

A DIFFERENT KIND OF HEALTHCARE



VAUGHAN
COMMUNITY HEALTH CENTRE



2024-2025 SOCIAL IMPACT REPORT



LAND ACKNOWLEDGEMENT, VISION, MISSION, VALUES AND PRIORITIES

Land Acknowledgement

We acknowledge that we are situated on the treaty lands and territory of the Mississaugas of the Credit First Nation and the Williams Treaty First Nation. These lands have been cared for by other Indigenous peoples including Huron-Wendat and Haudenosaunee. We are grateful to the First Nation, Inuit and Metis people and we thank them for sharing this land. We acknowledge the Chippewas of Georgina Island First Nation as our close neighbour, one with whom we strive to build a respectful relationship.

Vision, Mission, Values and Priorities

 VAUGHAN COMMUNITY HEALTH CENTRE		Strategic Plan 2023-2028
	Vision	A healthy, thriving community.
	Mission	Working with our community, VCHC provides exceptional client-centered community health services that address social determinants of health, foster more equitable health outcomes, and promote health and wellbeing.
	Values	<ul style="list-style-type: none"> • Belonging – We facilitate a community where all feel welcome and safe. • Equity – We advocate for and create culturally safe, inclusive, diverse and accessible environments. • Collaboration – We develop strong, inter-disciplinary partnerships that respond to client, staff, and community needs. • Accountability – We practice the highest standards of professional services. • Excellence – We are leaders in providing exceptional community health care through continuous learning and innovation.
	Priorities	<p>Organizational Vitality Develop a healthy, innovative organization with a stable, skilled, and engaged workforce.</p> <p>Inclusive Community Engagement Provide intentional and inclusive service delivery with and for local indigenous, black, racialized, and other disadvantaged communities.</p> <p>Innovative Partnerships Enhance collective capacities by strengthening existing partnerships and cultivating new relationships.</p>

BECAusE



MESSAGE FROM EXECUTIVE DIRECTOR AND BOARD CHAIR



LoAn Ta-Young,
Executive Director



Carin Binder,
Board Chair

The Vaughan Community Health Centre (VCHC) team is committed to serving our local underserved communities. In October 2024, we were proud to be awarded the Locally Driven Population Health Models (LDPHM) funding, thus, enabling our team to provide culturally responsive services for our local communities who are facing barriers in accessing healthcare services. Through our community ambassadors, we engaged our local African, Caribbean, and Black (ACB) and newcomer communities to obtain a better understanding of their experiences in accessing services for Type 2 diabetes management. We look forward to collaborating with local community leaders to develop and deliver culturally responsive Type 2 diabetes services to our ACB and newcomer communities.

On September 30, 2024, our staff acknowledged Truth and Reconciliation Day by learning about the significance of Orange Shirt Day and the history of residential schools. This marked the beginning of our journey into learning about the history and culture of Indigenous Peoples. Our staff's training on Indigenous Cultural Safety is ongoing. We look forward to connecting with local Indigenous leaders and learning about how VCHC can offer support in meeting the needs of our local Indigenous communities in Northern York Region.

The VCHC maintains its commitment to increasing access to primary care services for our clients and local communities. We supported the establishment of the Northern York South Simcoe Ontario Health Team primary care clinic by providing in-kind space and recruiting and managing staff for their clinic. To help our clients access primary care services in a timely manner, our primary care team used quality improvement strategies to triage client needs and continued to provide evening appointments and on-call services after hours. Our efforts are helping to alleviate the pressure on emergency departments for primary care services.

We sincerely thank our clients and community members for continuing to entrust us with their care. We are grateful to our community partners and dedicated VCHC team for their commitment to providing high-quality care and services for our clients and communities. We look forward to strengthening collaboration with our valued community partners and forging new partnerships to advance equity for underserved communities.

OUR BOARD OF DIRECTORS



**Carin Binder,
Board Chair**



**Dennis Bailey,
Vice Chair**



**Malcolm Wong,
Treasurer**



**Gino Caputo,
Secretary**



Louisa Poon



Emmanuel Abara



Sunder Singh



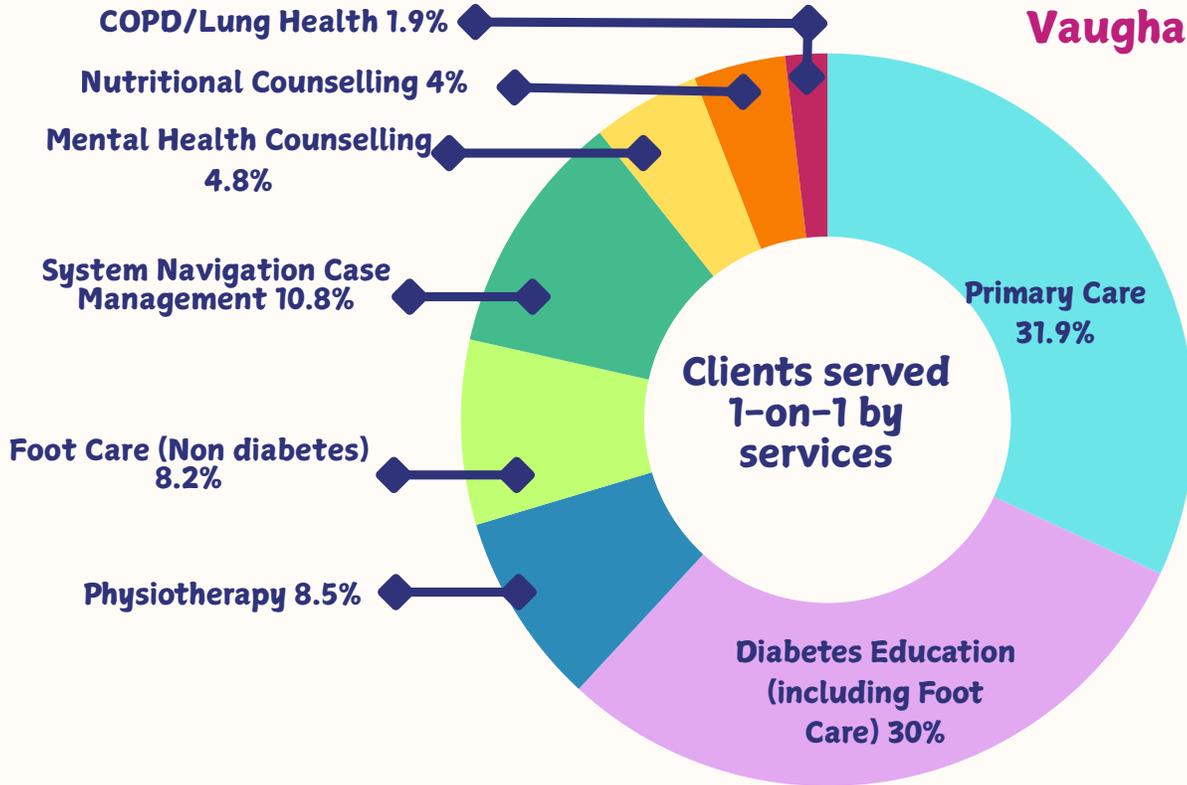
**Carmela
Campanella-
Borraccia**



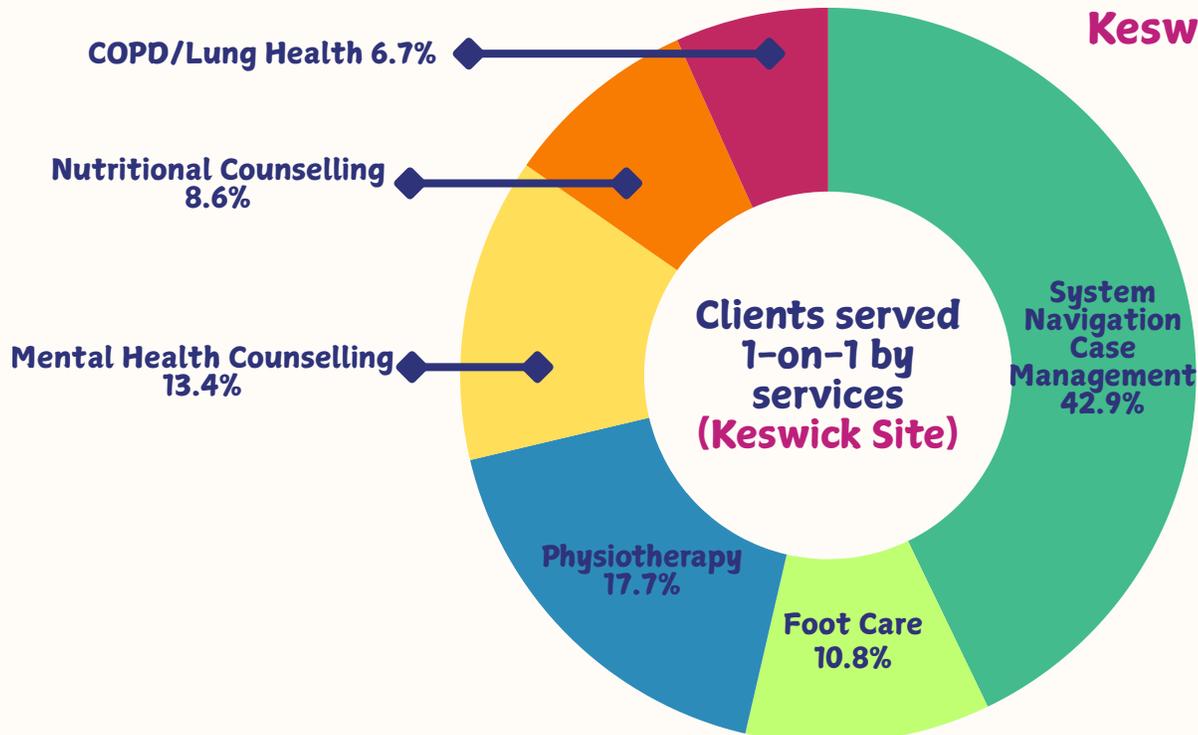
Patrick Clifford

SERVICE STATISTICS

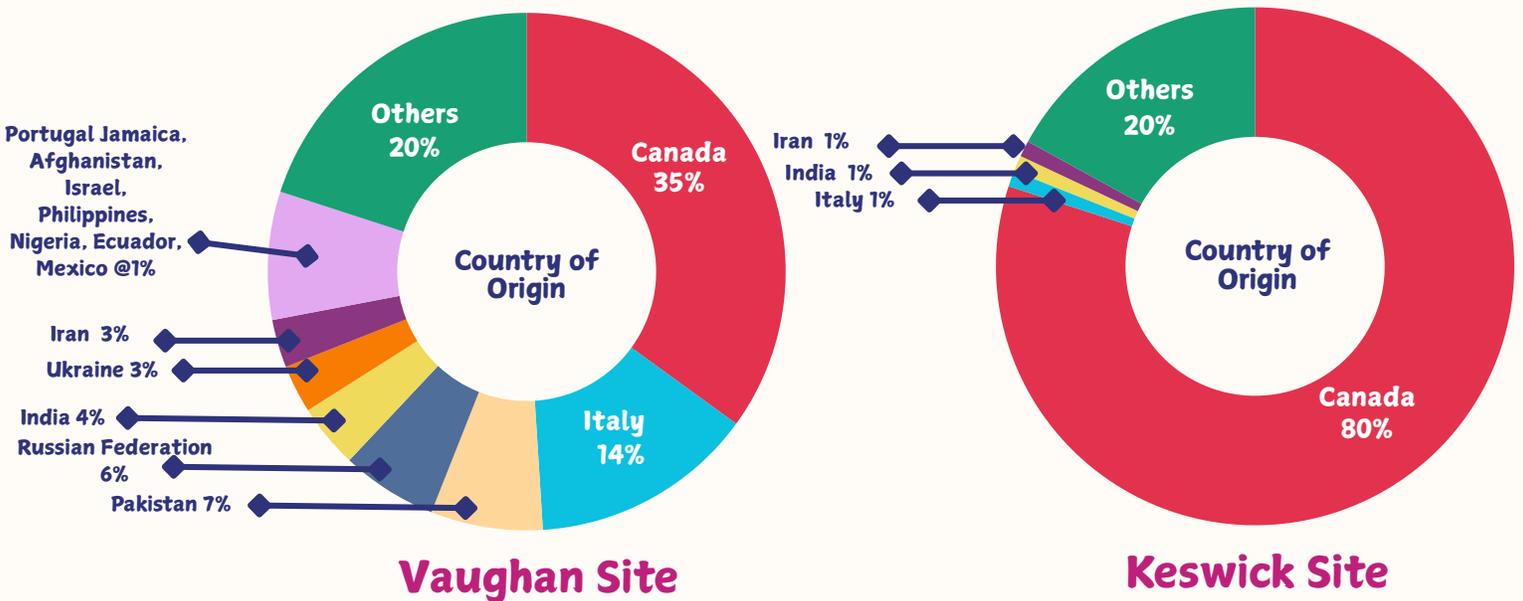
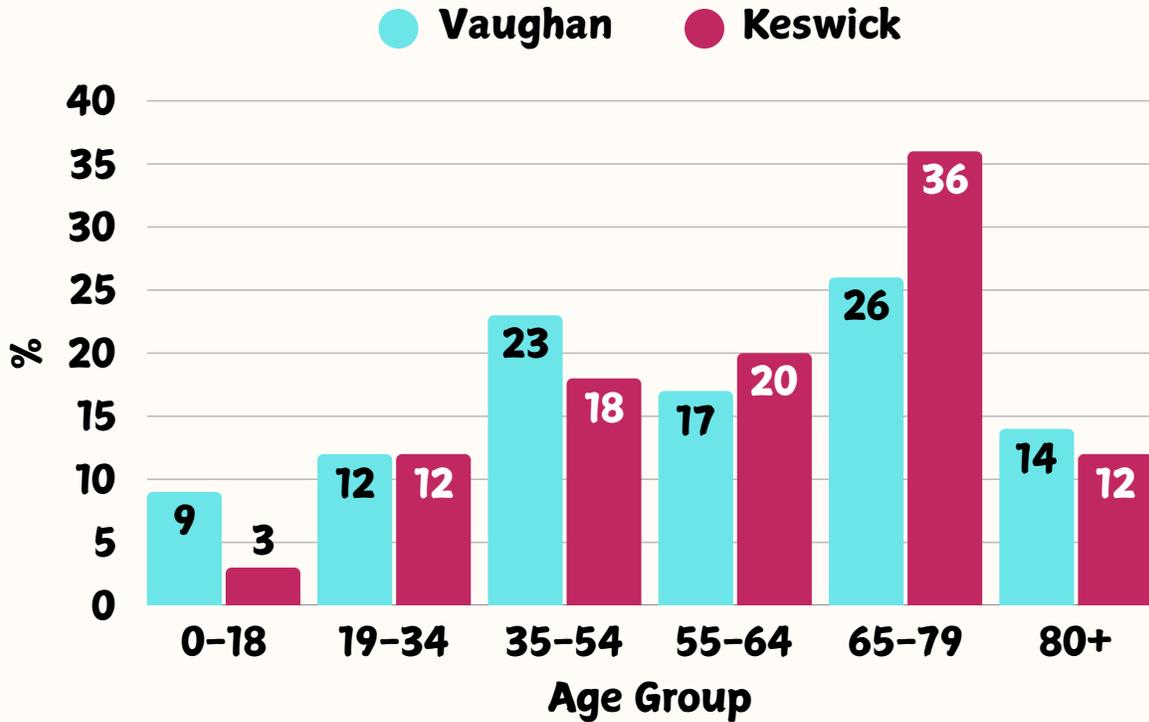
Vaughan Site



Keswick Site



DIVERSITY OF CLIENTS SERVED



LOCALLY INFORMED DIABETES PREVENTION AND MANAGEMENT STRATEGY

BUILDING ON OUR WORK

As the lead agency for Ontario Health's High Priority Communities strategy, in 2024, VCHC received additional funding to support the community with accessing healthcare services in ways that respected and considered people's different cultures, backgrounds and experiences.

With this funding we recruited 3 Community Ambassadors. The Community Ambassadors' role is to engage under-served communities and build trust in order to connect people to healthcare services they need.

Evidence shows that certain groups of people have a disproportionate burden of chronic diseases and prevalence of chronic disease risk factors, including Indigenous people, racialized communities, people with low socioeconomic status and those with poor mental health.

Did You Know?

"Social determinants of health can influence the rate of individual-level modifiable risk factors and thus the risk of diabetes. The main determinants of health include income, employment, education, childhood experiences, physical environments, social supports, access to health services, and racism."

Diabetes in Ontario: 2024 Background



According to Diabetes Canada,

"Certain populations are at higher risk of developing Type 2 Diabetes, such as those of African, Arab, Asian, Hispanic, Indigenous, or South Asian descent, those who are older, have a lower level of income or education, are physically inactive, or are living with overweight or obesity".

The Diabetes Education Team with Community Ambassadors began a collaboration with the goals of connecting with one of VCHC's priority populations: the African, Caribbean and Black (ACB) community, to increase awareness about Type 2 diabetes risk factors, screening and checkup schedules.

The Community Ambassadors have been out in the community, speaking with people, door knocking at local businesses, attending events, connecting with places of worship trying to understand and learn more about the barriers people may be experiencing in managing this chronic disease.



LOCALLY INFORMED DIABETES PREVENTION AND MANAGEMENT STRATEGY



We also consulted organizations leading the work of supporting the ACB and newcomer communities in Vaughan such as ANCHOR Canada, Human Endeavour and the Vaughan Welcome Centre.

IN SPEAKING WITH COMMUNITY RESIDENTS AND OUR PARTNERS,

we started to see themes emerging that may be preventing people from having the services required to manage their diabetes. Some emerging themes included:

Lack of engagement with ACB community and cultural awareness.

Lack of access to a primary care provider

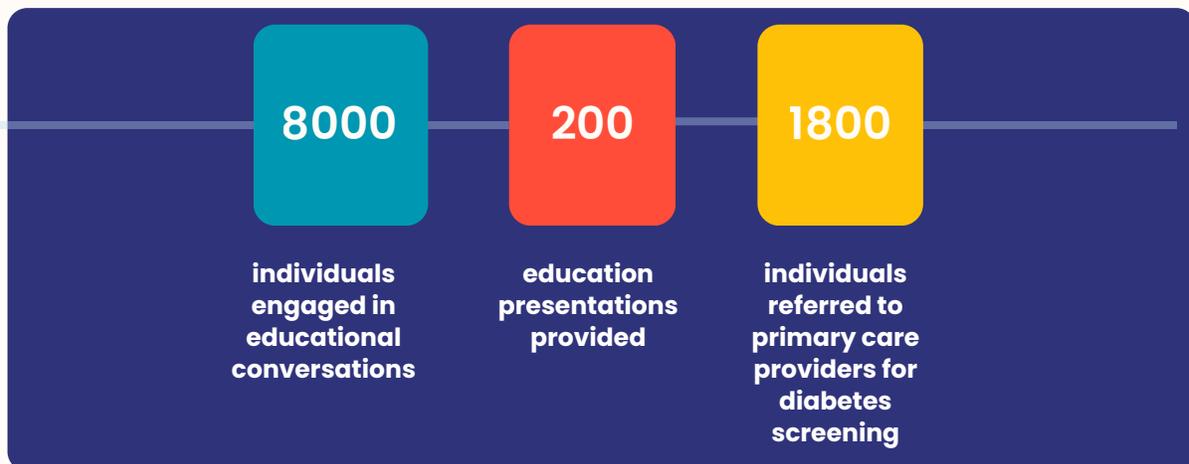
Lack of awareness about diabetes complications and preventative tests such as eye screenings.

We are using this feedback to work with local community leaders to develop strategies to support the community to have equitable access to care.

For example, in February 2024, together the Diabetes Education Team and Community Ambassadors collaborated on a blood glucose screening and awareness raising event which was provided at the request of the York Region Alliance of African Communities (YRAACC) during Black History Month Celebration.

We are also in the process of coordinating additional blood sugar screening events in collaboration with local places of worship.

IMPACT SINCE LAST YEAR



USING QUALITY IMPROVEMENT STRATEGIES TO ENHANCE PRIMARY CARE SERVICES FOR CLIENTS

Using the VCHC's Quality Improvement Framework, our team is continuously looking at best practices to deliver timely access to care and screening to improve community health outcomes.

ACCESS

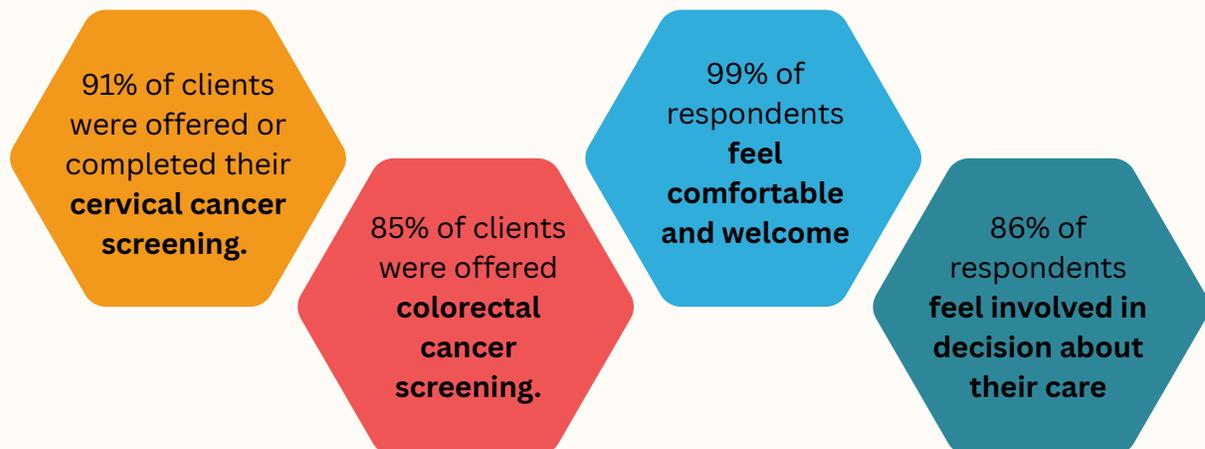
The Primary Care Team focused on ensuring clients with same-day health concerns had timely access to appointments with a VCHC primary care provider. When clients request an appointment, our Medical Secretaries ask questions about symptoms to determine how best to direct them. VCHC's Registered Practical Nurse (RPN) also triages needs and urgency particularly when a clinician is unavailable or all appointments are filled.

The team regularly tracks the number of same-day requests we are unable to schedule and surveys clients about their experience with obtaining an appointment. This quality improvement process allows us to ensure our clients receive care at the right place and time and reduces avoidable emergency department visits.



PREVENTATIVE CANCER SCREENING AND OTHER QUALITY IMPROVEMENT MEASURES

Ensuring that family medicine clients are up-to-date with preventative cancer screenings is one of our priorities. In fact, the VCHC is accountable to the Ministry of Health to ensure our clients are offered preventative cancer screenings when they are due. We implemented a quarterly reminder system where screen-eligible clients were contacted by the RPN and offered an appointment. Client data on race and ethnicity was also considered as research indicates increased risk of cancer disease in some communities compared to others. Clients are educated about the importance of staying up-to-date with these screenings for earlier identification of disease and need for intervention.



CHRONIC DISEASE PROGRAM IMPACT

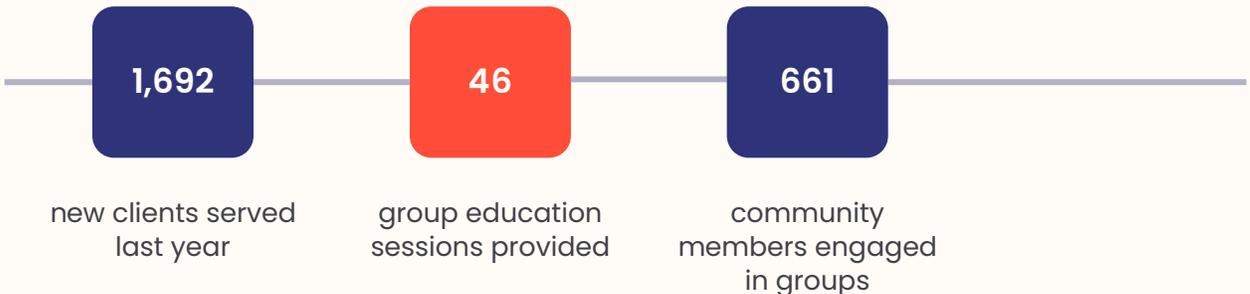
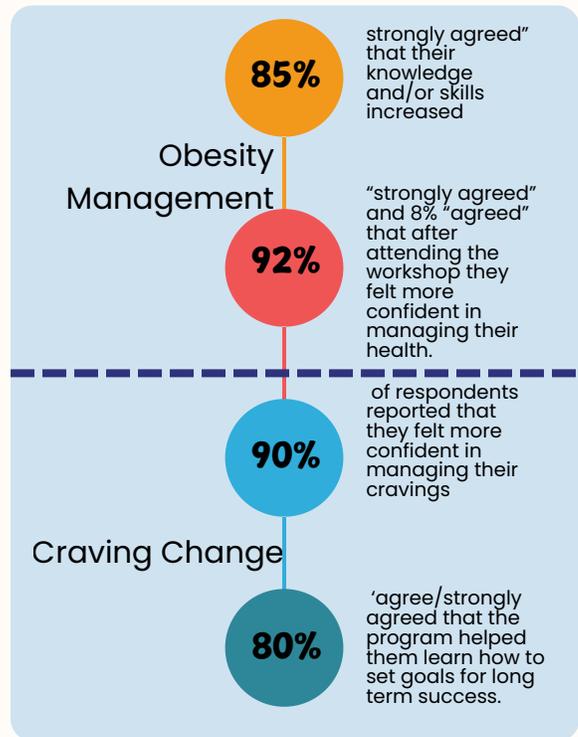
For many living with chronic diseases, accessing care and support in the community as part of their health care can be challenging. VCHC's Chronic Disease Program aims to decrease barriers to care and to empower individuals with the skills and knowledge needed to self-manage and maintain a high quality of life. We offer expert-led exercise programs designed with a focus on preventing and managing chronic conditions.

TYPE 2 DIABETES PREVENTION AND MANAGEMENT PROGRAM

VCHC's Diabetes Nurse Educators and Dietitians provide comprehensive one-on-one counseling to individuals at risk of developing or living with Type 2 Diabetes along with the Chiropodist who provides foot care services. The counselling services are provided at VCHC, virtually, at local doctor's offices and pharmacies in the community.

Community outreach provides an opportunity for the team to meet with the public to raise awareness about diabetes and promote the Centre's programs and services.

Independently and in collaboration with community organizations such as Elspeth Heyworth Centre for Women, Human Endeavour, Community Home Assistance to Seniors (CHATS), City of Vaughan libraries and others.





CHRONIC DISEASE PROGRAM IMPACT



EXERCISE EDUCATION PROGRAM

For those 19 years of age and older living with a chronic condition(s), the Exercise Education Program provides an opportunity for everyone to learn how to exercise safely and gain confidence in a supervised setting. Sessions focus on core elements such as improving balance and coordination, increasing muscular strength and endurance along with mobility and flexibility.

292 EXERCISE SESSIONS HELD

Three hundred and thirteen individuals participated in the Spring and Fall/Winter terms of the Exercise Education Program. A total of 292 sessions were conducted. Participants' evaluations noted many positive benefits with 98% of individuals reporting that the program met their expectations and 100% reporting that the program content met their level of physical fitness.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) PROGRAM

The VCHC provides services for those living with COPD and other lung conditions. Clients participated in monthly online support groups along with one-to-one sessions as needed with healthcare professionals either in-person or virtually.

403 GROUP EDUCATION SESSIONS HELD

The COPD Virtual Care group continues to meet twice a week. Support is tailored to individual care needs and group session topics provide participants with knowledge and resources to live well while managing their condition.



The COPD care team continued to expand its focus on Keswick clients by offering virtual and in-person support.

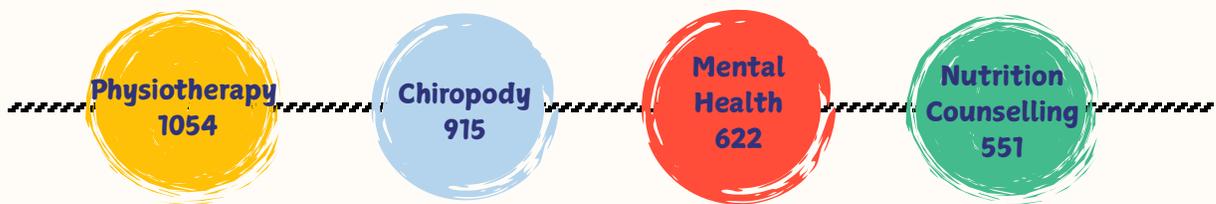


INTERPROFESSIONAL HEALTH SERVICES

As part of our model of care, health professionals work together to provide clients with comprehensive health care at the right place and at the right time. In addition to primary care and chronic disease prevention and management services, we provide interprofessional services which include physiotherapy, nutrition and mental health counselling and chiropody services. Our interprofessional team supports the clients of our internal health care providers and accept referrals from external solo family doctors and nurse practitioners.

Last year, our Vaughan site received 1770 referrals, while our Keswick site received 1043 referrals from solo practicing family doctors or nurse practitioners and provided care to 3,142 individuals.

Client Served by Service



We provide system navigation case management services. The Case Manager utilizes a model of social prescribing to ensure people have access to the resources and services they need. Clients often seek support for challenges related to mental health, housing instability and financial stress.

Many also present concerns about employment. Clients who seek the Case Manager's support frequently experience barriers such as limited access to stable and affordable housing.

These challenges often overlap, creating added stress and making it harder for clients to achieve stability and well-being. System navigation is crucial for clients because many face complex, overlapping challenges.

Client Success Story:

A client faced significant challenges navigating the system due to personal and systemic barriers was supported by the System Navigator with receiving financial assistance through the Canada Pension Plan Disability program. The client was provided with guidance throughout each step, helping them understand requirements, complete documentation and prepare for next steps. After the initial application was denied, the System Navigator helped in the appeal process and later represented them at the Social Benefits Tribunal hearing, advocating for the need for financial for instance related to disability. As a result of this advocacy the client's appeal was approved, and they were able to receive the financial support that was needed.

This work is deeply rewarding, but it can be emotionally challenging as it highlights systemic gaps and is distressing when necessary, services are unavailable. As a System Navigator, it is essential to do my best to explore available options and conduct research to ensure clients are connected to the most appropriate support."

~Mahek Randev, System Navigation Case Manager





ENGAGING COMMUNITY RESIDENTS IN HEALTH PROMOTION PROGRAMS



Chronic Disease Exercise Programs

- Chair Yoga
- Energize with Exercise
- Low Impact Exercise
- Step It up
- Total Body Conditioning

Diabetes & COPD Education Programs

- Craving Change
- Diabetes Group Sessions
- COPD Virtual Care
- COPD Virtual Support Group
- Insulin Education Program
- Introduction to Diabetes

Health Promotion Programs

Adults

- Coffee and Chats
- Cooking On A Budget
- Creative Art
- Creative Workshop: DIY Faux Stained Glass Painting
- Creative Workshop: DIY Faux Floral Centrepiece
- Decluttering 101
- Expressive Art 101 & 201
- Food Safety Program
- Mental Health and Nutrition Program
- Nourishing Possibilities
- Play and Laugh Family Game Day
- Sense of Self
- Taking Care of Yourself Care Program
- Train Your Brain
- Refresh: Morning Mindfulness
- Restful Sleep
- Watercolour Wellness Crafting Calmness
- Weight. Diet. Health
- Winter Staycation

Young Families

- Baby Music and Movement
- Brain, Logic and Tricks
- Creative Chefs
- March Break Arts & Craft
- Money-Smart Kids
- Play, Learn and Connect
- Ready for Success Tutoring Program
- Summer Camps

Older Adults

- Feet In Motion
- Tech Savy Seniors



SPOTLIGHT ON GROUP PROGRAMS

Nourishing Possibilities

In partnership with Georgina Food Pantry, VCHC provided the Nourishing Possibilities food literacy program designed to support the community of Georgina to build on existing knowledge of saving money while eating healthy, and overall food and nutrition education. The program provided a combination of nutrition education presentation from VCHC's Dietitian and activities focusing on new healthy and affordable recipes provided by the Community Health Worker Assistant.

RESULTS

- 100% of respondents reported feeling a larger sense of community after.
- 83% of respondents reported having a better idea of how to incorporate new healthy recipes into their lives while staying on a budget.
- 83% of respondents reported having learned about nutrition and have incorporated the newfound knowledge into more health eating habits.



Watercolor Wellness

The Watercolor Wellness program was established as a stress relief program that provides an opportunity for participants to come together to connect and engage in art and reflection-based activities. In a relaxed environment, the facilitator led instructions in art-based activities and shared strategies to enhance participants' mental and physical wellbeing.

RESULTS

- 100% reported positive changes to their stress level and emotions while immersed in art.
- 100% reported feeling safe and included while socializing and fostering connections in the program.
- 83% reported learning a new useful skill or activity from the program.



SPOTLIGHT ON GROUP PROGRAMS

Restful Sleep

Our team of Social Workers and Community Health Workers developed a 6-week cognitive behaviour therapy group which provided psychoeducation and skills building activities for improved sleep quality for those identifying with sleep issues.

RESULTS

- 100% reported having an awareness of their own sleep patterns
- 83% reported having an increased awareness of factors influencing sleep quality.
- 100% reported knowledge of skill-based techniques to manage thoughts.



Female Empowered Minds

In partnership with York Region District School Board, the VCHC provided a lunch time Female Empowered Minds program at local schools to girls age 9-14 years. The program focused on improving self-esteem, making informed life choices and learning new skills.

RESULTS

- 80% reported on gaining new knowledge about ways to improve self-esteem.
- 73% reported learning ways on how to make informed life choices.
- 73% reported learning new life skills.



**MAKING IT SIMPLE TO
ACCESS OUR SERVICES**



**Language
Interpretation
Services**



**Transportation
Support**



**In-person and
virtual group
programs**



**Tablet lending
program to
access virtual
programs and
services**



**In-person and
telephone
appointments**



**Secure email
communication
between
clients and
providers**



**Availability
of online
booking for
primary care
services**



**Same-day
visits for
semi-urgent
medical
visits**



**Appointment
email
reminders for
all services**



**Simple self-check
in Kiosks for
appointments**



STUDENT PLACEMENTS

I got to learn lots of therapeutic approaches, session structure, which made me more confident in conducting sessions.

My experience at VCHC has been incredible. I gained valuable insight into community health initiatives and many new skills in a supportive environment.



I had an amazing experience at the VCHC. I've built great relationships with my fellow tutors, supervisor and the kids. They provided me with everything I needed and answered my questions right away.

My experience at VCHC was unique and I enjoyed it. I learned some hard skills like EMR system and my soft skills like professionalism were also sharpened.

STUDENTS PLACED AT VCHC LAST ACADEMIC YEAR

- 4 Education students - York University
- 1 Social Work student - York University
- 1 Dietetic Intern - University of Toronto
- 7 Coop students - Maple High School

FINANCIALS

REPORT OF THE INDEPENDENT AUDITOR ON THE SUMMARY FINANCIAL STATEMENTS

To the Members of Vaughan Community Health Centre Corporation,

The summary financial statements, which comprise the summary statement of financial position as at March 31, 2025, and the summary statement of operations and changes in fund balance, and the related note, are derived from the audited financial statements of Vaughan Community Health Centre Corporation (the "Organization") for the year ended March 31, 2025.

In our opinion, the accompanying summary financial statements are a fair summary of the financial statements, on the following criteria by management:

- The information in the summary financial statements is in agreement with the related information in the complete financial statements; and
- The summary financial statements contain all the information necessary to avoid distorting or obscuring matters disclosed in the complete financial statements, including the notes therein. Management determined that the statement of cash flows does not provide additional useful information, and as such has not included this as part of the summary financial statements.

The summary financial statements do not contain all the disclosures required by Canadian accounting standards for not-for-profit organizations. Reading the summary financial statements and the auditor's report thereon, therefore, is not a substitute for reading the Organization's audited financial statements and the auditor's report thereon.

The summary financial statements and the audited financial statements do not reflect the effects of events that occurred subsequent to the date of our report on the audited financial statements.

SUMMARY STATEMENT OF FINANCIAL POSITION

AS AT MARCH 31	2025	2024
ASSETS		
Current Assets:		
Cash and cash equivalents	\$ 1,077,723	\$ 933,020
Accounts receivable	147,823	236,142
Prepaid expenses	59,423	56,988
	<u>1,284,969</u>	<u>1,226,150</u>
Capital Assets, net of amortization	182,181	244,428
TOTAL ASSETS	<u>\$ 1,467,150</u>	<u>\$ 1,470,578</u>
LIABILITIES AND FUND BALANCES		
Accounts payable and accrued liabilities	\$ 223,855	\$ 365,366
Due to Ontario Health	994,857	798,906
Due to other funders	6,568	2,365
	<u>1,225,280</u>	<u>1,166,637</u>
Capital assets fund	182,181	244,428
Growth and development fund	59,689	59,513
	<u>241,870</u>	<u>303,941</u>
TOTAL LIABILITIES AND FUND BALANCES	<u>\$ 1,467,150</u>	<u>\$ 1,470,578</u>

SUMMARY STATEMENT OF OPERATIONS AND CHANGES IN FUND BALANCE

FOR THE YEAR ENDED MARCH 31	2025	2024
REVENUES		
Ontario Health	\$ 7,114,188	\$ 7,207,898
Miscellaneous	151,699	82,820
	<u>7,265,887</u>	<u>7,290,718</u>
EXPENSES		
Salaries, benefits and relief	5,436,362	5,448,086
General and operating	985,060	941,741
Occupancy costs	803,802	765,149
Amortization	62,247	85,407
Medical supplies	40,487	41,587
	<u>7,327,958</u>	<u>7,281,970</u>
EXCESS (DEFICIENCY) OF REVENUES OVER EXPENSES	<u>(62,071)</u>	<u>8,748</u>
FUND BALANCE - BEGINNING OF YEAR	<u>303,941</u>	<u>295,193</u>
FUND BALANCE - END OF YEAR	<u>\$ 241,870</u>	<u>\$ 303,941</u>

We expressed an unmodified audit opinion on the audited financial statements in our report dated June 23, 2025.

Management is responsible for the preparation and fair presentation of the summary financial statements in accordance with the criteria disclosed in Note 1 to the summary financial statements.

Our responsibility is to express an opinion on whether the summary financial statements are consistent with the audited financial statements based on our procedures, which were conducted in accordance with Canadian Auditing Standard (CAS) 810, Engagements to Report on Summary Financial Statements.

Hogg, Shain & Scheck PC
 Authorized to practise public accounting by the
 Chartered Professional Accountants of Ontario
 Toronto, Ontario
 September 11, 2025



**OUR
PARTNERS**

WE PARTNER WITH MANY ORGANIZATIONS TO DELIVER PROGRAMS AND SERVICES. WE WOULD LIKE TO ACKNOWLEDGE THEIR COLLABORATION AND CONTINUED SUPPORT.

360 Kids
Academy of Learning Career College - Etobicoke Campus
ANCHOR Canada
Canadian Mental Health Association
Carefirst Seniors and Community Services Association
CAYR Community Connections
City Of Vaughan
CMHA York Region
Circle of Care
Community Legal Services of York Region
COSTI
EarlyON
Elspeth Heyworth Centre for Women
Family Practice Network
Grand Genesis Medical Centre
Georgina Food Pantry
Health Commons Solutions Lab
Health Shield Pharmacy
Humanity First Food Bank
Human Endeavour
Ivory Medical Clinic
Kids Up Front
Mackenzie Health Hospital
Mackenzie Health Vaughan Library
Maple High School
Markham Stouffville Hospital
Maple Health Centre
Miracle Arena For All Nations
Northern York South Simcoe Ontario Health Team
Panacea Pharmacy
The Centre for Addictions & Mental Health
The Regional Municipality of York
Vaughan Public Libraries
Vaughan Welcome Centre
Vitanova Foundation
Western York Region Ontario Health Team
Woodbridge Medical Centre
York Region Alliance of African Canadian Communities
York Region District School Board
York Region Seniors Club
University of Toronto
York University



CONTACT US

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Chronic Disease Program Fax:
905-303-0320
Allied Health-PACT Fax: 905-303-4922

Vaughan Community Health Centre - Keswick Site -

716 The Queensway South,
Keswick, ON, L4P 4C9
Telephone: 905-476-5621
Fax: 905-476-3008



THANK YOU

To make a donation visit: www.vaughanchc.com/donate

For more information visit:



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Accredited by
Canadian Centre
for Accreditation



Agréé par
Centre canadien
de l'agrément



Ontario Health
Central