Recommendations

It is recommended that the Board of Health:

1. Receive this report for information.

Key Points

- The 2015 Annual Report of the Chief Medical Officer of Health of Ontario, *Mapping Wellness: Ontario’s Route to Healthier Communities*, discusses the importance of monitoring the health of our community over time by collecting information to contribute to informed evidence-based decisions about how to invest in wellness.

- Health units face challenges in accessing data which include: relevance; timeliness; consistency; inclusivity and affordability.

- Wellington-Dufferin-Guelph Public Health (WDGPH) uses many internal and external sources of data. Data gaps are mitigated with primary data collection and collaborations with community partners to access local data.

- WDGPH has leveraged resources and implemented systems to effectively monitor the health of our local communities. These include:
  - Health Analytics Team enhancements
  - Increasing access to data
  - Implementing Business Intelligence
  - Sharing our knowledge
  - Evidence informed response
Discussion

In his report, *Mapping Wellness: Ontario’s Route to Healthier Communities*, Dr. David Williams, Chief Medical Officer of Health of Ontario, discusses the importance of monitoring the health of our community over time by collecting information to contribute to informed evidence-based decisions about how to invest in wellness.

The report further explains that information gathered through population health monitoring can be used to identify key threats to wellness in a community. Neighbourhoods or populations that are at-risk of poor health can be identified, as well as communities where people are thriving. Factors that contribute to healthy and unhealthy communities can be identified.

“Local data is important because health issues vary from community to community”

Mapping Wellness: Ontario’s Route to Healthier Communities, 2015

Organizations such as Public Health Ontario and the Ontario Communities Health Profiles Partnership provide snapshots and data tables of health information at a provincial, LHIN or health unit level. These resources provide interesting health information but fall short of identifying important differences within and between communities.

WDGPH has the capacity to monitor and share health information at a community level, which can be shared with community partners to inform decisions about how to best to use resources to improve health and well-being. For example, the map below illustrates meaningful differences between Wellington-Dufferin-Guelph (WDG) communities in the rates of children living in low income households.

**Child poverty**

We know that the rate of children living in low income varies greatly between towns and townships within WDG. In the township with the highest rate, 25% of children are living in low income households. While less than 5% of children are living in low income households in the township with the lowest rate.¹

**How low income was measured**

The Low Income Measure (LIM) identifies households with an after-tax (AT) income that is lower than 50% of the median national income for all families in that year. Living below this threshold is an indication of poverty.
“To improve health, we need to understand the health of our communities, share that information with our communities, invest in community wellness and strengthen our communities by ensuring that everyone has the same opportunities for health and wellness.”

Mapping Wellness: Ontario’s Route to Healthier Communities, 2015

A significant example of this type of work is the Social Determinants of Health Report which identified vulnerable neighbourhoods based on population indicators of health equity and the social determinants of health. As a result of this report, community partners collaborated to support the identified neighbourhoods through the Nurturing Neighbourhoods Initiative (NNI). The goal of the NNI is resilient communities where vulnerable children and families are supported to experience optimal physical, social, emotional and mental health. Partners are working to achieve this goal by:

- Increasing protective factors (e.g., resilience) for vulnerable children and families at the community level;
- Decreasing risk factors (e.g., poverty) for vulnerable children and families at the community level;
- Increasing community capacity to respond to social and economic needs of children and families; and
- Increasing early supports and access to services for vulnerable children and families.

In 2016, the Parent Outreach Worker component of the NNI was evaluated to assess its impact on families being served. The summary of the Parent Outreach Worker evaluation is included in Appendix “B”.

[Map of the area showing the different neighbourhoods]
Challenges

The *Mapping Wellness: Ontario’s Route to Healthier Communities* report discussed challenges in accessing local data experienced by health units. Key challenges were identified as:

- relevance
- timeliness
- consistency
- inclusivity
- affordability

“In many cases, health units lack the high-quality local data they need to map community wellness. Without that data, public health units are flying blind.”

*Mapping Wellness: Ontario’s Route to Healthier Communities, 2015*

Data Sources

WDGPH accesses data from external and internal sources. Primary external sources of data are the Canadian Census, the Canadian Community Health Survey, IntelliHealth, the Community Data Program, Acute Care Enhanced Surveillance and the Better Outcomes Registry and Network. Internal data are sourced from repositories and databases such as Excelicare, Panorama, iPHIS, HCD ISCIIS and Hedgehog. WDGPH also conducts primary data collection when information gaps are identified. Examples of this work are the WDG Youth Survey and the Infant Feeding Survey. Each of the above noted databases are described in Appendix “A”.

Population health monitoring at WDGPH

*Health Analytics Team enhancements*

Members of the Health Analytics Team continue to access educational opportunities to increase knowledge and skills in visualizing information.

A Health Analytics Specialist has joined the Health Analytics Team to increase our ability to deliver quality information to communities in a timely manner.

Computer software and hardware are being used to enhance population health monitoring.
**Increasing access to data**

Significant gaps in data are mitigated through primary data collection. A prime example of this is the WDG Youth Survey which is implemented every three years for WDG students in grades 7 and 10. For more information about the WDG Youth Survey see Appendix “A”.

WDGPH has access to the Acute Care Enhanced Surveillance (ACES). ACES is a real-time syndromic surveillance system that allows for routine monitoring of symptoms of respiratory, gastrointestinal and other illnesses in patients visiting local emergency departments, and thus has the capability to be used as an early warning system. For more information about ACES see Appendix “A”.

WDGPH has had a successful history of working with community partners to access local data. In a recent example, WDGPH has agreed to play a lead role in monitoring opioid use. WDGPH will be collaborating with community partners to access, analyze and report on opioid use and overdose data.

**Implementing Business Intelligence**

The Health Analytics Team has built a dynamic and sustainable report development and delivery infrastructure to support evidence-based practice and decision making at WDGPH.

This infrastructure uses current cutting-edge technology to build appropriate data models that support information development and visualization. This work is supported by sophisticated tools provided within Microsoft’s Business Intelligence Framework.

**Sharing our knowledge**

The WDGPH reporting format is transitioning away from printed reports and towards interactive data dashboards. Data dashboards allow for information to be refreshed quickly as new data are available and for consumers to interact with the data by choosing the characteristics they are most interested in such as geographies, age categories, time period, or gender. Dashboards can be easily shared internally and with community partners.

A variety of reports will be created in the form of dashboards:

- Community profiles
- Population profiles
- Health status reports
- Surveillance reports
Evidence informed response

WDGPH works with community partners to support the mobilization of evidence into practice. The importance of using data and information to inform decision-making at the local level has been well documented. Planning and delivery that is evidence informed is more effective in achieving outcomes. Programs and services must address needs that are influenced by differences in the context of local communities.

Need is established by assessing the distribution of social determinants of health. It is evident that population health outcomes are often influenced disproportionately by sub-populations who experience inequities. By tailoring programs and services to meet the needs of priority populations, networks contribute to the improvement of overall population health outcomes. Shared knowledge can assist in leveraging resources and aligning community goals and objectives. To work in an evidence informed way means understanding:

- the issue being addressed
- what works
- how to put what works into practice
- who to involve and how to involve them (such as communities and key stakeholders)
- why this action is required.  

Conclusion

WDGPH recognizes the importance of monitoring the health of our community over time by collecting information to contribute to informed evidence-based decisions about how to invest in wellness. Challenges in accessing data have been mitigated with primary data collection and collaborations with community partners to access local data.

WDGPH has leveraged resources and implemented systems to effectively monitor the health of our local communities. These include:

- Health Analytics Team enhancements
- Increasing access to data
- Implementing Business Intelligence
- Sharing our knowledge
- Evidence informed response
Ontario Public Health Standard

Population Health Assessment

“Population health assessment includes measuring, monitoring, and reporting on the status of a population’s health, including determinants of health and health inequities. Population health assessment provides the information necessary to understand the health of populations through the collaborative development and ongoing maintenance of population health profiles, identification of challenges and opportunities, and monitoring of the health impacts of public health practice.”

The board of health shall:

1. Assess current health status, health behaviours, preventive health practices, health care utilization relevant to public health, and demographic indicators.

2. Assess trends and changes in local population health.

3. Use population health, determinants of health and health inequities information to assess the needs of the local population.

4. Tailor public health programs and services to meet local population health needs.

5. Provide population health information, including determinants of health and health inequities to the public, community partners, and health care providers.

Surveillance

“Surveillance is the systematic and ongoing collection, collation, and analysis of health-related information that is communicated in a timely manner to all who need to know, so that action can be taken. Surveillance contributes to effective public health program planning, delivery, and management. Dissemination of surveillance analyses may take the form of reports, advisories, healthy public policy recommendations, alerts, or warnings. Surveillance has historically been associated with infectious diseases and vaccination programs, but its importance has become increasingly recognized for environmental health issues, child health, reproductive health, chronic disease prevention, and injury prevention.”

The board of health shall:

1. Conduct surveillance, including the ongoing collection, collation, analysis, and periodic reporting of population health indicators.

2. Interpret and use surveillance data to communicate information on risks to relevant audiences.  

Population Health Monitoring
WDGPH Strategic Direction(s)

Check all that apply:

☑️ Health Equity
   We will provide programs and services that integrate health equity principles to reduce or eliminate health differences between population groups.

☑️ Organizational Capacity
   We will improve our capacity to effectively deliver public health programs and services.

☑️ Service Centred Approach
   We are committed to providing excellent service to anyone interacting with Public Health.

☑️ Building Healthy Communities
   We will work with communities to support the health and well-being of everyone.

Health Equity

One of the requirements of Population Health Assessment is to “provide population health information, including determinants of health and health inequities to the public, community partners, and health care providers.”¹

Planning and delivery that is evidence informed is more effective in addressing needs that are influenced by differences in the context of local communities. Need is established by assessing the distribution of social determinants of health. Population health outcomes are often influenced disproportionately by sub-populations who experience inequities. It is known that living with less, limits choice and impacts health.

Tailoring programs and services to meet the needs of priority populations, results in improvements of overall population health outcomes.

Appendices

Appendix “A” – Data Sources

Appendix “B” – Parent Outreach Worker Evaluation
References


APPENDIX “A”

DATA SOURCES

Census

“The Census Program provides a statistical portrait of the country every five years. The Census offers a wide range of analysis, data, reference and geographical information according to topics (subjects) that paint a portrait of Canada and its population.”

WDGPH has built data models that allow us to efficiently examine demographic characteristics in each of the census cycles. Data from the 2016 cycle are being imported as they are available.5

Release dates of 2016 Census data

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<td>February 8</td>
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<tr>
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<td>Census of Agriculture</td>
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<td>Families, households and marital status</td>
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<td>Income</td>
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<td>Mobility and migration</td>
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Canadian Community Health Survey (CCHS)

CCHS data are used for health surveillance and population health research. The CCHS is a cross-sectional survey of Canadians 12 years of age and over living in the ten provinces and the three territories. It collects information related to health status, health care utilization and health determinants. The first years of data collection were 2001, 2003 and 2005. Starting in 2007, the survey was repeated annually. There has recently been a major redesign of the survey and, as a result, caution should be taken when comparing data from previous cycles to data released for the 2015 cycle onwards. One limitation of the CCHS is small sample sizes for some responses. WDGPH often combines collection years to examine populations or characteristics. Subjects covered by the CCHS are:

- Diseases and health conditions
- Health
- Health care services
- Lifestyle and social conditions
• Mental health and well-being
• Prevention and detection of disease

**IntelliHealth**

IntelliHealth is a health information database populated with datasets contained within the Provincial Health Planning Database (PHPDB). ‘Data Warehouse’ technology is used to store, manage and provide access to health-related information that has been consolidated from a range of sources. PHPDB is one of the primary sources of morbidity and mortality data in Ontario such as, hospitalization data (emergency room visits, hospital discharges, day surgeries etc.), vital statistics (births and deaths), inpatient mental health and rehabilitation, home care, medical service and billing providers, and population tables.

**Community Data Program (CDP)**

The Canadian Council on Social Development established the CDP in the mid-1990s as a gateway for municipalities and community organizations to access customized tables from Statistics Canada and other agencies to monitor and report on social and economic development trends within their communities. Relying on a Community Consortium model, the CDP reduces the cost of acquiring community data, builds community data analysis capacity and connects a national network of data users.

WDGPH played a lead role in building a consortium in WDG and continues to perform as the WDG consortium lead agency. In addition to the Statistics Canada products such as the Census, the 2012-2017 data acquisition cycle included tables and tools from over two dozen other government and private sector sources. The program has resulted in the following benefits for our community:

1. **Cost savings**: Using the consortia model, WDG has purchased a variety of datasets for a fraction of the cost by sharing the cost with consortia across Canada;
2. **Greater and easier access to data**: Members can access hundreds of datasets using the online CDP data portal;
3. **Enhanced partnerships**: The CDP has strengthened our local network of data users and has connected us to a Canada-wide network;
4. **Increased community capacity**: The program builds community data analysis capacity through access to analysis tools, training and networking opportunities.

**Acute Care Enhanced Surveillance (ACES)**

“ACES is a real-time syndromic surveillance system with temporal and spatial capabilities that enables public health to be better informed on the health of the community, which in turn can help improve public health protection and prevention initiatives. The system also allows hospitals to monitor emergency department (ED) volume, admissions, and surge capacity to help prepare for high volumes of patients, particularly in the event of a flu pandemic. The goals of the system are to monitor changes and trends in the incidence of endemic disease and to detect new or emerging public health threats. ACES’ syndromic surveillance capabilities are useful in a variety of situations, including:

• Acting as an early warning system for emerging pathogens
• Routine monitoring of respiratory and gastrointestinal illness
• Public health emergencies, such as extreme weather events
• Mass gatherings

The flexibility, adaptability, monitoring and analysis capabilities of ACES enhance situational awareness for a variety of common, emerging, or unexpected public health issues.9

**Better Outcomes Registry and Network (BORN)**

BORN is a registry and network for pregnancy, birth and childhood data in Ontario. BORN collects data about birth from hospitals, and then interprets and shares the data with hospitals and health units.10

**WDG Youth Survey**

The WDG Youth Survey collects self-reported information from youth about their well-being. It is a survey that provides information about students’ learning, health and development. The survey asks questions about risk and protective factors including physical activity, eating habits, drug and alcohol use, mental health, time spent with family and friends, sense of safety, and school involvement.

Grade 7 and 10 students at schools within the Upper Grand District School Board, Wellington Catholic District School Board and the Dufferin Peel Catholic District School Board have been surveyed every three years beginning in the 2011/2012 school year. The next cycle of collection will happen in 2017/2018. Grades 7 and 10 students were selected, for a number of reasons:

• It is still possible to intervene and provide supports in schools help youth at these ages.
• Risk-taking behaviours often begin in grade 10 or earlier.
• With survey administration happening every three years, those students surveyed in Grade 7 will be surveyed again in Grade 10, allowing for monitoring over time and trend analysis.

The response rate in 2011/2012 was 55%, with a total of 3,429 student respondents. In 2014/2015 the response rate was 73.5%, with a total of 4,896 student respondents. Superintendents and principals from the three boards of education have acknowledged the importance of the information collected through the Youth Survey to their understanding of emerging issues and their capacity to conduct evidence-informed planning. The increase in response rate is likely due to the increased recognition by superintendents and principals of the value of the information.

**WDG Infant Feeding Survey**

In order to understand, breastfeeding initiation, exclusivity and duration in WDG, WDGPH developed and implemented the Infant Feeding Survey. WDGPH first completed this survey in 2007, which allows for comparison over time. Our aim is to protect, promote and support breastfeeding, and to improve breastfeeding rates. The findings are used to guide program planning at WDGPH and for other community partners who work to support breastfeeding, including local hospitals. This information will continue to inform our collective efforts to provide evidence-based, best practices that meet the needs of families in our community.
**WDGPH databases**

**Excelicare**
Excelicare is the electronic medical record system for WDGPH. Demographic patient information, health information and service delivery information is entered and maintained in Excelicare. This includes sexual health, immunization, infectious disease, and infant/child growth and development information.

**Panorama**
Panorama is a central immunization information repository where all administered immunizations are recorded and tracked. It is “an initiative to provide Ontario public health professionals with a comprehensive, secure, web-based information system to more efficiently manage immunization information, vaccine inventory, and cases and outbreaks of communicable diseases.”

**The integrated Public Health Information System (iPHIS)**
iPHIS is a web-based client health record and reporting system for local and provincial communicable disease surveillance. Reportable and infectious disease data including:

- Enteric, Food and Waterborne Diseases
- Diseases Preventable by Routine Vaccination
- Diseases Transmitted by Direct Contact and Respiratory Routes
- Vectorborne and Zoonotic Diseases
- Encephalitis/Meningitis
- Rare Diseases
- Enteric Outbreaks
- Respiratory Outbreaks

**Healthy Child Development - Integrated Services of Children Information System (HCD-ISCIS)**
“The Ministry of Children and Youth Services (MCYS) supports children in Ontario to reach their full developmental potential through a number of programs that are collectively helping to provide children with the best possible start in life. For the purpose of this initiative, these include Healthy Babies Healthy Children (HBHC), Preschool Speech and Language (PSL), Infant Hearing Program (IHP) and Blind Low-Vision (BLV).

Each of these programs supports children and their families with particular risks and challenges, individually or in combination. These programs, under the HCD umbrella, provide screening, assessment and intervention services, family support and referrals to community resources – and all of these activities are entered and tracked in a database called HCD-ISCIS.”

**Hedgehog**
Hedgehog software is used by the Health Protection Division to manage information about rabies, foodborne illness outbreaks, complaints and premise inspections. Information about inspections of daycare, pools, salons, and tattoo parlors is entered and maintained in Hedgehog.
Parent Outreach Worker Program: Evaluation Report

The Parent Outreach Worker (POW) program supports families that may be isolated or struggling. It is a neighbourhood-based strategy. In late 2012, two Outreach Workers began supporting families in Guelph’s Brant and Two Rivers neighbourhoods. In July 2015, the program expanded to Grange Hill East with an additional Outreach Worker.

In 2016, the POW program evaluated its impact on families. The evaluation focused on whether families participating in the program experienced:

- Increased social connection
- Improved access to basic needs
- Greater awareness of and access to formal services and supports
- Increased community safety
- Improved family functioning

The data presented in this report was gathered from:

**Participant Feedback**
Current and former clients of the POW program completed a short survey about how the POW program had impacted their families. A total of 135 current and former clients participated in the survey: 59 participants lived in Two Rivers, 53 lived in Brant and 23 lived in Grange Hill East.

**Who is participating in the POW program?**
Between July 2013 and September 2016, Outreach Workers made 5525 contacts. In that time, 276 registered clients and families have received support. Hundreds more have been supported anonymously.

Top three ways participants first connected with their Outreach Worker:

- Being involved with local neighbourhood groups (37%).
- A friend, neighbour or family member (20%).
- Another community service they were using (19%).

Among families whose household composition was documented, 69% are headed by single parents. Household composition was documented for 68% of all registered families.

**Program Tracking Data**
Outreach Workers regularly document program information such as the number of clients and families supported. Some program data has been collected since July 2013. Other indicators were added more recently as part of the developmental evaluation. Collection timeframes are included for all program tracking data.

65% of participants have stayed connected to their Outreach Worker for more than a year.
Increased Social Connection

Social connection refers to informal social and community supports that people can depend on in times of stress. According to participants, Outreach Workers helped families build social connections in two ways:

1) Providing One-on-One Support

In the comments section, many participants highlighted the value of the social, emotional and informational support they received from their Outreach Workers.

"Without [My Outreach Worker], I wouldn't have a safe place to share these troubles. I wouldn't have someone to listen to me without judging, and I wouldn't have someone to encourage me by offering supports and suggestions...."

Outreach Workers have supported clients to address stress 337 times (Jul 2013 - Sep 2016).

They also supported 29 clients to adopt leadership roles (Feb 2016 - Sep 2016).

2) Encouraging Participation in Programs & Events

In the past year:

- Attendance at Outreach Worker programs was 3767.
- 559 referrals were made to neighbourhood groups.
- Outreach Workers supported 68 clients to increase their social connections. (Oct 2015 - Sep 2016)

3 out of 4 participants agreed that they had met new people in their neighbourhood since they started working with their Outreach Worker.

"She helps connect neighbours with each other so we no longer feel alone but part of a community."

One of the most common participant comments was how Outreach Workers helped families connect with and access recreational activities in their communities.

Improved Access to Basic Needs

Outreach Workers supported participants’ access to basic needs by connecting them with community services and organizations that provided material resources. Frequently mentioned services included: Garden Fresh Box, Christmas Hampers, Back-to-School Backpack Project and food and clothing services.

Food

Outreach Workers have helped clients access food 1375 times. That is roughly once every day since the POW program started. 80% of participants said that because of their Outreach Worker they can get food for their family if they don’t have enough. (Jul 2013 - Sep 2016)

Financial Needs

77% of all clients have received support for financial concerns. Outreach Workers have offered this support 1191 times. Several participants shared stories of how their Outreach Workers had helped them find funding or income tax rebates. (Jul 2013 - Sep 2016)

School Supplies

84% of participants said that it was easier to get their children’s school supplies since they started working with their Outreach Worker.

"She kept in contact with me throughout the process and said she wasn’t giving up until I had what I needed for my son’s first day of school."

Population Health Monitoring
Greater Awareness of and Access to Formal Services and Supports

Many participants shared stories of receiving support from Outreach Workers to access and navigate formal services. The most commonly mentioned were: Family and Children’s Services, Ontario Works, healthcare systems, mental health supports and counselling, legal proceedings and the education system.

Information and Referrals

Last year, Outreach Workers connected 239 families with 2700 services and supports in Guelph. (Oct 2015 - Sep 2016)

93% of participants said they can get advice from their Outreach Worker about where to go if they need help.

Since they started working with their Outreach Worker, 92% of participants have used services or supports that they did not know about or would not have used before.

Navigating Services

“[My Outreach Worker] has helped greatly through the process of having my high needs children assessed for supports at school, she has been an advocate for me and my family… and has been an unbelievable support and caring friend through the struggles we have had over [the] last year.”

Since meeting with their Outreach Worker:

96% of participants felt better about their ability to access services and supports.

95% of participants are able to get services and supports when they need them.

Increased Community Safety

Since they started working with their Outreach Workers…

83% of participants said they felt more responsibility to create a safe and welcoming neighbourhood.

69% said their neighbours were more willing to help each other out.

76% of participants reported feeling safer in their neighbourhood.

83% said that the neighbourhood had become a better place for their families.

Improved Family Functioning

40 families in Guelph are no longer involved with Family and Children’s Services since receiving support from Outreach Workers.

Another 22 estimated families avoided Family and Children’s Services interventions by working with Outreach workers.

“She is an amazing person and if it wasn’t for her I don’t believe that my family would still be together as she has helped us work through rough times.”

Since meeting with an Outreach worker:

88% of participants said that they know more about where to go or who to talk to if they need help with parenting.

85% reported having more skills for helping their children learn and grow.

81% spent more time connecting with or doing special activities with their children.

79% of participants have a better idea of what to do to help their children when they are upset.
Conclusions

There is compelling evidence that the Parent Outreach Worker program is achieving its goals. The program’s influence continues to grow in Brant, Grange Hill East and Two Rivers as Outreach Workers make connections and build relationships with families who may be struggling.

According to participants, Outreach Workers provide much needed social, emotional and informational support. They also play an important role in connecting families to formal and informal services. Outreach Workers are highly valued parts of their communities and are considered essential resources.

Recommendations

✓ Continue to operate the POW program in Brant, Grange Hill East and Two Rivers.
✓ Explore opportunities to expand into additional Guelph neighbourhoods.
✓ Support Outreach Workers to continue advocacy for and with clients.
✓ Increase awareness of the program and its successes.
✓ Document the specific agencies and services to which clients are referred.

The POW program is part of the Nurturing Neighbourhoods Initiative. Partners include:

For more information visit: http://www.guelphchc.ca