled to find transportation for work.
- 3.5% (n=59; 2019=3%) of participants identified that they have trouble reading.

Income and Poverty

- 66.5% (n=949) of participants agreed or strongly agreed that Haldimand and Norfolk needs more income support services.

Expenses

- 25.6% (n=431) of participants stated that they have little to no money left for extras after they pay for essentials such as food, housing, and utilities.
- 8.5% (n=143; 2019=15%*) of participants identified having used Ontario Works (OW) or Ontario Disability Support Program (ODSP) in the past 12 months.
- 5.1% (n=86; 2019=13%*) of participants self-identified as living in a low-income household (i.e., below the poverty line: $19,930 for a single adult or $28,185 for a family, per year, after tax).

Access to Food

- 48.8% (n=692) of participants reported growing some of their own food and 19.9% (n=283) reported raising their own animals for consumption.
- 17.3% (n=252) of participants disagreed or strongly disagreed that they could access healthy foods for their family.
- 14.1% (n=204) of participants stated they worried they did not have enough money to afford food in the past month.
- 7.9% (n=133; 2019= 16%*) of participants stated they had used a food bank in the last 12 months.

Housing and Homelessness

- 81.4% (n=1,161; 2019=72%*) of participants agreed or strongly agreed that Haldimand and Norfolk needs more affordable housing.
- 25.4% (n=363) of participants disagreed or strongly disagreed that they could access affordable housing for themselves and their family. Further, 18.3% (n=262) of participants disagreed or strongly disagreed that they could access safe housing for themselves and their family.
- When asked what supports would help individuals find and stay in their housing, participants most commonly chose financial help to afford utilities (24.3%, n=339; 2019=18%*), financial help to afford rent (23.6%, n=330; 2019=20%), and housing with accessibility features for persons with disabilities (17.8%, n=245; 2019=5%*).
- 5.9% (n=99, 2019=5%) of participants stated they had used affordable or social housing in the past 12 months and 4.7% (n=79, 2019=5%) identified that they have needed affordable or social housing and been waitlisted in the past 12 months.
- 5.8% (n=98) of participants identified they had lived in a shelter or on the street in the past 12 months and 8.7% (n=146, 2019=5%*) of participants identified they had lived in the home of a friend or family member in the past 12 months because they had nowhere else to go.

Social Networks

- Participants most frequently described their current overall social support network as good (37.7%, n=536), compared to very good (24.5%, n=349) or excellent (15.7%, n=224; combined= 40.3%, n=573; 2019 combined=58%*) or fair or poor (21.3%, n=303), which was significantly poorer overall social support networks than participants reported in 2019. When asked how their overall social health had changed over the course of the pandemic, 28.1% (n=401) of participants reported their social system had worsened and 9.4% (n=134) reported their social system had improved.
- 81.5% (n=1,223, 2019=72%*) of participants agreed or strongly agreed that Haldimand and Norfolk is a good place to raise a family.
- 72.8% (n=1,092, 2019=79%*) of participants agreed or strongly agreed that Haldimand and Norfolk is a good place to grow old.
- When asked who their primarily social supports were, most participants chose their family (76.6%, n=1,094; 2019=73%), friends (65.7%, n=939; 2019=81%*), or doctor (36.6%, n=523; 2019=52%*). There was a significant decrease in the proportion of participants who reported seeing their friends or doctor as a primarily social support, compared to 2019.
- 9.5% (n=161; 2019=12%) of participants stated that they felt they had little or no social support network and 7.6% (n=129, 2019=12%*) of participants stated that they felt socially isolated where they live.

Safety

- 79.5% (n=1,193, 2019=78%) of participants agreed or strongly agreed that Haldimand and Norfolk is a safe place to live, while 15.6% (n=234) disagreed or strongly disagreed.
- 76.9% (n=1,154, 2019=78%) of participants agreed or strongly agreed that Haldimand and Norfolk is a safe place to be their true self, while 18.3% (n=275) disagreed or strongly disagreed. However, when considered against key self-identification characteristics, individuals who identified as 19-29 years, 30-49 years, LGBTQ2S+, Black or a Person of Colour, Indigenous, having an unhealthy body weight, or having a disability were significantly less likely to agree or strongly agree that Haldimand and Norfolk is a safe place to be their true self ($p<0.05$ each).
- 12.0% (n=203; 2019=22%*) of participants self-identified as living in a sexually or physically abusive situation.

Childcare

- 71.6% (n=1,021, 2019=71%) of participants agreed or strongly agreed that Haldimand and Norfolk needs more childcare services.
- 6.9% (n=116; 2019=8%) of all participants stated they struggle to find childcare for work or school. However, 17.5% of participants who reported having a child(ren) under 12 years old reported struggling to find childcare for work or school

Social Services and Service Experiences

- 64.9% (n=974) of participants agree or strongly agree that they know where to find the social services they need.
- When asked what social services are needed to improve the social health of themselves and their family, participants most commonly chose more accessible mental health services (46.3%, n=714; 2019=48%), more recreational opportunities (40.6%, n=604; 2019=52%*), and more housing supports (34.7%, n=516; 2019=48%*).
- When asked what social services are needed to improve the physical health of themselves and their family, participants most commonly chose access to education or more schooling (22.6%, n=319; 2019=31%*), affordable housing services (21.7%, n=305; 2019=34%*), and public transportation services (18.7%, n=263).
- When asked what social services education they would most like to receive, participants most commonly chose available children's services (24.8%, n=343.7; 2019=30%*), access to education (22.4%, n=310), and employment skills training (22.2%, n=307).
- When asked where they get most of their social services information currently, most respondents chose their doctor or healthcare provider (41.7%, n=620; 2019=46%), family or friends (38.0%, n=565; 2019=41%), and websites (29.4%, n=436; 2019=43%*).
- When asked where participants usually go when in crisis, participants most commonly chose their family's home (35.6%, n=507; 2019=49%*), friend's home (31.0%, n=442; 2019=44%*), or doctor's office (25.96%, n=370; 2019=29%). There was a significant decrease in the proportion of participants who reported attending a family or friend's home in crisis, compared to 2019.
- When asked what barriers they face to access social services, participants most commonly chose that they were unsure where to go (22.1%, n=310; 2019=19%), cost of services (21.3%, n=299;2019=23%), or long waitlists (21.2%, n=298; 2019=29%*).

Public Health and Wellness

General Health and Wellbeing

- Participants most frequently described their current overall health as good (47.2%, n=682; 2019=33%*), compared to very good or excellent (combined= 28.3%, n=409; 2019 combined= 43%*) or fair or poor (combined= 23.2%, n=335; 2019 combined=22%), which was significantly poorer overall health than participants reported in 2019. When asked how their overall health had changed over the course of the pandemic, 36.0% of participants reported their health had worsened while 10.6% reported their health had improved.

- When asked what services are needed to improve the health of themselves and their family, participants most commonly chose more primary care supports (50.1%, n=752), more acute care supports (e.g., walk-in clinics; 42.3%, n=634), and more mental health supports (42.1%, n=632; 2019=50%*).
- When asked what public health services are needed to improve the health of themselves and their family, participants most commonly chose more exercise or physical activity opportunities (39.2%, n=584; 2019=47%*), more mental health supports (33.7%, n=499; 2019=54%*), and dental services for seniors (25.4%, n=377; 2019=20%*).
- When asked what public health education they would most like to receive, participants most commonly chose exercise or physical activity (30.5%, n=449; 2019=37%*), mental health supports (28.8%, n=423), and cancer prevention (20.9%, n=308; 2019=20%).
- When asked where they get most of their health information currently, most respondents chose their doctor or healthcare provider (62.6%, n=936; 2019=80%*), websites (37.9%, n=567; 2019=52%*), and family or friends (27.0%, n=404; 2019=30%*). Less commonly listed responses that increased significantly since 2019 include faith community (9.8%, n=147; 2019=5%*), media (19.6%, n=293; 2019=14%*), and workplace (8.4%, n=126; 2019=4%), amongst others.

Chronic Disease and Injury

- 70.6% (n=1,025, 71%) of participants agreed or strongly agreed that Haldimand and Norfolk needs more access to active transportation, such as bike lanes. 55.2% (n=783) of participants considered their community walkable (e.g., well-lit, sidewalks).
- 36.4% (n=528; 2019=45%*) of participants stated they exercised for at least 30 minutes at least three times per week, down significantly from 2019. 28.7% (n=417; 2019=35%*) of participants stated they had dieted or attempted to lose weight in the past month.
- 33.8% (n=489) of participants reported their physical activity levels decreased during the pandemic.
- Some risky behaviours, such as not wearing a helmet when riding a bike (79.8%, n=1,159; 2019=75%*) and using cannabis before or while driving (2.0%, n=29; 2019=0*), increased significantly since 2019

Food and Nutrition

- 23.4% (n=339) of participants reported their fruit and vegetable consumption decreased during the pandemic.
- 22.5% (n=380) of participants self-identified as having an unhealthy body weight.
- 12.3% (n=174) of participants wanted more education about disordered eating to support mental health for themselves or their families.
- 10.6% (n=154) of participants disagreed or strongly disagreed that they had basic skills to prepare healthy meals.
- 9.5% (n=160) of participants self-identified as having a “fat-phobia” or other major body image concerns.

Mental Health

- 80.3% (n=1,166; 2019=85%*) of participants agreed or strongly agreed that Haldimand and Norfolk needs more access to mental health services and counselling.
- 31.0% (n= 524; 2019=45%*) of participants self-identified as experiencing depression and/or anxiety and 6.9% (n=117; 2019=18%) of participants self-identified as having mental health difficulties other than depression or anxiety.
- When asked what mental health services are needed to keep themselves and their family safe, participants most commonly chose general mental health supports (46.4%, n=657; 2019=54%*), mental health supports for children and youth (28.1%, n=398), and support circles (15.6%, n=221; 2019=31%*).
- When asked what mental health education they would most like to receive, participants most commonly chose stress management and coping skills (39.2%, n=561; 2019=47%*), mental health and/or depression resources (38.2%, n=547; 2019=44%*), and available community resources (33.4%, n=478; 2019=26%*).

Less commonly listed but significantly increased from 2019 responses included the low-risk drinking guidelines (9.0%, n=128; 2019=5%) and safe consumption sites (8.3%, n=119; 2019=2%), demonstrating a shift toward substance use focus.

Substance Use and Addictions

- 11.8% (n=200) of participants identified that another adult and 4.9% (n=82) of participants identified that a teen in their house has a substance use disorder.

Treatment Resources

- 69.7% (n=1,012) of participants agreed or strongly agreed that Haldimand and Norfolk needs more access to supports for individuals who misuse alcohol and drugs.
- 66.8% (n=970) of participants agreed or strongly agreed that Haldimand and Norfolk needs more access to supports for individuals who want to quit smoking.

Alcohol

- 25.3% (n=338; 2019= 36%*) of participants stated that they were aware of the low-risk drinking guidelines for men and women.
- 17.2% (n=249) of participants reported their alcohol use increased during the pandemic and similarly, 17.0% (n=246) of participants reported their alcohol use decreased during the pandemic.
- 15.9% (n=231; 2019=9%*) of participants stated they consumed one or more alcoholic drinks per day, up significantly from 2019.
- 5.5% (n=93; 2019=3%*) of participants self-identified as having an alcohol use disorder, up significantly from 2019.

Cannabis and Tobacco

- 12.3% (n=208; 2019= 26%*) of participants self-identified as cannabis users.
- 11.9% (n=201; 2019=19%*) of participants self-identified as tobacco users.
- 7.4% (n=108) of participants reported their cannabis use increased during the pandemic while 10.2% (n=148) of participants reported their cannabis use decreased during the pandemic.
- 6.9% (n=100) of participants reported their tobacco use increased during the pandemic while 12.5% (n=181) of participants reported their tobacco use decreased during the pandemic.

Other Drugs

- 3.9% (n=66; 2019=3%) of participants self-identified as a person who uses drugs currently. 7.7% (n=130) of participants self-identified as a person who has used drugs in the last 12 months.
- 3.8% (n=55) of participants reported their drug use increased during the pandemic while 9.4% (n=135) of participants reported their drug use decreased during the pandemic.

Maternal and Child Health

- 13.2% (n=196; 2019=7%*) of participants wanted more family planning or sexual health support, such as birth control, condoms, and pregnancy planning, up significantly from 2019.
- 12.0% (n=173) of participants wanted more post-natal provisions to support the mental health of families with new babies.
- 9.0% (n=133; 2019=6%*) of participants wanted more information about breastfeeding.
- 5.9% (n=87; 2019=2%*) of participants wanted more falls prevention information for children.

Infectious and Vector-Borne Diseases

- 64.3% (n=913; 2019=75%*) of participants reported they check for ticks after outdoor activities, down significantly from 2019.
- 54.6% (n=793) of participants stated they were up-to-date on their recommended vaccinations (i.e., non-COVID-vaccines).
- 9.4% (n=139; 2019=4%*) of participants wanted more infectious disease information, up significantly from 2019.
- 8.6% (n=128; 2019=12%*) of participants wanted more vector-borne disease information, down significantly from 2019.

Environment and Health

- 84.4% (n=1,198; 2019=98%*) of participants considered a safe environment important for their health, down significantly from 2019.
- 76.4% (n=1,084) of participants reported having air conditioning at home.
- 61.3% (n=869) of participants felt that climate change was affecting their local environment and 44.7% (n=634) felt that climate change was affecting their family's health.
- When asked about their concerns for local weather and climate effects, 60.4% (n=857) of participants were concerned about wind and storms, 52.8% (n=749) of participants were concerned about extreme heat locally, and 36.5% (n=518) of participants were concerned about flooding.
- When asked about their concerns for local environmental issues, 51.1% (n=725) of participants were concerned about the risk of invasive species locally and 50.2% (n=712) of participants were concerned about food supply locally.
- 48.5% (n=689) of participants wanted more information about the impacts of climate change.
- 44.7% (n=634) of participants felt unprepared for a climate emergency locally, compared to 37.0% (n=525) of participants who felt prepared for a climate emergency locally.
- 16.3% (n=231) of participants reported having sufficient access to public transportation.

Health Service Experiences

- 68.7% (n=1,031; 2019=76%*) of participants agree of strongly agree that they know where to find the health services they need.
- When asked which healthcare providers participants see annually, participants most commonly chose their doctor (65.2%, n=945; 2019=97%*), dentist (56.8%, n=824; 2019=62%*), optometrist (37.0%, n=971; 2019=51%*), and pharmacist (36.6%, n=531;

2019=39%). There was a significant decrease in the proportion of participants who reported seeing their doctor, dentist, or optometrist annually, compared to 2019.

- 21% (n=300) of participants reported they were seeking additional healthcare providers who they have been unable to access. Participants most commonly stated they were seeking a doctor/ primary care provider (30%, n=9), walk-in or after-hours clinic (13%, n=4), or a physiotherapist (10%, n=3).
- When asked where participants usually go when sick, participants most commonly chose their doctor (66.1%, n=958; 2019=86%*), the hospital emergency room (41.3%, n=599; 2019=51%*), or a walk-in clinic (27.7%, n=402; 2019=42%*). Less common answers that were selected significantly more often in 2022 than 2019 included community health centres (16%, n=232; 2019=3%) and family health teams (16.6%, n=240; 2019=7%).
- When asked what barriers they face to access healthcare services, participants most commonly chose hours that do not fit their schedule (20.9%, n=297; 2019=29%*), cost of services (19.9%, n=282; 2019=26%*), and they were unsure where to go (13.6%, n=193; 2019=6%*). Also, there was a significant increase in the proportion of participants who reported cultural or religious beliefs were a barrier to accessing services (6.27%, n=89; 2019=0%*).

COVID-19-Related Experiences

- 56.9% (n=826) of participants stated they were up-to-date on their COVID-19 vaccinations.
- 36.5% (n=611) of participants stated that the pandemic negatively impacted their mental health and 26.8% (n=443) of participants stated that the pandemic negatively impacted their child(ren).
- 27.3% (n=457) of participants stated that the pandemic negatively impacted their relationships with family or romantic partners and 29.7% (n=497) of participants stated that the pandemic negatively impacted their relationships with friends or colleagues.
- 23.5% (n=328) of participants reported they tested positive on a Rapid Antigen Test (RAT) and 15.5% (n=216) of participants reported they tested positive on a Polymerase Chain Reaction (PCR) Test for COVID-19.
- 23.4% (n=391) of participants stated that the pandemic negatively impacted them financially.
- 23.3% (n=387) of participants stated that the past two years were traumatic for them.
- 20.2% (n=338) of participants identified as a frontline or healthcare worker and 16.6% (n=278) identified as a non-healthcare essential worker.
- 14.5% (n=243) of participants stated that the pandemic did not really impact them.

- 13.0% (n=181) of participants reported that the pandemic impacted their access to medical procedures, such as delayed surgeries (44% of those who provided a response, n=7).
- 5.4% (n=90) of participants stated they lost their job or business due to the pandemic. 19.1% (n=266) of participants stated that the pandemic caused a loss of employment income for their family.

Health and Social Services Collective Programming

- 74.5% (n=1,034; 2019=75%) of participants reported they were only somewhat or not at all familiar with programming offered by HNHSS, compared to 20.0% (n=278; 2019=19%) who reported they were very familiar with programming offered by HNHSS.
- When assessed by demographics, familiarity with programming offered by HNHSS was typically lower for individuals who were over the age of 50 years compared to less than 50 years of age, had lower educational attainment compared to those with a college diploma or higher, lived on Indigenous Reserve lands or in more rural towns compared to more suburban communities, who identified as gender non-conforming compared to males and females, or who had lower or higher household incomes compared to families making $30,000-$80,000 per year.
- Participants reported that the public health programming they used most in the last 12 months was attending a COVID-19 vaccination clinic (52.2%, n=730), speaking to staff for COVID-19 advice (25.9%, n=362), and speaking to staff for COVID-19 case investigations (22.5%, n=314). 10.4% (n=146; 2019=33%*) of participants reported not using public health programming in the past 12 months.
- Participants reported that the social services programming they used most in the last 12 months was visiting the HNHSS website (28.6%, n=390; 2019=15%*), following HNHSS social media accounts (22.1%, n=301; 2019=12%*), and reading brochures (20.5%, n=279; 2019=34%*). 28.8% (n=391; 2019=49%*) of participants reported not using social services programming in the past 12 months.
- 57.0% (n=786) of participants agreed or strongly agreed that HNHSS showed they care in their interactions in the past 12 months, compared to 10.8% (n=149) who disagreed or strongly disagreed.
- 47.4% (n=654) of participants agreed or strongly agreed that it was easy to seek assistance from HNHSS in the past 12 months, compared to 19.6% (n=270) who disagreed or strongly disagreed.
- When asked how they would like to receive information from HNHSS, participants most commonly chose email (57.6%, n=802; 2019=60%), website (54.3%, n=756; 2019=66%*), and social media (50.7%, n=706; 56%*). Also, there was a significant decrease in the proportion of participants who chose to pick up print materials or receive mailed print materials from HNHSS, compared to 2019.

Focus Group and Interview Themes

Participants

- The qualitative portion of the CNA 2022 included 80 key informant interviews and nine focus groups with 44 participants, for a total of 124 participants (2019= 124 participants).
- Key informant and focus group participants included HNHSS staff, partner agency staff from across Haldimand and Norfolk counties, and individuals with various lived-experiences.

Emerging Themes

- Main ideas emerged from the dataset and can be displayed visually, according to their relative frequency (Figure 1).

Figure 1. Word cloud of relative frequency distributions for codes applied to qualitative data during coding and thematic analysis.

- Two frames and five themes emerged from the dataset (Figure 2). Frames were overarching ideas that each theme in the final structure was related to and that support the interpretation of each theme as part of the whole. The five themes represent the most prominently discussed ideas in the interview and focus group discussions.

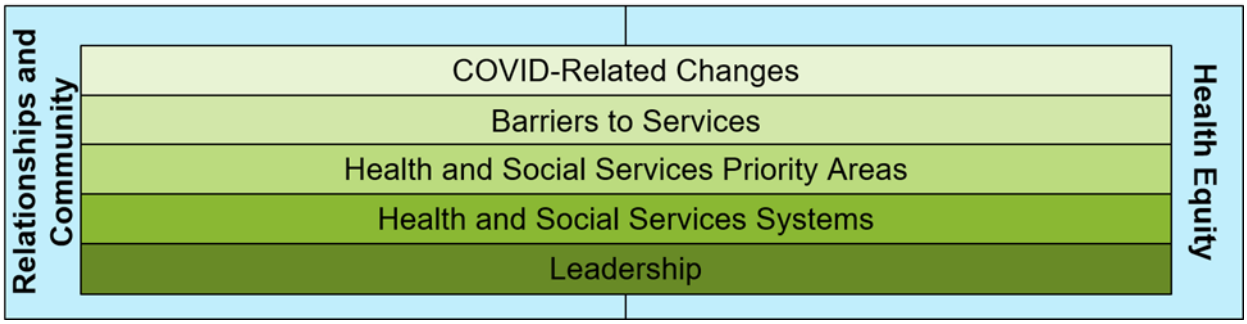


Figure 2. Emergent thematic structure of qualitative data for the Community Needs Assessment (CNA) 2022. The blue boxes represent frames, which are used to understand the five key themes. The five themes are presented in green bars.

- Each theme was broken down with descriptors, which are key words that described the five emergent themes (Figure 3).

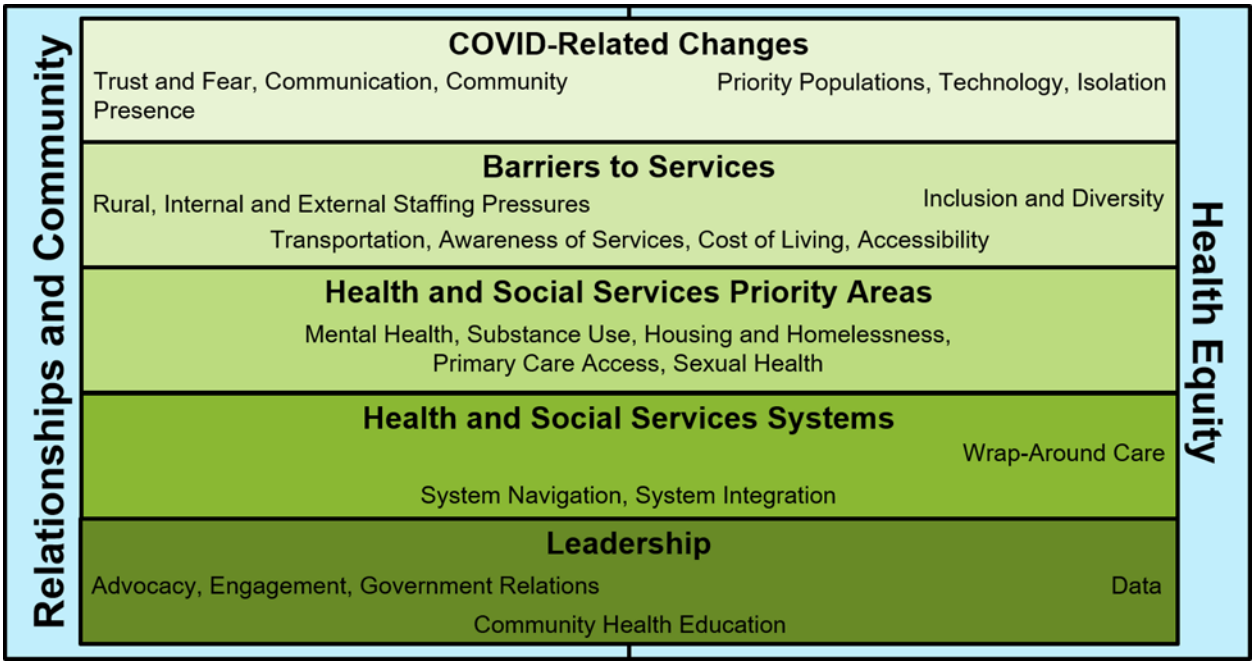


Figure 3. Descriptions of the emergent thematic structure of qualitative data for the Community Needs Assessment (CNA) 2022. The smaller text in each theme (i.e., green bars) ties each overarching theme to the two main frames (i.e., blue boxes). The descriptors positioned to the left are more closely related to the frame for relationships and community while descriptors positions to the right are more closely related to the frame for health equity. Descriptors positioned in the center were equally relevant to both frames.






COVID-Related Changes

Trust and Fear

- Participants expressed that community trust in HNHSS was damaged during the pandemic. Further, some participants described fear of the organization related to the pandemic.
- Comments around trust and fear were commonly discussed alongside COVID-19 "lockdowns," restrictions, and/or vaccines. In part, HNHSS's role in enforcing or implementing provincial guidelines contributed to these ideas.
- Comments related to trust and fear were often fraught with emotion and included some of the strongest and most frequently stated ideas.

Communication

- Some participants called for HNHSS rebranding post-pandemic. Ideas included suggestions to highlight the role of public health in the community, direct attention to non-COVID-19-related activities, and to consider stylistic changes that may help HNHSS reach new and younger audiences.
- Frequently, partners and internal staff expressed the need for strengthened communications between agencies. Participants outlined the challenges around COVID-19 communication. Some challenges noted included delays in communication of decisions and a lack of awareness of other agencies' roles in COVID-19 assessment, immunization, and so on.

Community Presence

- Participants commonly wanted to see HNHSS offering in-person service and being more available to the community at events and stakeholder meetings.
- Many participants relayed the desire to be present in the community in relation to the way things were before the pandemic, including having the supports of staff in offices, staff at community-based meetings, and the ability to attend events such as county fairs and early learning centers.

Priority Populations

- Participants outlined the ways that COVID-19 exacerbated health inequity amongst the most vulnerable individuals in our community.
- When discussing the impacts of COVID-19 on priority populations, many participants outlined the ways that the gap had widened between higher-income and lower-income

individuals and families. Some of the most discussed challenges faced were related to precarious work that required individuals to go to work in essential roles, experiences for individuals and families with low incomes, and challenges faced by individuals experiencing homelessness when shelters and food programs were generally limited.

- Separately, there were also a number of participants who outlined that some priority populations experienced intense stigmatization locally for not participating in certain COVID-19 measures or vaccination programs based on their cultural or religious beliefs.

Technology

- Technology use increased and became a necessity for health and social services access during the COVID-19 Pandemic.
- Participants highlighted both strengths and weaknesses of the use of technology, noting that technology often supported ongoing health and social services provisions during lockdown periods at the beginning of the pandemic and that use of this potential solution relied on individuals to have access and competencies with the technology and internet.
- Technology was also mentioned in context of the descriptor for community presence, suggesting that technology was sometimes becoming too comfortable and should not be used as a substitute for in-person service offerings, when safe to do so.

Isolation

- Participants described that lockdowns and other COVID-19-related measures increased challenges related to feeling isolated. Many participants also shared that this isolation often increased challenges with mental health for themselves or their loved ones.

Barriers to Service

Rural

- As in 2019[3], the rural nature of Haldimand and Norfolk was a commonly noted barrier to accessing services locally.
- Rurality often referred to ideas of the two county service area's vast geographical spread, the distance required to access services, and the resultant lack of specialized services due to the large area and relatively small population.

Internal and External Staffing Pressures

- Health Human Resources (sometimes referred to as HHR) challenges for HNHSS and other health and social services providers were common.
- Staffing pressures further added to key informants commenting on workload-related challenges, caregiver burnout, and an overstretched healthcare system.

Inclusion and Diversity

- During interviews and focus group discussions, many participants discussed ideas around inclusion, which referred to a broad list of identifiable and invisible characteristics including race, gender, sexual orientation, language, or religion.
- Moreover, many participants suggested there was an opportunity for HNHSS to lead change for creating safe and inclusive environments in Haldimand and Norfolk and provide teaching or training for other agencies and community partners.

Transportation

- Transportation was the most commonly noted barrier to accessing health and social services, including limited or no public transit, cost of vehicle/gas/maintenance, and was closely tied to rurality.

Awareness of Services

- A lack of awareness of services was one of the most commonly noted barriers to service.
- Participants sometimes described how they or clients were unsure of where to look for resources or that they were unclear on what services public health or social services provided.

Cost of Living

- Inflation, housing prices, and food cost concerns were top of mind for many participants. Individuals often shared challenges they had experienced recently with paying for essentials, such as utilities.
- When discussing the cost of living, many HNHSS and partner agency staff noted the implications for cost-of-service provisions when community members cannot afford to meet their most basic needs. Specifically, participants suggested that avenues for individuals to participate in programming for free or reduced fees would help many clients.

Accessibility

- Accessibility referred to ideas related to physical location of services as well as technological access, such as internet or phone for virtual appointments, related to COVID-19. Some participants described the exacerbation of health inequities in context of accessibility as well.

Health and Social Services Priority Areas

Mental Health

- Mental health was discussed independently and in context of virtually all other health and social services program areas.
- Mental health topics included overall wellness, individual resiliency, impacts of COVID-19, and access to necessary resources, such as counselling and psychiatric services, among others.

Substance Use

- Substance use was commonly noted as a high priority and a major concern for the

community, particularly around addictions and opioid or "harder" drug use.

- Substance use concerns often included mental health challenges, access to services such as detoxification beds and methadone clinics, community safety, and prominence of drug use and overdoses in "downtowns."

Housing and Homelessness

- Housing was often described as an urgent and ongoing crisis, particularly with regards to homelessness and access to affordable and available housing, or options for subsidized and supportive housing.
- When discussing housing and homelessness challenges, provincial housing issues and the regional scope of the housing crisis were frequently mentioned.

Primary Care Access

- A commonly mentioned challenge during interviews and focus group discussions related to obtaining a primary care provider locally.
- Access to primary care was often related to the number of physicians, options for alternate levels of care such as walk-in clinics and urgent care centers in Haldimand and Norfolk, and wait times for appointments with primary care providers, due to these care providers carrying very large patient rosters.

Sexual Health

- Lack of choice in providers of sexual health services and the locations of offices were mentioned in some interviews and focus group discussions. Comments were often related to health equity, stigma for seeking care, ability to provide "wrap-around care", and rurality.

Health and Social Services Systems

System Navigation

- One of the most commonly mentioned roles or responsibilities of HNHSS noted by participants was support with knowing what services exist, locating services, and accessing them.
- System navigation typically referred to both support for clients and support for other agencies to refer their clients to required services.
- Discussions about system navigation was also common during conversations related to Ontario Works clients.
- Several ideas for solutions came from participants who saw system navigation as a crucial priority for HNHSS. Examples included a web-based portal, a 4-1-1 number, and lists of resources for various topics.

Wrap-Around Care

- Wrap-around care referred to being able to provide fulsome care to members of priority populations who came to HNHSS for support.
- Participants desired to provide a warm-handover, where they could introduce a client to another program or service provider, for clients who come in needing a variety of HNHSS services, and more ability to walk alongside clients who are facing multiple complex and related vulnerabilities.

System Integration

- Participants from both HNHSS and external agencies noted the value of bringing health and social services closer together.
- Suggestions included options for data sharing and warm handovers to support clients. This also included ideas related to working as a team and institutional networks.
- Further, many partner organizations commented on the desire to bridge gaps between services with each other and HNHSS in a facilitated way that was led by HNHSS.

Leadership

Advocacy

- One of the most common roles of HNHSS described by participants was the need to advocate for clients and the community at large. Advocacy topics included OW payment increases and housing options. Opportunities for advocacy included discussions with the Board of Health and/or County Councils, where HNHSS could provide contextual knowledge around social determinants of health; applications for government funding, where HNHSS could champion the advocacy for necessary dollars to do additional health or social services projects; and more.

Engagement

- Participants noted the need for HNHSS to engage with the community and partner agencies to provide opportunities for individuals with lived-experiences to be involved at HNHSS planning tables.
- Additionally, participants described wanting HNHSS to be present at community roundtables that are led by other organizations as well.

Government Relations

- Tensions between HNHSS and other government-based agencies within the community were described as damaged or lost and needing to be intentionally rebuilt due to COVID-19. These comments were generally made in specific reference to government mandates or policies for COVID-19.

Data

- Participants sometimes described needing HNHSS to be the leader in local data collection and analyses. Moreover, participants sometimes noted HNHSS as having a responsibility to provide other health and social service providers local context for their planning through the dissemination of that data.

Community Health Education

- At times, participants noted the role that HNHSS should play in communicating health risks, healthy behaviour, and general health promotion for things like chronic disease or vector-borne disease.
- Similarly, there were many comments related to HNHSS's role as educators to other organizations in the community.

Discussion and Recommendations

The quantitative data (i.e., the Community Profile and the Community Survey) and the qualitative data (i.e., interviews and focus group discussions) for the HNHSS CNA 2022 were cross-validated (i.e., triangulation, member checking, prolonged engagement, and researcher reflexivity). Not only does the data validation process strengthen the robustness of the data interpretation, but it also provides support to the two frames and five emergent themes from the qualitative analysis as the overarching priorities of the data.

Representativeness of the Data

The CNA 2022 Community Survey statistically over-represents adults compared to youth, females compared to males and gender non-conforming individuals, higher educational attainment compared to individuals with less than a college diploma, and higher income brackets compared to individuals who lived in households that earned less than $50,000 per year. However, the qualitative data collected in interviews and focus group discussions for this study typically over-represented those with challenging lived-experiences such as homelessness, poverty, mental health or addictions challenges, or those partner agency staff who directly serve those priority population groups. The combination of the quantitative and qualitative datasets for the 2022 CNA provides a more robust dataset, representing the diversity of the community.

Additionally, the Community Survey had nearly 300% of the total participation of the CNA 20193, suggesting that the residents of Haldimand and Norfolk counties are particularly engaged in the process this year. This may be due to increased social media traction brought on by a larger local following over the duration of the pandemic, the political atmosphere locally and across the country, or that community-members have become increasingly responsible for their own overall health throughout the pandemic.

The recommendations presented in this report should be interpreted in context of the entirety of the dataset and the overall representativeness of the data. While the quantitative and qualitative components of the data have the potential to balance one another, they cannot be treated as separate and equal entities. Instead, the recommendations were weighed against what is known about the local population as a whole and recommendations presented in this report should be considered accordingly.

Relationships and Community

'Relationships and Community' was one of two key frames used to understand the themes that emerged from this data.

When considering the community's present state and how the community has changed over the course of the pandemic, relationships were often described as fraught with tension. These relationship tensions included family dynamics, friendships and professional relationships, and relationships between the public and organizations, such as HNHSS with the public or partner agencies.

While relationships were generally described as challenging, there was often a forward focus on rebuilding relationships to be even better than before the pandemic. These comments often highlighted the importance of relationship rebuilding and the necessity to rebuild fulsomely and intentionally, highlighting the amount of work needed to do so successfully.

A key element to the entire relationship and community frame was the resounding internal and external desire to see HNHSS staff increasingly back in the community. As a way to rebuild relationships with the residents of Haldimand and Norfolk counties, HNHSS staff should be available at events, meetings, and in the offices to meet with clients, answer questions, and provide services.

Health Equity

'Health Equity' was the second of the two key frames used to understand the themes that emerged from this data. Health equity refers to creating fair opportunities for good health for all individuals, regardless of any characteristics of their life, such as age, ethnicity, gender, or income.

Throughout the conversations conducted as part of the CNA, individuals expressed the ways that the gap between the "haves" and "have-nots" in our communities has widened. In both quantitative and qualitative data for the CNA 2022, it was apparent that many of the community's most vulnerable individuals were struggling more than they had been pre-pandemic. Challenges spread the gamut of life experiences from mental health or addictions struggles, to increasing challenges affording housing and food, to increasing feelings of stigmatization or isolation in the community.

While inequities in the community were at the forefront of many people's minds, so too were ideas for solutions to make the community more inclusive and the role for HNHSS to play in that community growth. In much the same way as relationship rebuilding, comments often highlighted the importance of doing this work fulsomely and intentionally, recognizing the amount of effort needed to do so successfully.

COVID-Related Changes

A substantial proportion of the participants in the CNA 2022 reported that they had experienced traumas related to the COVID-19 pandemic. Traumas may have been related to damaged relationships, financial strife, and challenges with trust, which may have sometimes resulted in poorer mental health outcomes. Further, population-level inequities were exacerbated by COVID-19, particularly around low-income households, employment experiences, and health.

COVID-19-related impacts were not a surprising theme when considered against the existing literature, such as the HNHSS Community Safety and Wellbeing Plan[15] and the Public Health Ontario (PHO) Enhanced Epidemiological Summary on COVID-19 and Material Deprivation[27], which suggested that health and social service statuses were declining due to the pandemic and that the effects were inequitable. In particular, data from PHO demonstrated that community members in the most vulnerable groups, such as those experiencing homelessness[28] and racialized communities[29], experienced the greatest risks and challenges due to COVID-19. Additionally, the CNA 2022 results suggest that there may have been shifts in substance use patterns and that substance use supports continue to be a local priority (as seen in 2019[3]), as was highlighted by PHO in 2020[30].

Looking forward, adjusting to a new phase of public health and social services in context of COVID-19 should consider mental health implications of the pandemic, the impact of the pandemic on relationships, and the ways that COVID-19 exacerbated inequity locally.

Barriers to Service

Barriers to accessing HNHSS and other health and social services programming were numerous amongst the participant responses in the CNA. Participants highlighted how necessary it was to have a social network they could rely on for access to services due to the distance they needed to travel for services, awareness of services, and support with the cost of accessing or receiving services. Further, many participants noted how barriers to services were not equitable, but rather that hurdles to reach services were bigger for more vulnerable community members.

The barriers to service most commonly identified in the CNA 2022 are similar to those from the CNA 2019[3], which included transportation, awareness of services, rurality, and stigmatization. According to the Rural Health Systems Model developed by the Canadian Institutes for Health Information[31], travel time, travel cost, and travel availability are geographically tied parameters that impact health access in rural areas. Moreover, contextual factors such as infrastructure, partnerships and community readiness, service delivery models, and resource models and allocation also impact the ways that rural communities access healthcare[31].

Additional barriers to service arose out of the COVID-19 pandemic compared to those in the CNA 2019[3]. Specifically, local health and social services staffing pressures at HNHSS and other agencies have been extended. Reports from across Ontario highlight the extent of these challenges, including locally in Norfolk County[32], Haldimand County[33], and Niagara Region[34], and across the province[35,36].

Health and Social Services Priority Areas

Community members who participated in the CNA highlighted several health and social services priority areas for immediate action and focus. Participants noted programming areas that may have reflected their own needs or those of their community at large, such as homelessness, which was mentioned by individuals experiencing challenges with housing and those who are not facing those types of challenges alike. Comments about these priority areas reflected the desire of local residents to see dignity and respect in the form of health equity for their neighbours.

Mental health was extensively highlighted as a priority in the Community Survey and in the interviews and focus groups, as was true in 2019[3]. Participants described mental health services as a top-three need to keep their family healthy, a top-three need to protect the social health of their family, a top-three need for health education for their family, and highlighted significant decreases in their overall social supports or the likelihood they would seek crisis supports from family members or friends in crisis. These findings are similar to reports from across Ontario[37,38,39] and around the world[40], that mental health is a top priority as we emerge from the emergency response phase of the pandemic.

Similarly, substance use was highlighted by participants in both the Community Survey and interviews and focus groups, as it was in the CNA 2019[3]. Generally, survey responses suggest that alcohol consumption is increasing significantly in Haldimand and Norfolk counties, while tobacco and cannabis use may be decreasing. Trends for opioids and other drugs were less consistent in survey responses but suggest that substance use is still top-of-mind for local residents, along with related detoxification and rehabilitation services for the community. Throughout the pandemic, substance use-focused agencies have highlighted the concerns for increased substance use related to isolation, mental health impacts, and other challenges brought on by COVID-19[41,42,43].

Housing and homelessness was a third major priority from the CNA 2019[3] and remains a priority in Haldimand and Norfolk counties in 2022. In the Community Survey, participants chose housing supports as a top-three need to improve the social health of their family, along with options such as financial help to afford rent, and financial help to afford utilities to help them maintain their current housing. Housing and decreasing the risk of homelessness are essential priorities for maintaining the health and wellbeing of the community, as noted in the literature[15,44,45], as well.

Access to primary care providers was commonly mentioned in the quantitative and qualitative components of this assessment and is reflective of the findings in the CNA 2019[3]. There was also a significant decrease in the proportion of participants who reported seeing their primary care provider annually. As the available number of physicians for the two county service area stayed steadily around 50% of the average for the province per capita for Haldimand and Norfolk counties[19], it is not surprising that this concern continues to be important to local residents and is a demonstrated priority for local policy makers[46].

The health and social services priorities highlighted in the CNA 2022 suggest that priorities are very similar for the years ahead as what was identified as priorities in the CNA 2019[3]. Given the need to pivot HNHSS's priorities to emergency management during the earliest parts of the pandemic, limited progress was made on addressing these concerns in the past three years and exacerbations of these priorities due to COVID-19 have occurred in some instances.

Health and Social Services Systems

Health and social services is a large and complex system that includes HNHSS and many other local, provincial and federal agencies. The challenges that this complexity imposes on community members who require services and their allies is the resultant inability to identify necessary and available services. The ability to navigate the system more seamlessly has the potential to decrease health inequities.

Participants in the Community Survey and interviews and focus groups often noted a lack of awareness of services as a major barrier to using them, along with comments related to not being sure where to look to get started. Increasingly, local and regional health and social services agencies are developing tools[47,48] to help the public navigate service offerings, due to the inherent complexity[49].

Moving forward, development of tools that will help clients and their advocates, such as agency staff and family members, should be a priority for HNHSS. The magnitude of possible gains from such systems was noted by participants in interviews and should be considered in the prioritization of available funding.

Leadership

As the overseer of health and social services in the community and the organization mandated to fulfill community necessities[5], participants described this as a vital responsibility for HNHSS. According to participants, leadership must involve community engagement and relationship building to inform decision-making. Additionally, data provisions and health education are important to improve equity in Haldimand and Norfolk counties.

The National Collaborating Centre for Determinants of Health[50] describes advocacy, an element of leadership in the CNA 2022, as a "critical population health strategy that

emphasizes collective action to effect systemic change." Moreover, some of the key components in preparing advocacy efforts outlined by the Centre are the gathering and disseminating of data and working in collaboration with alliances[50].

Time and again the CNA highlighted the importance of health education and health promotion, including agencies hoping that HNHSS can lead community or partner education campaigns on key issues such as inclusion and diversity. The World Health Organization has prioritized health promotion action for more than three decades[51], including calls to build healthy public policy, create supportive environments, strengthen community actions, develop personal skills, reorient health services, and move into the future. Inclusive settings are essential to positive health and social services provision, however, in 2019[3] and in 2022 individuals who identified as members of priority population groups, such as being a person of colour, LGBTQ2S+ or gender non-conforming, Indigenous, or having a disability, were less likely to agree that Haldimand and Norfolk is a safe place to be their true self. See the Community Profile for more information about priority population groups in Haldimand and Norfolk counties.

Locally, shifts have occurred in the desires for health promotion topics, such as increases in the proportion of participants who reported wanting infectious disease information (e.g., COVID-19, Influenza) coming into a different phase of the COVID-19 pandemic. Similarly, shifts have occurred in the needs for health promotion topics, such as Haldimand and Norfolk counties being endemic for Lyme disease and other vector-borne infections yet the proportion of participants who reported doing a tick-check after outdoor activity decreased since 2019[3]. Further, Community Survey results suggested that some risky behaviours, such as not wearing a helmet on a bicycle or driving while under the influence of cannabis may be significantly increasing locally[3].

Limitations

The CNA 2022 is filled with robust data and provides a thorough understanding of the local community. However, some limitations exist in any assessment of this magnitude. First, the dataset should be interpreted in context of the representativeness of the populationii. Some population groups are over or under represented in the CNA 2022 dataset. Second, the changes in the findings from 2019 to 2022 must be considered in context of the broader changes experienced during this time. Specifically, the CNA 2022 measures how the community has fared after more than two years of COVID-19 pandemic response locally (i.e., data collection occurred from June 6 to August 2, 2022). During the data collection phase, many HNHSS and other health and social service providers still had pandemic-related restrictions in place, such as reduced in-person programming. This impacted the survey respondents because the CNA 2019 included more than one-third of responses as paper surveys collected from participants in HNHSS buildings and local libraries[3]. This decrease in response rates from program areas like current Ontario Works recipients may artificially inflate the improvement in some parameters. An effort was made to adjust for this sampling bias by providing the 11 survey pop-up booths that went into the community and sought out participation that represented the community at large.

Recommendations

A number of recommendations for future activities for HNHSS and health and social services providers came from the CNA 2022 dataset. The following outlines those recommendations and outlines potential ties to the health and social services priority areas locally.

Events, Meetings, and In-Person Service Options

Health and Social Services service providers, including HNHSS, should continue to consider safely (i.e. in context of COVID-19 considerations) and equitably (i.e. fairly, in context of various locations, needs, and preferences) increasing in-person service options and community

presence. Intentional planning to be present in both counties and to be available in more rural and isolated communities, including such activities as attendance at community events and stakeholder meetings, could be explored to fulfill the requests of residents. This recommendation aligns with the mental health priority area, amongst others, as it supports provision in more isolated areas.

HNHSS Service Hubs

In an attempt to address potential barriers to accessing health and social services through HNHSS and other agencies, development of a network of virtual hub spaces in HNHSS buildings or other partner locations could be considered. These hubs should have access to telephones, computers with internet access, a webcam, and a microphone, along with privacy barriers, to allow residents in more isolated areas of the two County service area to access the needed technology for virtual appointments. For example, this recommendation serves well to support those where housing is a priority, as they may not have access to these technologies in other ways.

HNHSS Communication Plan

A thorough Communication Plan that includes the types of activities and possibility of rebranding (i.e. reimagining the image of the HNHSS Division, including new logos, colours, etc.) should be considered. The Communication Plan could include insights from the Community Survey around awareness of services, preferred communication channels, and community demographics, as well as suggestions brought forward in interviews and focus group discussions around the broader idea of rebranding, which was described as a solution for general lack of program awareness.

Evaluation of Cost-for-Service Models

To make services more accessible and equitable across HNHSS programming, an assessment of which services currently require a cost to participate (e.g. in-person prenatal classes) and the target audiences for each program could be completed. A pilot project and evaluation program for improved program access could be undertaken later.

HNHSS Prioritization Activities

It is recommended that HNHSS uses the CNA as one of the guiding documents when completing annual Ministry service plans and determining service and program priorities. Using the CNA findings as a guiding document to inform the next several years of planning activities will help to put community needs at the center of the next strategic plan for HNHSS and will support relationship rebuilding by demonstrating that community engagement informs future action.

Health and Social Services System Integration

In response to staff and partner agency suggestions, health and social services agencies should work more closely together to reduce paperwork and redundancies in the intake system and in the transfer between programs or agencies. Specifically, participants noted that they were sometimes in a position of retelling their circumstances time-after-time

to work with multiple program areas simultaneously. For example, a client seeking housing supports, mental health supports, and substance use supports simultaneously may be asked to re-tell their story multiple times to multiple intake workers at various program agencies. An evaluation of programming intake processes and a continued quality improvement process should be considered.

Health and Social Services System Navigation Portal
Amongst the most commonly suggested ideas from participants was the idea for a system that would help community members identify available services. Internal staff, external partner agency staff, and individuals with various lived experiences each made some version of this suggestion. It was further substantiated by the high proportion of survey participants who reported they were 'somewhat' or 'not at all familiar' with health and social services programming (i.e. internally and broadly in the community). Moreover, many survey participants noted that a barrier to service was that they did not know where to look for services. Suggestions included an online portal system, 4-1-1-style phone line, or paper resources to help locate available services for various needs. An environmental scan of neighbouring areas and a comprehensive literature search should be conducted to determine the most effective and efficient models for implementing some sort of navigation portal at HNHSS. A diverse group of staff and individuals with lived-experiences could be engaged and consulted in this process.

Advocacy
A commonly noted responsibility of HNHSS was to encourage the prioritization of health and social services provisions within the community. This advocacy may take the form of leading the initiation of additional programming, requesting funding to operationalize programs, or other programming activities. The HNHSS Division may consider whether this perceived responsibility from participants is in line with the overarching operations of the Division.

Health Promotion Activities
Participants highlighted priority areas for education and information throughout the Community Survey and strategies and priorities for health promotion activities in the interviews and focus group discussions. The implementation of educational activities across a variety of formats is imperative for the success of a number of recommendations above. Specifically, health promotion activities could underpin recommendations such as attending events and meetings, development of an HNHSS Communications Plan, a health and social services navigation portal and related engagement activities, and provisions of education to the community and agency partners.

Next Steps

The HNHSS has demonstrated a desire to engage with the residents of Haldimand and Norfolk counties throughout the CNA 2022 process. The CNA 2022 serves as a launching pad for the HNHSS to move forward from the crucial and nearly all-consuming public health and social services emergency management tasks of the COVID-19 pandemic. The HNHSS is undergoing significant strategic planning initiatives and task prioritization that will be informed by the results of this CNA, and thus, the voices of the community.

Conclusions

The HNHSS CNA 2022 is one of the most comprehensive health and social services status reports available in the community at this time. The CNA aimed to describe current health and social status and changes since 2019, identify gaps in currently available health and social services provisions, and to support evidence-informed decision making locally. The CNA 2022 accomplished its goals and will be the foundation for related future activities.

The results of this assessment demonstrate that the community in Haldimand and Norfolk counties has changed in the last three years. There are many opportunities for HNHSS to grow and opportunities to fulfill the needs outlined by the participants. However, the role of partner agencies in accomplishing the goals set out in this report cannot be understated. The HNHSS Division may have a vital role to play in organizing partnerships and collaborations to accomplish these aims.

The HNHSS CNA 2022 will be considered within the new five-year strategic plan for the Health Unit. The CNA will be used in conjunction with multiple other documents and data. A move forward plan for health and social services in Haldimand and Norfolk will require a cohesive team of internal and external stakeholders who can address the identified needs together and lead where they have great strengths. The collaboration of other agencies will be essential to meet the recommendations contained in this report.

Additional Information

Requests for additional information, data, or presentations can be submitted to HNHSS by email at communications@hnhss.ca or by phone at 519-426-6170.

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Glossary

Beneficiary:
A beneficiary refers to an individual who indirectly receives Ontario Works money as part of a household that includes an individual who is supported by the program.

Community-Based:
Community-based research refers to research that is rooted in local participation. Active engagement is a crucial element of community-based research and work.

Data Validation:
Data validation refers to methods in qualitative or mixed-methods analysis that aim to examine the potential reflectiveness of the interpretation from the raw data and substantiate the claims made in the findings.

Environmental Scan:
An environmental scan refers to a broad, scoping assessment of available resources; aiming to cast a wide net that seeks to collect as much relevant information as available.

Health Equity:
Health equity refers to fair opportunities for good health for all individuals, regardless of any characteristics of their life, such as age, ethnicity, gender, or income.

Intentional Injuries:
Intentional injuries refers to all hospitalizations for individuals who were harmed due to self-inflicted, intentional injuries.

Low-Income Households:
Low-income status was defined according to the definition employed by Statistics Canada10 in the 2020 national census. Low-income households referred to a statistical threshold known as the "low-income measure, after-tax (LIM-AT)." According to Statistics Canada, LIM-AT is the fixed percentage of 50% median-adjusted after-tax income of private households. Specifically, at this time, the LIM-AT was: $26,503 (1 person), $37,480 (2 people), $45,904 (3 people), $53,005 (4 people), $59,005 (5 people), 64,918 (6 people) or $70,119 (7 people). Source: https://www12.statcan.gc.ca/census-recensement/2021/ref/dict/tab/index-eng.cfm?ID=t2_4

Mixed-Methods:
Mixed-methods refers to research that marries the use of both quantitative (i.e. numeric) and qualitative (i.e. text, visuals) methodologies or tools and datasets or outcomes.

Participatory:
Participatory research refers to research procedures that intentionally integrate community insights, activities, and opinions into the design, implementation, data collection, analyses, and interpretation of findings.

Priority Populations:
Priority populations referred broadly in this analysis to individuals who might experience health or social inequities as a result of social determinants of health, which are non-medical parameters that influence health outcomes, such as income or employment status.

Semi-structured Discussion:
A semi-structured interview or focus group discussion guide refers to a conversational guide tool that allows for increased flexibility compared to a traditional interview or conversation guide. Semi-structured guides allow for the probing of seemingly tangential ideas and the ability to skip questions entirely.

Statistical Significance:
Statistical significance refers to the likelihood that an outcome is due to chance alone, or is due to differing factors of interest. When applying a p-value of alpha <0.05, a statistical test assesses whether the outcome was likely to have occurred by chance alone, one in every 20 times.

Visible Religious Minority:
A visible religious minority, as it was intended in this survey, would include any identifying characteristic, garb, or otherwise, that an individual believes makes them identifiable to a group that is not the majority.

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Footnotes

[i]The most recently available cancer mortality data from Public Health Ontario's "Mortality from all cancers" snapshot is from the year 2015.

[ii]Survey respondents were primarily above the age of majority, with only 1.6% (n=33) of participants identifying as youth (e.g. aged 12-17 years).

Survey respondents represented a diverse cross-section of communities in Haldimand and Norfolk counties, with the largest proportion of participants coming from the two largest communities: Simcoe (20.6%, n=370) and Caledonia (12.4%, n=223).

CNA Community Survey over-represented females compared to males or gender non-conforming individuals, with 69.8% females (n=1,240, 27.7% males (n=492), and 1.1% gender non-conforming (n=20), but had better gender-diversity amongst respondents than in 2019 (2019= 80% female).

Survey respondents over-represented higher education levels, with 68.9% (n=1,228) of respondents having a college diploma or higher, which was similar to the representation across education levels in 2019 (2019= 67.8% college diploma or higher).

Survey respondents represented language distribution of Haldimand and Norfolk, with 93.5% (n=1,664) speaking English at home, compared to 93.0% for all residents[11].

Survey respondents also represented immigration status in Haldimand and Norfolk counties, with 7.6% (n=134) identifying as born outside of Canada, compared to 9.6% for all residents[11].

Survey respondents over-represented higher income brackets, with only 29.9% (n=533) of respondents reporting a household income of less than $50,000 per year, compared to 58.7% of all residents, which was less representative than in 2019 (2019= 46.4% with household income less than $50,000).

Survey respondents represented a diverse cross-section of employment statuses, with the largest proportion of participants reporting they were employed full time (47.2%, n=845), retired (21.2%, n=380), or employed part time (8.9%, 159).

[iii]Individuals were not provided with a definition or "example" of a visible religious minority in the survey.

Health and Social Services
Haldimand and Norfolk

April 2023

Council-In-Committee Meeting – May 09, 2023

Advisory Committee Meeting – April 24, 2023

Subject:	Ontario Works Service Plan 2023
Report Number:	HSS-23-014
Division:	Health and Social Services
Department:	Social Services and Housing
Purpose:	For Decision

Recommendation(s):

THAT staff report HSS 22-014, Ontario Works Business Plan 2023, be received as information;

AND THAT Council direct staff to submit the Ontario Works Service Plan for 2023 to the Ministry of Community and Social Services for their approval.

Executive Summary:

The Ministry of Children, Community and Social Services requires all Employment Services Transformation (EST) sites to complete a refreshed Business Plan for 2023.

Receipt of Ontario Works funding from the Ministry of Children, Community and Social Services (MCCSS) is contingent upon the completion of a business plan. The 2023 Business plan is to be submitted along with the annual budget submission, which together, creates the Service Plan, and is attached to the report.

As part of the Service Plan, the 47 Ontario Works delivery sites will articulate the efforts they will undertake to address the following ministry priorities for the current business cycle:

1. Social Assistance (SA) Service Delivery, including the following
    - Accelerated digital delivery solutions(no levy impact; Ministry initiative)
    - Centralized and automated delivery
    - Risk-based eligibility review
    - Access to employment and training
    - Collaborating with municipal sites
2. Improving Employment Outcomes
3. Develop and Maintain Local Community Service Partnerships
4. Strengthen Program Accountability

Discussion:

The development of the attached Business Plan was completed by the Ontario Works management team and was guided by the requirements set out by the MCCSS.

MCCSS has identified a vision and mandate that is shared by all Consolidated Municipal Service Managers (CMSMs):

Vision

To create an efficient, effective and streamlined social services system that focuses on people, providing them with a range of services and supports to respond to their unique needs and address barriers to success so they can move towards employment and independence.

Mandate

To provide life stabilization and financial assistance to people in financial need. The Ontario Works program:

- Recognizes individual responsibility and promotes self-reliance through participation in life stabilization activities
- serves people needing assistance by Providing financial assistance to those most in need while they meet obligations to become and stay employed
- Is accountable to the taxpayers of Ontario.

Employment Services Transformation (EST)

While the Ministry of Labour, Training and Skills Development (MLTSD) through local Service System Managers (SSMs) will provide employment and training services to Ontario Works clients, Ontario Works delivery partners will assess readiness for employment, prior to the referral to the Employment Ontario/SSMs, and determine client's life stabilization needs.

Life Stabilization Framework

Life stabilization supports are services that support an individual in attaining stable living conditions, community inclusion and readiness for employment for those with participation requirements or interest in working. It includes providing a continuum of supports and services to people in financial need, while recognizing individual responsibility and promoting self-reliance. All of these factors are important in supporting an individual along their path towards employment.

Ontario Works Case managers assess the client for readiness for employment to determine if a referral to Employment Ontario is appropriate. If a referral is not appropriate, Life Stabilization supports and services are determined to address barriers to employment referral readiness. Case Managers work collaboratively with Employment Ontario staff, Social Services and Housing staff, and community agency partners to support clients along the path to employment.

The strategies identified in the Service/Business Plan are continually reviewed to ensure that outcomes are being achieved. Because the Service Plan is intended to be a living document, where necessary, based on local environmental changes, the strategies and targets identified in the Service Plan will be modified.

Financial Services Comments:

Norfolk County

There are no direct financial implications within the report as presented.

As part of the Ontario Works Service Plan, MCCSS requires submission of the program budget for administration and employment related expenditures. The submission was prepared based on the Final 2023 Levy Supported Operating budget; this includes a total budget of $4,553,800 funded by MCCSS ($2,390,000), Norfolk County ($1,302,200) and Haldimand County ($861,600) per the funding agreement with MCCSS and the cost sharing agreement with Haldimand County.

Client benefits remain 100% funded by the province and the total approved budget for 2023 includes an allocation of $12,010,900.

Haldimand County

Haldimand Finance staff have reviewed this report and agree with the information provided by Norfolk Financial Services.

Interdepartmental Implications:

Norfolk County

Haldimand County

The Service Plan for Ontario Works (OW) is mandated by the Ministry of Children, Community and Social Services, but it also offers a chance to evaluate the delivery of services to clients for optimal efficiency and effectiveness. OW plays a critical role in providing financial aid and support to stabilize the lives of individuals, including setting goals and facilitating activities to help them attain employment.

Consultation(s):

Strategic Plan Linkage:

This report aligns with the Council Strategic Priority "Focus on Service".

Explanation: The delivery of the Ontario Works program provides financial and life stabilization assistance to people in financial need.

Conclusion:

The Ontario Works Business Plan for 2023 must be submitted to the MCCSS in order to secure our on-going funding. The Business Plan is a living document, reviewed by the Haldimand & Norfolk Social Services Management Team on a regular basis. If necessary, adjustments to targets will be made to reflect any major changes in our local environment.

Attachment(s):

- Ontario Works Business Plan 2023

Approval:

Reviewed and Approved By:
Al Meneses
Chief Administration Office, Norfolk County

Prepared By:
Stephanie Rice
Director, Social Services and Housing

Ontario Works Business/Service Plan Template:

For Ongoing Employment Services Transformation Consolidated Municipal Service Managers (CMSMs)

ONTARIO WORKS
BUSINESS/SERVICE PLAN TEMPLATE FOR EMPLOYMENT SERVICES TRANSFORMATION SITES

Note: This template includes items for Employment Services Transformation (EST) delivery sites to consider when undertaking service planning. EST delivery sites must submit a Business Plan for 2023. EST sites may use this template or an alternate format. Approval of a Business/Service Plan requires that sufficient information is presented, to meet Ministry standards for approval.

Business/Service Plan template for 2023

Ontario Works Vision and Mandate

All Ontario Works delivery sites share the same vision and mandate. This serves as a common starting point for the service planning process.
Vision To create an efficient, effective, and streamlined social services system that focuses on people, providing them with a range of services and supports to respond to their unique needs and address barriers to success so they can move towards employment and independence. ***Mandate*** To provide stability support and financial assistance to people in financial need. The Ontario Works program: • Recognizes individual responsibility and promotes self-reliance through participation in stability support activities • Serves people needing assistance by providing financial assistance to those most in need while they meet obligations to become and stay employed • Is accountable to the taxpayers of Ontario.

Ministry Priorities

Ontario Works delivery sites play a key role in delivering on many of the government's priorities and have the ability to leverage provincial investments in infrastructure, employment, education, and social services to create new opportunities for clients. As part of the service plan, Ontario Works delivery sites will articulate the efforts they will undertake to address the following ministry priorities for the current business cycle:

Enter specific activities and strategies used to address the following key Ministry priorities, including any activities that will be held for the start of 2023:

As part of the Business Plan, articulate how you plan to address the following Ministry priorities:

1. Social Assistance (SA) Service Delivery

- **Accelerated digital delivery solutions,** including the launch of a new and easy-to-use SA Digital Application and expansion of the MyBenefits digital platform to improve access for people receiving social assistance and allow two-way digital messaging between clients and caseworkers.
- **Centralized and automated delivery,** beginning with centralized intake pilots across several municipalities that reduce paperwork, giving caseworkers more time to support clients through crisis and helping them get back to work.
- **Risk-based eligibility review,** to be developed alongside the centralized intake pilots, that uses provincial, federal and third-party sources to make financial assistance processing faster, while strengthening program integrity.
- **Access to employment and training**, partnering with the Ministry of Labour, Immigration Training and Skills Development to support people to get back to work, including people with disabilities who have been particularly hard hit by job losses.
- **Collaborating with municipal sites**, to continue to address administrative costs.

2. *Improving Employment Outcomes*

For the interim, while a SA performance management framework is being developed, EST Ontario Works delivery sites will use the interim performance metric as outcomes for service planning.

As outlined in the Ministry of Children, Community and Social Services (MCCSS) memo, the Ministry is requesting an outcome target to be set for each performance metric as part of the Budget Submission and contract negotiation.

Note: EST sites will have the flexibility in setting targets for the EST performance metrics as per the Service Objectives Document.

3. *Develop and Maintain Local Community Service Partnerships*

Build on and strengthen local community partnerships and work with Service System Manager (SSM) on the range of supports available to Ontario Works clients, including long-term recipients of SA and marginalized or disadvantaged groups across service sectors, including health, developmental services, housing, and child-care.

4. *Strengthen Program Accountability*

The ministry continues to refine program controls to support greater delivery and financial accountability. Delivery sites will need to consider how these controls impact their business processes and delivery approaches when constructing their service plans.

Key elements include:

- Compliance with expectations related to completing the Eligibility Verification Process
- Participation in current, and prospective, Oversight Intelligence activities aimed at preventing and reducing financial losses.
- Documentation requirements for Ontario Works benefits that are managed outside of Social Assistance Management System (SAMS)

Section 1: Environmental Scan

Service Delivery
• A summary of outcomes achieved in relation to establishing targets for 2023, and a description of service system outcomes and delivery successes, client outcomes, challenges and lessons learned.

Enter specific strategies used for the ongoing management of EST service delivery, including any improvements – below are some guiding questions:

1. ***Strategies used to complete Module 1 of the Common Assessment Tool and Action Plan for new clients and existing clients, including determining which clients remain in stability support activities rather than referred to Employment Ontario (EO) and reconfirming readiness for employment, including those with earnings – both employed and self-employed?***

    - Once the Common Assessment is completed a client may be referred to Employment Ontario if they are ready. Whether a client is ready or not can be examined through the Common Assessment Module 1.
    - Clients who want to work on self-employment will be referred to Employment Ontario.
    - The "Mental Health Addiction Screening" tool is used to further support a client with Life Stability goals.
    - Three month "Checkpoints" are completed with a client to support continual movement in determining if the client continues with Life Stability goals or moves onto Employment Ontario.

2. ***Provide a brief description of how referrals to Employment Ontario (EO) are determined and how cases are reassessed to determine employment readiness? Include the following:***

    - ***Describe the Integrated Case Management strategies used with EO***
        - EO referrals are determined at the local level through conversation stemming from the Common Assessment Module 1 (CAM1). At this time, our Case Managers are engaging with individuals accessing Ontario Works benefits through conversation from the questions listed on the CAM1. These conversations allow the Case Manager to assess the individual's readiness for employment. Case Managers work on a plan with the individual for next steps. These steps will include the referral to Employment Ontario (EO) if necessary. In addition to this, a Case Manager may also determine that the individual has items outside of the referral that needs to be addressed/supported by our office. Individuals within this category will work on the stabilization items with the local OW office and will work on the employment/training items with the EO office in their area.
        - Open communication with EO sites has allowed for integrated case management. This is a joint effort between the local OW office and EO sites. A joint protocol was put in place locally with supports from SSM and EO sites. In addition to the joint protocol, we have a weekly and bi-weekly (depending on the EO site) communication tool. This comes in the form of a spreadsheet and allows staff within our local OW office to see the status and progress of a referral. Any individuals

who have not made contact with the EO site from referral are also included on this communication tool. This allows for intervention at the OW office if needed. The staff at the EO sites and our local OW office also have frequent communication via email to ensure support is provided to the individual. Lastly, we also complete a handful of warm referrals when necessary. Working together and being connected to the EO sites is a top priority for the local OW office. Program Managers are the point of contact for EO sites if an individual is currently not connected to a Case Manager due to office vacancies. This communication is often in the form of an email. If an email regarding an individual is received, the Program Manager ensures that a covering worker completes the required follow-up or action.

- ***Challenges or other lessons learnt.***
  - Although we believe we have done quite well, we are able to reflect back and have identified some challenges and lessons learned.
  - Challenges:
    - One of the largest challenges to date is the lack of system integration. With the absence of integrated technology between SSM, EO and the Local Office (LO), increased administration tasks are required. With decreased staffing at the LO due to the transition and funding, working smarter with technology would lessen the administration burden Case Managers are facing and decrease the workload pressures that are impacting the ability to serve the participants of the program. If able, increased integration with our technology would allow for an easier communication method across offices. In addition to this, being able to clearly see progress in real time would be beneficial to the individual accessing services as it would allow smoother connection between offices within the integrated case management model. Time spent on administrative tasks (communication, noting files from updates outside of the system and having to plan time within schedules to connect) could be spent supporting the clients on a more frequent and meaningful basis.
    - Staffing pressures on the Ontario Works side. Individuals have either been without a dedicated Case Manager or have changed Case Managers since time of referral. As our caseloads have continued to grow, staffing complement has remained the same. This has increased the workload pressures for existing staff and the ability to work closely with EO providers. Although locally we would desire to have the capacity to work closely with EO and the individual, it is not always the reality due to the pressures of the

financial case management components remaining within the scope of the role locally.

- Those experiencing Homelessness and poverty has increased which has added stress on existing resources. As we are all aware, there is a national housing crisis. Due to our rural setting and limited resources available, it can be challenging to meet all needs of the individuals. Many of the resources available are centralized to the larger city centers or are waitlisted. This continues to pose challenges for us locally.

- Lessons learned:
  - The importance of change management strategies. The change management was a pain point for us locally. We were ill equipped with the staffing needs and had difficulty keeping up with the changes at the pace they were coming. Staff in our LO transitioned to Centralize Intake and EST concurrently. In addition to this, the lack of learning facilitators and dedicated staff caused strain on our support team. As EST continues to evolve, locally we are attempting to get ahead of the changes and equip our team as best we can. Reaching out to other municipalities for connection and discussion has been a vital part of our change management strategies in the recent months. This allowed for an easier rollout of the Mental Health and Addiction Screening questionnaire now required locally. Although we are able to reflect and learn, we continue to feel the pressures of change management due to capacity and staffing complement within our local office.

- *Quarterly target for EO referrals:*
- The quarterly OW referral target based on St. Leonard's Community Services contract is 126.
- The quarterly OW referral target based on Fanshawe contract is 291.

3. ***Percentage of participants currently receiving employment services from existing EO providers***
   - In the month of February 2023 3.43% of clients were referred to Employment Ontario
   - Referrals to EO accepted by FedCap in January 2023 is 82.7% (referrals of OW clients to EO that were accepted)

4. ***Explain the alternative case/change management used to serve ODSP Non-Disabled Adults, if any?***

    - Individuals who are working with the local office that fall under the ODSP NDA category are treated no differently than individual accessing Ontario Works benefits.
    - Case Managers complete the same process and follow up with these individuals. Individuals working with an Ontario Works Case Manager as a NDA participating individual has access to the same supports and services. The only exception to this is benefit coordination with the local ODSP office. This has not been an issue locally to date.

5. ***A brief description on the strategies used for referrals to broader supports and services (i.e., to other programs, - housing, childcare needs, etc.)***

    - Referrals to broader services are completed based on the one-to-one conversation and assessment completed by the case management team. The need for broader services may be discovered at initial application or through action planning and check point discussions. Utilizing weekly case conference roundtables has also been a strategy used locally. This is a time that any staff from the Ontario Works branch is able to log onto a virtual call and connect with peers. Cases scenarios are brought forth as needed and reviewed in a larger team setting. This has allowed for increase ideas and solutions for challenging situations. In addition to this, we have also equipped customer service representatives to first point of contact for individuals not yet connected to the program. This means that individuals attending or calling the LO identifying a need within social services are transferred to the Intake Support team. This team is up to date with resources and processes and will field the scenario as able.

Caseload

- An overview of the current composition of the caseload and anticipated changes over the next two years (i.e., projected growth/decline, shifts in demographics, etc.).
- Note: Potential sources of caseload information include the Ontario Works Caseload at a Glance, Social Assistance Operations Performance Reports, Local Case Management System Reports, 2016 Statistics Canada/Census Data and other caseload information compiled locally by the delivery site.

Caseload at a Glance report of September 2022

- September 2022 report shows an increase in caseloads of 19%
- September 2022 total cases 1,115 for Haldimand and Norfolk County
- Current 2023 total cases 1,346 for Haldimand and Norfolk County
- September 2022 report shows Average months on assistance as of September 2022 was 37 months (or 3 years)
- From the report we can see that caseload sizes will continue to increase
- MCCSS projection data estimates the OW caseload to grow by 14.1% in 2022/23 and a further 8% in 2023/24 based on economic forecasts.

Provincial Social Assistance Caseload Forecast

- Following recent caseload trends, the Ontario Disability Support Program (ODSP) caseload (including Assistance for Children with Severe Disabilities cases) is expected to increase 4.2% in 2023-24.
- Unemployment rates remain higher than prior to COVID, it is forecasted to increase by about 8.0% in 2023-24.

Caseloads are currently growing and expected to increase which will cause workload pressures for the existing staff complement and local service providers.

Note: A full assessment of impact barriers must be addressed as part of the service plan prepared at the start of 2024.

Local Service Delivery Landscape and Community Partnerships

A description of how delivery sites have developed, maintained and plan to grow relationships with local community stakeholders that enhance access to services and support for clients and that may impact stability support outcomes for participants. This includes *(if details are unknown, the completion of this section can be held until the development of a service plan)*:

- **Current and future socioeconomic factors that may influence employment and employability.**
- **Education and skills required to obtain available jobs.**
- **Access to transportation, health, housing, and other services.**
- **Regional and local demographic trends (e.g., shifts in population size, age groups, and increases or decreases in immigration).**

The population of Haldimand and Norfolk counties, a two-county service region that is supported by the Health and Social Services Division, is a rural region with a growing population. According to Statistics Canada (2021a), the population of this region was

116,872 at the time of the 2020 census, up more than 5,000 from the 2015 census (109,787). Haldimand and Norfolk counties have a higher proportion of older adults, over the age of 65 years, than in Ontario (Statistics Canada 2021a, 2021b); the proportion of population aged 65 or older in Haldimand and Norfolk is 23.6%, compared to 18.5% of the population of Ontario. Immigration plays an increasing role in population demographics for Haldimand and Norfolk counties than it previously did; however, immigrants still make up a significantly smaller portion of the population here than in Ontario (Statistics Canada 2021a, 2021b). In Haldimand and Norfolk, 10.0% of the population identified as immigrants in the last census, compared to 30.0% in Ontario. Statistics Canada (2021a) identifies that 8.4% of the population of Haldimand and Norfolk had moved in the previous 12 months in 2020, and 35,550 individuals had moved in the previous 5 years. These high rates of movement demonstrate a changing demographic that has been estimated to continue to increase since the last census. In addition to the internal movement of residents and individuals from across the province, as well as new immigrants to Haldimand and Norfolk counties, the region is home to an estimated 4,500 international agricultural workers for 3-10 months of the year. These international workers primarily come to Haldimand and Norfolk to work in agricultural and food processing roles from Mexico and the Caribbean.

Of note, the average after-tax income in Haldimand and Norfolk counties is significantly lower than the provincial average (Statistics Canada 2021a, 2021b); average after-tax income in Haldimand and Norfolk was $42,160 in 2020, compared to $46,280 for the province.

References:

Statistics Canada, 2021(a). Census Data for Haldimand and Norfolk. Link: https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/details/page.cfm?Lang=E&SearchText=Haldimand%2DNorfolk&DGUIDlist=2021A00033528&GENDERlist=1,2,3&STATISTIClist=1&HEADERlist=0

Statistics Canada, 2021(b). Census Data for Ontario. Link: https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/details/page.cfm?Lang=E&SearchText=Ontario&DGUIDlist=2021A000235&GENDERlist=1,2,3&STATISTIClist=1&HEADERlist=0

Key Community Partnerships – to enhance stability support services for clients include a list of stakeholders (e.g., SSM, community agencies, and mental health providers, including other human social service providers).

Key Community Partners:

To enhance stability support services for clients means working closely with community partners. Monthly meetings are completed with clients and community partners are invited to further support the client with life stability goals. In addition to this, Community Support Workers are actively collaborating with agencies within the community (as able) and are providing services to Ontario Works recipients on site. Having this opportunity has allowed us to reach the hard to serve individuals to better support.

Haldimand and Norfolk are rural communities, which bring challenges to clients and staff. Haldimand and Norfolk offer a moderate selection of services however some of these services are shared between both counties which leads to wait lists, some that are years long. Resources are centralized in larger cities, so our clients face challenges when needing transportation, as rural counties do not offer bus services.

In-Services are planned with community partners to support clients and build rapport.

Community Partners:

Canadian Mental Health Association
Community Addiction & Mental Health Services of Haldimand & Norfolk
FedCap Canada
Employment Ontario (St. Leonard's and Fanshawe College)
Haldimand Norfolk Housing Corporation
Ontario Disability Support Program
Haldimand Norfolk Women's Shelter (shared in both counties)
Community Legal Clinic- Brant, Haldimand, Norfolk (shared in three counties)
Salvation Army
Brant Haldimand Norfolk RAAM Clinic

Section 2: Strategies and Outcomes

Performance
• EST performance metrics identified in the Service Objectives Document are to be used by EST municipalities. • To help with tracking the progress of the nine EST metrics, key performance data will be made available through the Interactive Report. Ongoing EST sites already have access to EST metrics data from 2021 through this interactive

report, and therefore has been updated to align with the nine metrics. The report provides interactive visualizations of relevant metrics to help establish targets for the 2023 service contract and to identify emerging trends.

- Note there will be no history for CA, AP-related metrics prior to a municipality becoming an EST site.

The Interactive Report features data for all 9 EST performance metrics:

1. **Percentage of Ontario Works adult caseload with a completed Common Assessment Module 1**
   - 2022 average: 87%
   - January 2023 85% from the Power BI (**employment services Transformation Service contract Metrics report)**

2. **Percentage of Ontario Works adult caseload with an Action Plan created.**
   - 2022 average: 84%
   - January 2023 90.28%

3. **Proportion of Ontario Works clients (out of total Ontario Works caseload) that were accepted by the Service System Manager**
   - 2022 average: 35%
   - January 2023 37.5%

4. **Proportion of Non-Disabled Adults (out of total Non-Disabled Adults) that were accepted by Service System Manager**
   - Average 2022: 48.5%
   - January 2023 89.2%

5. **Average days from intake into Ontario Works to referral to Employment Ontario**
   - 191 days
6. **Average days from referral to Ontario Works to referral to Employment Ontario for ODSP Non-Disabled Adults**
   - 88.64 days

7. **Percentage of ODSP Non-Disabled Adults referred to Employment Ontario with new or increased earnings.**

- In 2022 (which is the most up to date) 8.6%

8. **Percentage of Ontario Works cases (individual or family units) exiting to employment**
    - In 2022 (which is the most up to date) 5.1%

9. **Percentage of Ontario Works cases (individual or family units) who exit the program for any reason and return within one year**
    - In 2022 (which is the most up to date) 17.5%

Enter service strategy and details on setting 2023 targets.

- 2022 data and January 2023 were used to form a frame of reference for our current performance. Each target was evaluated for a moderate improvement for the 2023 year
- Continued work on assisting staff on training needs, workload management and accessing appropriate service needs in the community
- Continued dedicated to the partnerships and working relations and shared practices.
- Utilizing the reports and data to monitor our performance. This will be done on a regular and ongoing basis so work can be done to address gaps
- Process in place to book clients referred to us via IBAU within 30 days to complete the CAT1 and Action Plan
- All clients seen for review of action plan every 1-3 months to review referral readiness and to review progress toward goals
- Continue to meet with our SSM, EO partners and ODSP office to review processes and referrals
- We will continue to leverage collaboration and integration opportunities with our local department of Social Services, Housing and Children Services.
- Details on the strategies used that align with findings from Action Plans and Ministry priorities will follow in 2023.

Note: Performance metric targets are to be identified in the TPON Budget template under Outcomes tab. Due date for the 2023 Budget Submission is March 31, 2023.

Action Steps and Resources

- Outline the key strategies that will be used to achieve 2023 targets. Describe how the proposed strategies will be monitored to determine progress towards the achievement of outcome targets.

Enter monitoring strategies, action steps and resource alignment here.

- Locally we are engaging in an Employment Service Transformation working group to develop local framework. This is a project with Ministry support. We have dedicated weekly meetings in a group of members consisting of individuals from management team, and first-line staff. This included a Senior Case Manager, Case Managers, and a Community Support Worker. Our goal is to have this work completed and framework developed by end of April 2023. We are also working with an external consultant. In addition to first-line staff and a consultant, we will be completing staff and community engagement. This will allow feedback from all individuals.

- We will continue to utilize training opportunities for first-line staff. Our training with Person-Centric Strategies (offered by OMSSA) allowed us to investigate the needs of our staff to better support the individuals on the program. We will continue to engage as able any training opportunities.

- Eligibility Verification process (EVP) has been, and will continue to be, a strategy used locally. When the EVP auditor is reviewing files they will continue to identify gaps and challenges for Case Managers.

Note: Details on the strategies used that align with findings from Action Plans and Ministry's priorities.

Section 3: Program Management

Provide brief details on the service delivery approach used, including analysis of resources and key program management activities.

Overview of Learning Supports
• An overview of other strategic learning plans to train staff in the delivery of stability supports, to achieve program objectives and improve program outcomes (i.e., Supportive Approaches through Innovative Learning (SAIL)).

- Late 2022 staff was provided with OMSSA training “Person-Centric Strategies” to assist them in delivering life stability supports to clients as part of EST.

- Staff have received training on the Risk-Based approach to case management to help them redirect effort from a compliance focus to case management which should reduce administrative burden in case management.

- SAIL principles will be reviewed at monthly staff meetings to reinforce concepts.

- There will be a continuation of opportunities for meet and greet with community partners both virtually and in person where possible. This will assist staff in keeping up to date with local services.

- EST resources available on SA Extranet will continue to be utilized staff on an ongoing basis for training/refresher needs.

- Additions and revisions have been made to policies so that local business practices can be incorporated into the Life Stabilization model. This includes updates on permitted use of Participation Benefits, electronic communications, promotions of modernization tools, verification standards reflecting a more risk-based approach.

- A local Working Group has been developed to establish a “client pathway” in EST. The aim is to develop a clear client path through EST and promote consistency of service amongst Case Managers.

- Our department does not have a dedicated trainer. Our office has two Senior Case Managers who provide Case Managers updated information and provide ongoing support in learning.

- Staff and Program Managers continue to communicate with our Employment Ontario (EO) providers through weekly communication tools and in person or virtual meetings periodically throughout the year. The aim is to make a positive client and staff experience in the work shared between the two agencies.

- Staff and Program Managers continue to communicate (monthly meetings etc.) with our local ODSP office. This is in support of the non-disabled adults who are referred to Ontario Works for support with Life Stabilization goals.

- Continue to seek and provide training opportunities to our staff related to self-care and compassion fatigue.

- Eligibility Verification Process (EVP) is given high priority so that all audits are completed within the expected timeframe. The EVP auditor completes follow up items or notifies the Case Manager of ongoing follow up that may be needed.

The EVP auditor also makes any necessary referrals to the Eligibility Review Officer (ERO) in cases of potential social assistance fraud and makes recommendations on training needs and quality assurance issues, if trends are observed while reviewing files.

- The ERO completes investigations of fraud allegations as well as completing quality assurance measures, such as file reviews and client appeals to ensure program integrity. The ERO will also training and quality assurance recommendations if trends are observed while reviewing files.

- Our office was asked by the Ministry to complete a Framework for Life Stability. Currently this work is being completed collaboratively with staff

- Program Manager has been trained as a trainer in Non-Violent Crisis Intervention. Staff training to begin in April 2023

Strategy to Deliver French Language Services (FLS)

- A strategy to ensure active delivery of French Language Services within designated communities.

- There is a small population seeking French Language services in our counties. However, all forms are available in French and English, and the County has contracted services with interpreter services available as needed.

See the 2023 Service Contracting memo for further information on the FLS requirements for 2023-24. *Enter strategy to deliver FLS compliant services here.*

Business Practices

- A description of required changes, where warranted, to business practices that meet standards for performance in compliance with program policy (e.g., developing local policies to support program delivery).

- We are now fully onboard with Intake and Benefits Administration Unit (IBAU) and are receiving the majority of our applications through IBAU. We need to continue referring clients to complete online applications but provide additional support for people who are not yet comfortable with technology.

- We have trained staff on the risk based eligibility (RBED) determination used with SADA applications as well as concepts in taking a risk based approach to case management. This is an ongoing effort.

- Both Norfolk and Haldimand offices will be equipped with application stations for members of our communities. This will be in the form of desktop computers,

telephones and printing stations. This will allow individuals the opportunity to connect to the resources available electronically.

- Undertaking a review and update on all policies and procedures with a focus on modernization and efficiency as several policies do not yet reflect changed methods of practice.

- Computer stations are being added to reception area of both offices that would allow a space and internet access to members of the public who want to apply for social assistance through the IBAU/online SADA application.

- Continue to promote client registration with MyBenefits and electronic submission of documents. Locally, each individual who is new to the Ontario Works program is provided all of the information to enroll in MyBenefits. This is encouraged by first-line staff to all individuals to promote secure, effective communication. Administration staff are including MyBenefits promotional flyers in all client mail outs and Case Managers have add a message on their email signatures to promote registration. Application stations will be equipped with MyBenefits app for easy access for all clients, especially those without internet/computer access.

- Promotional of DBD enrollment is ongoing through our Intake Support Worker position. All vendors not currently using DBD payment method are being contacted and advised of this feature. Promotion of this is being offered verbally with follow up supplemental information provided. This promotional material is the material offered from the Ministry.

- Locally, we have a group of 3 staff that are Community Support Workers (CSW). These individuals complete their support to the most vulnerable members of our communities. CSW's are community based which means they often will meet individuals in their homes, local libraries or attend doctors' offices/appointments to support. In addition to this, we have CSW's in the local RAMM clinic weekly and Women's Services bi-weekly. This has allowed program information to be provided outside of the local dedicated offices.

- We have continued to explore and leverage all opportunity for community partnering with agencies that we work with closely to support individual in Haldimand and Norfolk counties. Building strong relationships is important to the work we do and we will continue to investigate ways for outreach services as applicable.

- Program Integration efforts are still ongoing to combine duties and job roles to align with renewal and recovery plans.

- Reloadable Payment Cards are in full use and efforts underway to eliminate payments by paper cheque. Using only Direct Bank Deposit and RPC is the

end goal.

- We are now at the end stage of phasing out of hard copy client files. All client file information is now on EDM in SAMS or in electronic format in our local file hold system. Paper documents are scanned into a password-protected system and later shred following confidentiality guidelines.

- We continue to educate staff on confidential document management protocols as we are shifting to electronic methods.
- Quarterly meetings continue to be held with our local ODSP office to strengthen working relationships, especially in matters relating to transferring files between offices and accepting referrals for Non-Disabled Adults (NDAs).

- Moving through COVID-19 pandemic, we quickly shifted work methods to provide client service in different ways, such as doing more phone appointments. We are reviewing the efficiencies this has provided staff as well as reducing transportation barriers for clients in a rural area. We will be incorporating many of these changed work methods into current and future practices.