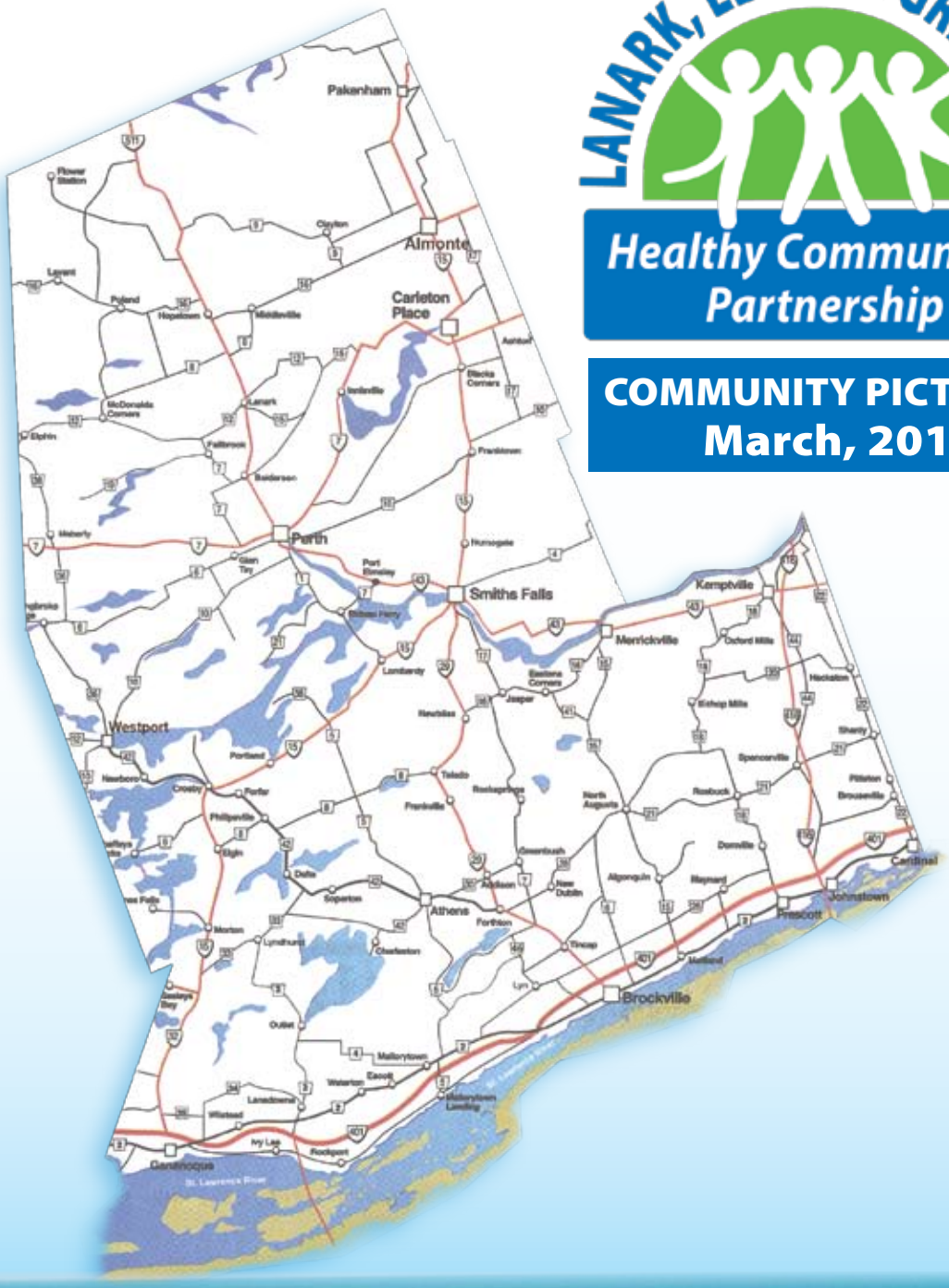
LANARK, LEEDS & GRENVILLE

Healthy Communities Partnership

COMMUNITY PICTURE
March, 2011



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1.0 Executive Summary

Profile of Community

- Population: 162 990 (as of 2006), spread out over 6 329 km^2, only one city with ~ 22 000 people
- 3.7% Francophone population, 0 First Nations bands, and 7.6% immigrant population
- 58% of residents live in rural environment compared to 16% for Ontario overall

Profile of Stakeholders Involved

- A LLG HCP Core Committee was formed with over 20 members representing health, municipal, education, and community sectors
- In addition, over 100 individuals are involved as "peripheral" members who are consulted for input and kept informed of the LLG HCP's activities
- Support from the French Language Health Services Network of Eastern Ontario to engage the francophone community.

Community Assessment

- A Community Profile was developed in fall 2010 and will be available on the LLG HCP website: www.HealthyLLG.org
- This profile contains demographic information, data for the six Healthy Communities Priority areas, data on local causes of morbidity and mortality, and local assets

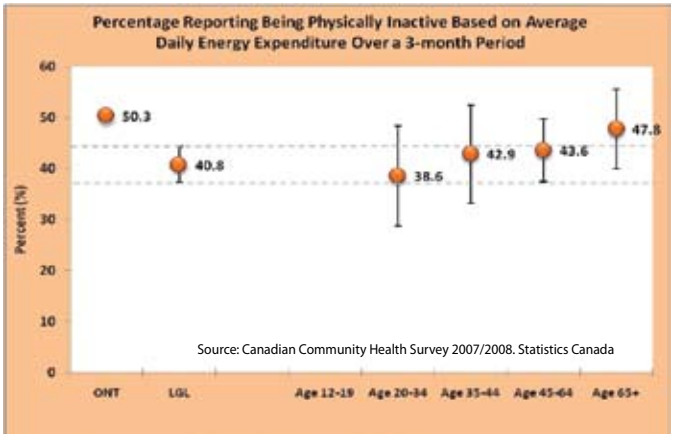
Partnership Day at Camp Merrywood. October 2010

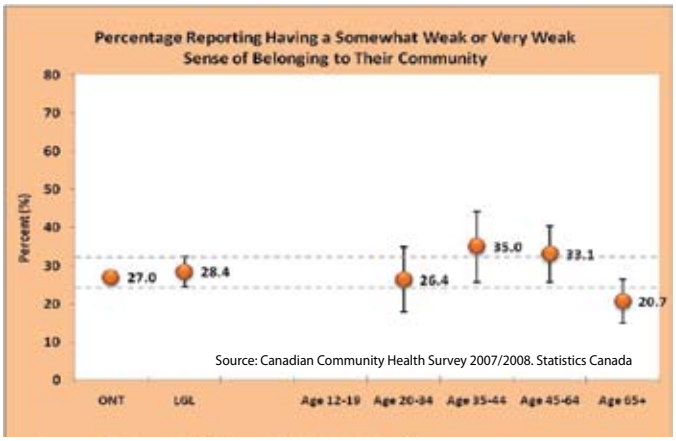
Photo: Courtesy of the EMC

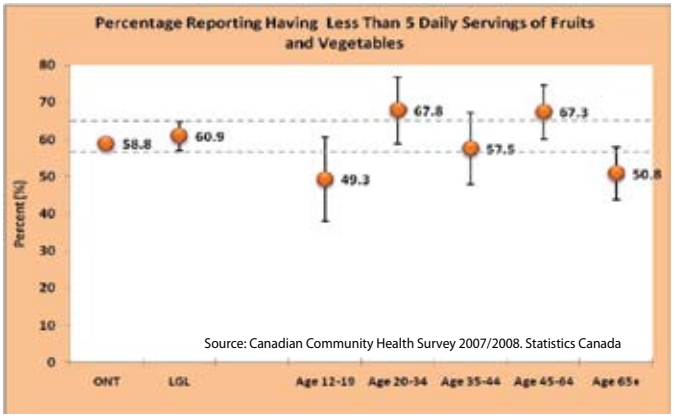
Population increased by 2.4% between 2001 to 2006 with greatest positive rate of population change in the 55+ age groups and greatest decrease in population in the 0-4 and 5-14 year age groups

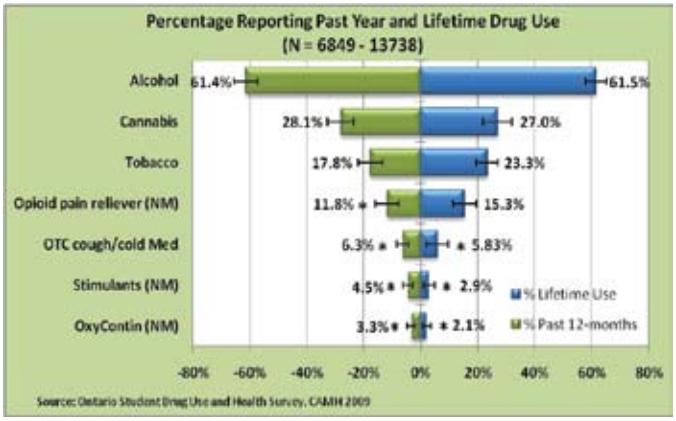
1.0 Executive Summary

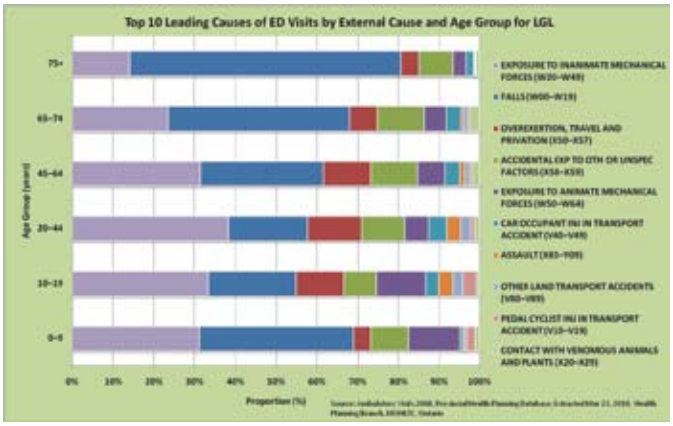
Key Findings

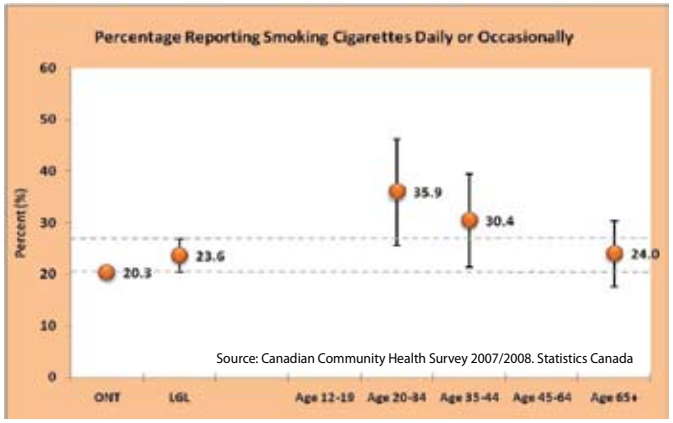












1.0 Executive Summary

Community Consultations

- A Partnership Day was held in October 2010 at Camp Merrywood and over 85 participants took part in small group discussions related to local issues for the six priority areas
- 15 focus groups were completed in 13 communities throughout LLG during fall 2010 with a wide variety of age groups (youth, parents, seniors, etc.) to solicit feedback about community members' visions for a healthy community, and their perceptions of local strengths and needs related to the six priority areas
- 3 focus groups were completed with networks of individuals representing over 50 community organizations

Key Findings – Issues Identified in Community Consultations

- Access to a variety of sport and recreation opportunities for children, youth and families, and need to create supportive environments
- Safe environments and prevention/education of injuries
- Access to healthy food and promoting healthy food choices
- Youth tobacco use, contraband tobacco, and adult role modelling
- Youth substance and alcohol use and adult role modelling
- Youth mental health and support for families

Summary of Process for Developing Recommended Actions

Inputs

- Data from community profile
- Data from community consultations
- Guidance documents/best practice/research
- Problem statement for each priority area and list of potential recommended actions for each priority area prepared by taskforce for Core Committee (based on data listed above)

Process

- Small group of Core Committee members for each priority area:
  - Developed vision statement
  - Reviewed community data
  - Reviewed problem statement and recommended actions from task force
- Decided on up to 5 recommended actions per priority area
- Discussed and finalized with Core committee as a whole
- Surveyed all LLG HCP organizations to determine which recommended actions have the most support
- Core Committee reviewed results and selected top 2 actions from survey results

Outputs

2 recommended actions for each of the 6 priority areas

1.0 Executive Summary

Recommended Actions

Physical Activity, Sport & Recreation

- Provide a variety of opportunities for accessible and inclusive physical activity.
- Promote physical activity as do-able for all.

Substance & Alcohol Misuse

- Enhance and facilitate adaptive qualities in youth that promote protective factors that buffer risky environments and lead to resilience (e.g. Developmental Assets).
- Implement health promotion programs in schools, workplaces, communities and with families that encourage appropriate use of alcohol and avoid problematic substance use for all ages.

Mental Health Promotion

- Provide individuals/ families/ communities with information and resources to help them maintain good mental health, recognize mental health challenges and get support
- Foster environments that enhance community connectedness for children, teens, adults and seniors

Injury Prevention

- Create & implement policies and programs that support safe environments.
- Promote safe environments and healthy lifestyles to prevent injuries in all ages, especially falls among seniors and children.

Healthy Eating

- Provide opportunities for individuals to develop food selection, food preparation, and food safety skills.
- Provide supportive environments for healthy food choices.

Tobacco Use/ Exposure

- Support tobacco-free lifestyles by increasing the availability of comprehensive tobacco awareness, prevention, cessation services for youth and adults.
- Implement health promotion programs that encourage a smoke free lifestyle for all ages.

2.0 Community Profile

2.1 Community Assessment Data

Description of Assessment of Data

A Community Profile report was produced in October for the HCP Partnership Day (see description of HCP Partnership Day in 2.3, below). This document contained background information about the HCP, demographic information, local data related to the six priority areas, local morbidity and mortality data, and information about local assets.

The data in the report were primarily from Statistics Canada (the Census), the Canadian Community Health Survey (CCHS), the Provincial Health Planning Database (PHPDB) and the Ontario Student Drug Use and Health Survey (OSDUHS).

Data from the 2006 census were reported from Statistics Canada's Community Profile webpage for the LGLDHU health region. As well, 2006 census data were analyzed to report population distributions and census-to-census population change by census subdivision for LGL.

CCHS data were analyzed specifically for Leeds, Grenville and Lanark and compared to the province. As well, select variables were reported by income. The following CCHS variables were analyzed:
Leisure time and physical activity
Current daily or occasional smoker
5+ drinks on one occasion
Less than 5 recommended daily servings of fruit and vegetable
Perceived life stress
Sense of belonging to local community

The LGLDHU was one of six health units that was oversampled in the 2009 OSDUHS as regional strata to provide better regional estimates at the health unit level. This provided local data for LGL students in grades 7-12.

Data from the PHPDB were used to identify the leading causes of emergency department visits by external cause and age group, and were used to identify local causes of morbidity and mortality.

Data analyses were conducted using SPSS software (SPSS Inc., Chicago, IL, Version 18). Microsoft Excel spreadsheet software was used to produce charts and graphics (Excel; Microsoft Inc., Redmond, WA, Version 2007). The descriptive analyses focussed on calculation of percentages and associated 95% confidence intervals.

Community Profile

See Appendix 1, pg 16

Gaps/Limitations in Community Assessment Process

Gaps were noted in local data for children under age 12 for healthy eating and for physical activity, sport and recreation. To address this gap, national and provincial data for this age group were examined. As well, it was noted that local data is lacking about the causes behind the data reported for the six priority areas (e.g. causes of unhealthy eating or causes of physical inactivity). To address this gap, a high-level literature search was conducted to identify general causes related to the six priority areas. As well, the HCP will consider potential data sources to fill both of these gaps in 2011.

2.2 Community Consultation and Engagement

Overview of Process

The LLG HCP has undertaken an extensive community consultation and engagement process. To date the partnership has: held a Healthy Communities Partnership day that engaged over 80 individuals to discuss the Community Profile and the six priority areas (see description in section 2.3); held 15 community focus groups that engaged 163 people of all 'ages and stages' in 13 different communities across the HCP area; and held 3 'organizational' focus groups with individuals representing over 50 different organizations.

Throughout the consultation process a capacity-building approach was used that builds on the assets and strengths of existing programs and organizations, and encourages community organizations to work together to create communities that are healthy places in which

to live, work, learn and play. Rather than focusing solely on issues and needs, community members were also asked to share their vision of healthy communities, and to identify existing community strengths upon which they would like to build.

Specific Steps Taken to Consult and Engage Community Members

Community Focus Groups

The Interim Steering Committee felt that the most efficient way to engage the community in a discussion about their vision for a healthy community and their perceptions of the community's needs was to complete focus groups with a variety of existing community groups (e.g. Kiwanis Clubs, women's groups, youth centres, parents' groups, etc). The Committee members agreed to facilitate 1-2 groups in their communities and brainstormed a list of potential focus groups. This brainstormed list was converted into a chart outlining the ages that the proposed groups represented, and their geographic area. The Committee reviewed this chart to ensure that a wide variety of age groups were covered (e.g. youth, parents, seniors) and that all three counties were covered.

In October 2010, the HCP Interim Steering Committee members participated in a focus group training session. This session was facilitated by a member of the Healthy Communities Consortium and provided members with information on managing focus groups, as well as provided members with the script for the focus groups (see copy of script in Appendix.)

Committee members conducted 15 focus groups in 13 different communities throughout Lanark, Leeds and Grenville. Participants in the focus groups represented all 'ages and stages' of life: 28 parents of young children, 37 youth, 54 adults and 44 seniors were consulted, for a total of 163 people. Participants were asked to share their thoughts on three main questions: 1) their vision of a healthy community; 2) community strengths and assets upon which they would like to build; and 3) "burning" issues that need to be addressed in order to create healthy communities. The consultant from the Healthy Communities Consortium summarized the results of the focus groups and identified the top issues for each priority area, as well as the top issues overall.

Top Community Focus Group Recommendations

The following list summarizes the issues identified as priorities by four or more of the fifteen focus groups. The number in brackets represents the number of focus groups that identified each issue as a priority:

1. (7) Provide more mental health programs, supports and services for youth.
2. (7) Address poverty through affordable sports, recreation, health and affordable housing programs.
3. (6) Provide a variety of accessible and affordable sports and recreation programs for youth.
4. (6) Develop new indoor sports facilities (eg pools, rinks, curling surfaces and gymnasiums).
5. (5) Raise awareness and provide supports for youth related to alcohol and substance abuse.
6. (4) Provide a variety of accessible and affordable sports and recreation programs for children.
7. (4) Provide a variety of family-oriented sports and recreation activities to fit different work schedules.
8. (4) Raise awareness about injury prevention for youth (cycling, skateboarding etc).
9. (4) Support all ages to make healthy food choices (awareness, availability, affordability).

Organizational Focus Groups

In addition to the focus groups completed with community members, three focus groups were also completed with existing networks which involved individuals representing over 50 local community organizations. The focus groups were hosted by Every Kid in Our Communities, the Lanark Planning Council and the Healthy Community Partnership (in conjunction with the focus group training session). These focus groups followed the same format as the community focus groups and asked the same three questions. The results were summarized by priority area, as well as the top issues overall.

The following is a list of recommended actions identified as priorities by the Organizational Focus Groups:

Physical Activity, Sport & Recreation: Advocate for a balance between academic achievement and physical activity for youth; provide funding for recreation programs; provide opportunities for safe outdoor recreation; and develop workplace policies to encourage recreation.

Healthy Eating: Increase access to healthy food; and improve access to healthy food for low income families.

Injury Prevention: No priorities were identified.

Tobacco Use/Exposure: No priorities were identified.

Substance and Alcohol Misuse: Supporting adults to be good role models; harm reduction; and intergenerational education.

Mental Health: Services for youth in crisis (especially rural youth); suicide prevention strategies; and increased focus on prevention.

Feedback from HCP Day

At the Healthy Communities Partnership Day (described in 2.3, below), all 85 participants broke into small groups to discuss the data from the Community Profile that had been presented for each priority area (see description of Community Profile in section 2.1, above). These small group discussions were facilitated by a member of the Interim Steering Committee, and another committee member acted as the recorder. Participants discussed what had surprised them about the data, what they felt was missing, and what the major issues were for each priority area. This data was summarized for each priority area.

The following themes and needs were identified at the Healthy Communities Partnership Day: vibrant downtowns; intergenerational interactions; connectedness between people; local hubs and community centres; public transportation; local food; people interacting outdoors; outdoor recreational spaces; trails and green spaces; activities for seniors; meaningful local jobs; telecommuting; safe environments and spaces; and accessible services (health care, education, daycare etc).

Francophone Engagement

The LLG HCP has begun working with The French Language Health Services Network of Eastern Ontario (the *Reseau*). The HCP Coordinator met with a staff member of the *Reseau* as well as two French-speaking public health nurses to discuss the Francophone context in Lanark, Leeds and Grenville. Following this meeting, the staff member of the *Reseau* agreed to join the LLG HCP as a member of the Stewardship Committee. This will help to ensure that the Francophone community is engaged in the work of the HCP.

Rationale for Targeting Specific Populations and Communities

Pre-existing community groups were targeted for focus groups in an effort to obtain feedback in the most efficient and timely manner. Rather than trying to promote community focus groups or forums and recruiting participants, the LLG HCP felt it would be most efficient to approach existing community groups and invite them to participate in a focus group. The LLG HCP attempted to ensure that a wide variety of community members were represented by the groups consulted, and that these groups represented communities throughout Lanark, Leeds and Grenville. As well, since Lanark, Leeds and Grenville does not have large immigrant or First Nation populations, these groups were not specifically targeted. Since Lanark, Leeds and Grenville is a predominantly rural area, a concerted effort was made to reach out to smaller communities.

The organizations that participated in the three 'organizational' focus groups were part of pre-existing community networks. Again, the LLG HCP felt that this was an efficient method to obtain feedback from a variety of organizations in a short time period.

The wide variety of individuals who attended the HCP Day represented both organizations as well as community members who were interested in the HCP. The feedback that these individuals provided was recorded and summarized.

Outcomes of Community Consultation & Engagement Process

The main outcome of the community consultation and engagement process was data about community members' vision for a healthy community, their perceptions of assets and what is currently working well, and their perceptions of the community needs. Summary documents from the community focus groups, organizational focus groups, and feedback from the HCP Day were used to help set the recommended actions for each priority area. This information was vital to ensuring that the recommended actions would reflect not only the data from the Community Profile, but also the community's priorities and interests.

Gaps and Limitations

The community and organizational focus groups provided an excellent snap-shot of issues facing different populations and 'ages and stages' across Lanark, Leeds and Grenville. The major limitation of this approach is that not all residents of Lanark, Leeds and Grenville had an opportunity to provide input. Although common themes surfaced when looking at the data across all focus groups, it is possible that other issues were missed.

The LLG HCP is planning another Partnership Day in March 2011 to share the finalized recommended actions and the process for arriving at the recommended actions. This will provide community members with another opportunity to become engaged with the HCP. As well, when the recommended actions are revised in the future, the LLG HCP will have an opportunity to review its strategies for engaging the community and may be able to undertake a more extensive consultation process.

2.3 Partnership Development

Interim Steering Committee and Partnership Development & Asset Mapping Task Force

After the announcement of the shift to Healthy Communities Partnerships, the original Heart Health Coalition members (Tri-Health) agreed to continue meeting as members of the LLG HCP. The LLG HCP began meeting as an 'Interim Steering Committee' in April 2010 and a Partnership Development and Asset Mapping Task Force was formed to address partnership development (see terms of reference Appendix.) The task force updated the logo for the LLG HCP, developed a brochure that provided information about HCP, and planned and promoted a Healthy Communities Partnership Day for October 21, 2010.

Partner Engagement

The HCP Coordinator met with and gave presentations to local municipal leaders, county councils, various organizations and individuals about the HCP and invited these individuals to join the Interim Steering Committee and/or attend the Partnership Day in October. During these presentations the Coordinator distributed the brochure developed by the Partnership Development and Asset Mapping Task Force and provided contact information to answer any questions about the HCP.

Partner Survey

The Interim Steering Committee developed an electronic partner survey to begin identifying local assets. They brainstormed a list of potential partners to send the survey to, building on a contact list provided by the Leeds, Grenville & Lanark District Health Unit. Participants in the survey were asked to describe who their target audience was, what sectors of the community they worked in, which municipalities/ counties they worked in, their interest in being involved in the LLG HCP, the types of activities they were involved in, and which social determinants of health they addressed. A total of 37 individuals representing various local organizations completed the survey and the results were included in the Community Profile produced for the Partnership Day in October (described in section 2.2).

Partnership Day and Stakeholder Wheel

A total of 85 individuals attended a Partnership Day in October, held at Camp Merrywood (see agenda in Appendix). They came from the public and the following types of organizations: health services (36); NGOs/ community organizations (14); children's services (10); youth services (8); municipalities (6); seniors' services (3); education (3); and other sectors (5). At the partnership day, participants received an overview of the HCP and filled out paper copies of the network map for Health Nexus. Data from the Community Profile was presented and discussed, and participants took part in small group discussions related to the six priority areas. They also discussed their vision of a healthy community and the stakeholder wheel was introduced.

At the end of the day, participants were asked to use their name tag to indicate if they would like to be involved in the HCP as a "peripheral" or "core" member. It was explained that "core" members would join the Stewardship Committee and attend meetings, whereas "peripheral" members would be kept informed about the activities of the LLG HCP and could choose to join at a later date. A complete listing of the "core" members of the Stewardship Committee organized by sector, as well as a listing of "peripheral" members and the sectors they represent (i.e. Stakeholder Wheel) can be found in the Appendix.

Steering Committee and Structure & Governance

Following the Partnership Day in October, all individuals who had indicated that they would like to be involved in the HCP as a "core" member became part of the Stewardship Committee. The Stewardship Committee held its first meeting in November to address governance, and to develop its terms of reference (see agenda in Appendix.) A facilitator from the Tamarack Institute provided the committee with information about collaborative governance and the committee discussed its vision, how it would like to make decisions and how it would like to engage the community. At the end of the meeting a Structure and Governance Task Force was formed to create the terms of reference for the Stewardship Committee using the Constellation Model of Governance. The Stewardship Committee finalized the terms of reference that the task force drafted at a meeting on February 1, 2011. The terms of reference can be found in the appendix.

Network Map

As mentioned above, during the HCP Partnership Day in October, participants completed paper copies of the Network Map survey for Health Nexus. Electronic copies were also completed by individuals who were unable to attend the HCP Partnership Day. A small task force was created to meet with Health Nexus and discuss the type of data that should be included in the network maps. In total, 110 surveys were completed, 213 people's names appeared in the data, and there were 5224 links between people.

Figure One, below, illustrates the LLG HCP's network and Health Nexus describes this as "a nice healthy network with a strong, dense core, a slightly looser layer of inner periphery (who may be more connected elsewhere than within this network) and a few people in an outer periphery of those who are much more loosely connected, mostly through one person."

Figure One: LLG HCP's Network Map

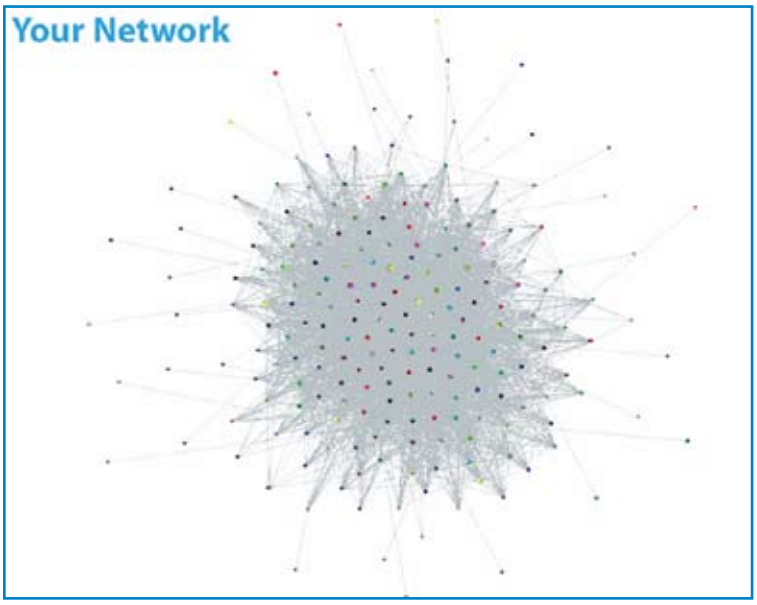
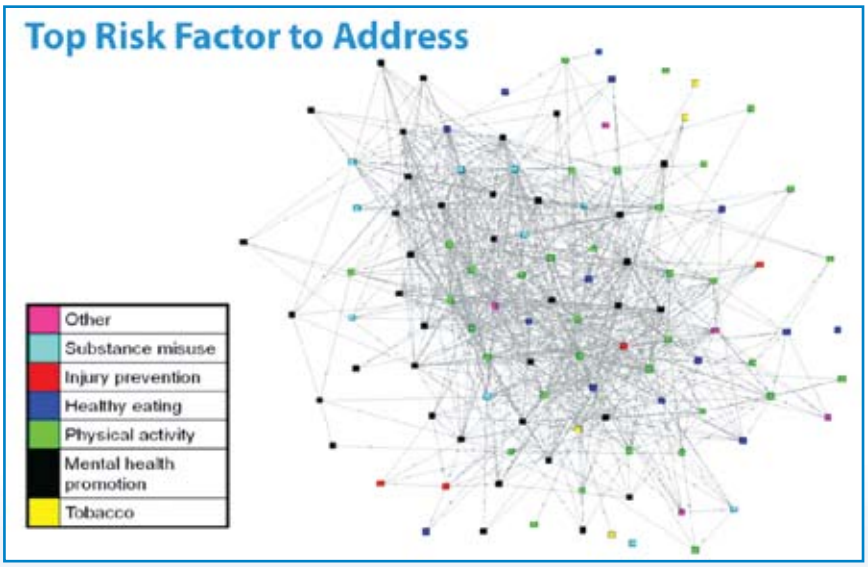


Figure Two illustrates the top risk factor that respondents felt should be addressed. Both physical activity and mental health promotion appear strongly on the map. Health Nexus states that those individuals who chose physical activity and mental health promotion are already well-connected which should facilitate coordinated action. Interestingly, the LLG HCP also identified physical activity and mental health promotion as the top risk factors to address through the partnership's policy work. Tobacco appears infrequently and peripherally, and substance misuse, injury prevention, and healthy eating appear less often although they do still each have a distinct presence.

Figure Two: Map of Top Risk Factor to Address



2.4 Priority Setting

Preparation for Priority Setting Workshop

The Stewardship Committee formed a Priority Setting Task Force in November to help plan a workshop in December on priority setting. A consultant from The Health Communication Unit was hired to facilitate a full-day workshop for the HCP on setting priorities (see agenda in Appendix). In preparation for the workshop, the Task Force members were assigned a priority area from the Community Profile (described above in Section 2.1) and reviewed the available data from the community profile and the focus groups and identified the key highlights for their assigned priority area. The Task Force also asked members of the Stewardship Committee to review the Community Profile and select the one statistic from each priority area that they thought was most important.

Priority Setting Workshop

This workshop took place on December 10 and the objectives of this workshop were to:

- Define the intended output of the process i.e. definition/examples of 'recommended action' and 'policy development'
- Identify the criteria to be used for priority setting
- Identify the process for priority setting

The facilitator provided members of the Stewardship Committee with an overview of different processes for priority setting and the group discussed criteria that could help to develop recommended actions. The Stewardship Committee developed a set of 'need to have' and 'nice to have' criteria to guide the development and selection of recommended actions. At the end of the Priority Setting Workshop, the Priority Setting Task Force was asked to prepare problem statements and a list of potential recommended actions for each priority area in advance of the Stewardship Committee's priority setting meeting (dubbed 'Decision Day').

Preparation for Priority Setting – 'Decision Day'

Following the priority setting workshop, the Priority Setting Task Force prepared a summary for each priority area that included the relevant background data (highlights from the Community Profile, themes from small group discussions at HCP Partnership Day, results of the community focus groups, and results from the organizational focus groups), a problem statement, and a list of potential evidence-based recommended actions. Each committee member was assigned a priority area again and was responsible for putting together the background document for that priority area, writing a problem statement(s), and developing a list of potential recommended actions. The group met again before Decision Day to finalize these documents and ensure they were consistent.

Priority Setting – 'Decision Day'

A consultant from Healthy Communities Consortium was hired to facilitate Decision Day on January 6, 2011 (see agenda in Appendix). Following a brief review of the HCP and information about Asset Based Community Development, members of the Stewardship Committee worked in small groups to review the prepared material and develop for each priority area a vision statement, and a list of no more than 5 recommended actions. Once this exercise was complete, the small groups presented their vision statements and recommended actions and the Stewardship Committee discussed and finalized them.

Feedback on Priorities

An electronic survey was developed to obtain feedback from organizations about the recommended actions. The survey asked respondents to comment on the recommended actions for each priority area, indicating:

- I agree with this recommended action and am willing to work on it
- I agree with this recommended action but am not interested in working on it at this time
- I disagree with this recommended action

A total of 51 organizations responded, representing the following ages, stages and sectors: health unit (4); other health organizations (7); NGOs/community organizations (14); lower and upper tier municipalities (8); youth (7); babies and children (7); and other (education, individuals, adults, Francophone).

The following chart outlines the top two Recommended Actions (RAs) for each Priority Area and the percentage of respondents who supported these RAs.

Top Two Recommended Actions (RAs) for Each Priority Area

Priority Area	RECOMMENDED ACTION	% of respondents who agreed with the RA and were willing to work on it
Physical Activity	Provide a variety of opportunities for accessible and inclusive physical activity in communities.	63%
	Promote physical activity as "do-able" for all.	62%
Tobacco Use & Exposure	Implement health promotion programs that encourage a smoke-free lifestyle for all ages.	35%
	Increase the availability of tobacco awareness, prevention and cessation services for youth and adults.	26%
Injury Prevention	Promote safe environments and healthy lifestyles to prevent falls in seniors and/or children.	30%
	Create and implement policies and programs that support safe environments.	30%
Healthy Food	Support individuals to develop food selection, preparation and safety skills in all community settings.	41%
	Provide supportive environments for healthy food choices.	36%
Mental Health	Foster environments that enhance community connectedness for children, teens, adults and seniors.	66%
	Provide individuals, families and communities with information and resources to help them maintain good mental health, recognize mental health challenges and get support.	62%
Substance & Alcohol Misuse	Enhance adaptive qualities in youth that promote protective factors, buffer risky environments and lead to resilience.	44%
	Implement health promotion programs with schools, workplaces, communities and families that encourage appropriate use of alcohol and avoid problematic substance abuse for all ages.	40%

The results of this survey were reviewed by the Stewardship Committee on February 1, 2011 and were used to finalize 1-2 recommended actions for each priority area. The Stewardship Committee agreed to take the top two recommended actions for each priority area (as indicated by partners' agreement with the recommended actions and willingness to work on them). Following the meeting on February 1, the Stewardship Committee finalized 2 recommended actions for each priority area.

The diagram below summarizes the process used to select the Recommended Actions for each priority area.

Inputs

- Data from community profile
- Data from community consultations
- Background sheet for each priority area
- Guidance documents/best practice/research
- Problem statement for each priority area and list of potential recommended actions for each priority area prepared by task force (based on data listed above)

Process

- Small group for each priority area:
  - Developed vision statement
  - Reviewed background document
  - Reviewed problem statement and recommended actions
  - Decided on no more than 5 recommended actions per priority area
- Discussed and finalized with Stewardship Committee as a whole
- Surveyed all LLG HCP organizations to determine which recommended actions had most support
- Stewardship Committee reviewed results and selected top 2 actions from survey results

Outputs

- Vision statement for each priority area
- 2 recommended actions for each of the six priority areas

3.0 Community Priorities/ Recommendations

3.1 Visions and Recommended Actions across the six Healthy Communities priority areas

Physical Activity Sport and Recreation: *All residents of Leeds Grenville & Lanark have the necessary resources/ desire/exposure and/or knowledge to be physically active and all age levels meet the daily recommended minimum physical activity requirement.*

Recommended Actions:

- Provide a variety of opportunities for accessible and inclusive physical activity.
- Promote physical activity as do-able for all.

Mental Health: *A supportive community that understands and promotes mental health and responds appropriately to mental illness.*

Recommended Actions:

- Provide individuals/families/ communities with information and resources to help them maintain good mental health, recognize mental health challenges and get support
- Foster environments that enhance community connectedness for children, teens, adults and seniors.

Healthy Eating: *All residents of Leeds Grenville and Lanark have a healthy body weight and the necessary resources, food skills & knowledge to access safe, healthy, affordable and culturally appropriate food.*

Recommended Actions:

- Provide opportunities for individuals to develop food selection, food preparation, and food safety skills.
- Provide supportive environments for healthy food choices.

Substance / Alcohol Misuse: *Lanark, Leeds and Grenville has children, youth and adults who have a healthy, respectful, knowledgeable attitude and behavior towards alcohol and other drugs.*

Recommended Actions:

- Enhance and facilitate adaptive qualities in youth that promote protective factors that buffer risky environments and lead to resilience (e.g. Developmental Assets).
- Implement health promotion programs in schools, workplaces, communities and with families that encourage appropriate use of alcohol and avoid problematic substance use for all ages.

Tobacco use/exposure: Less *use of and exposure to tobacco and better health outcomes for all ages.*

Recommended Actions:

- Support tobacco-free lifestyles by increasing the availability of comprehensive tobacco awareness, prevention, cessation services for youth and adults.
- Implement health promotion programs that encourage a smoke free lifestyle for all ages.

Injury Prevention: *Leeds Grenville and Lanark residents have the knowledge and skills to prevent injuries (including before, during and after an incident) and a safe environment exists in which to live, work and play.*

Recommended Actions:

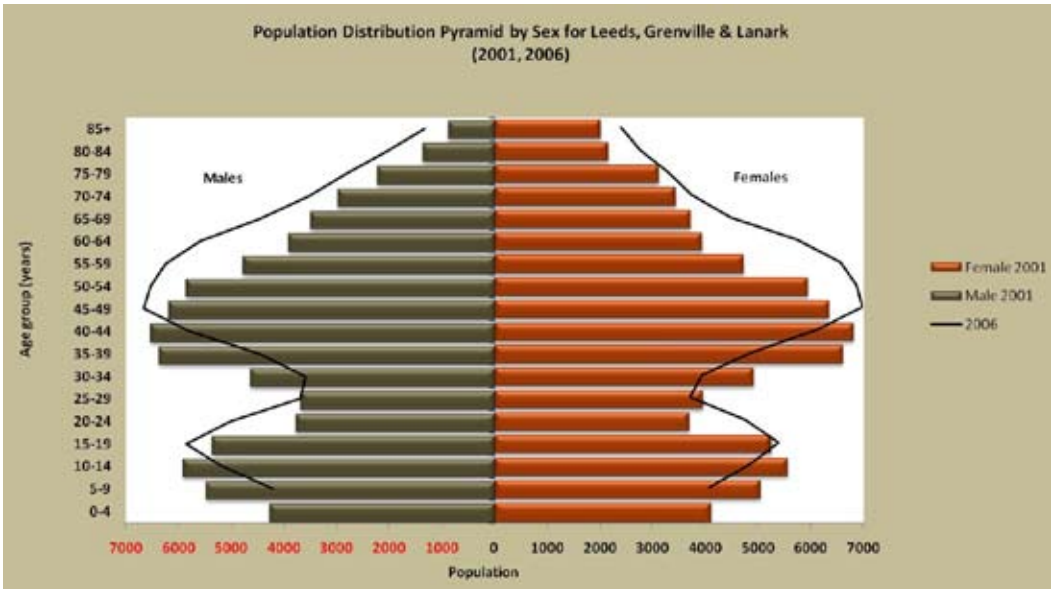
- Create & implement policies and programs that support safe environments.
- Promote safe environments and healthy lifestyles to prevent injuries in all ages, especially falls among seniors and children.

APPENDICES:

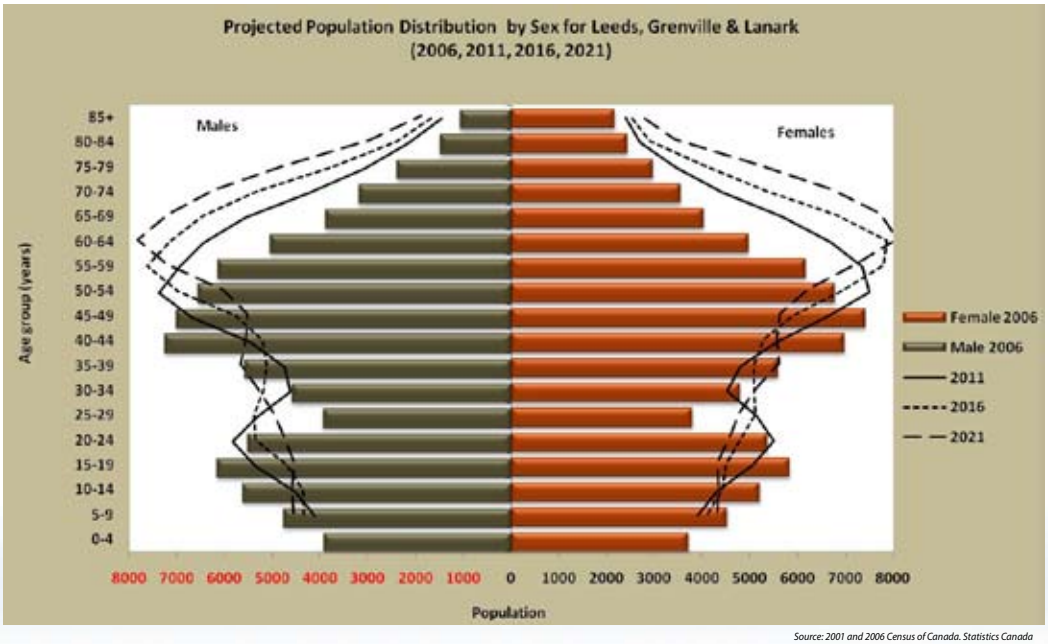
Appendix 1: Excerpt from *Community Profile - October 21, 2010 (pgs 2-37)*

2.0 Demographics

The Ministry of Health and Long Term Care has classified the Leeds, Grenville and Lanark Health Unit as a Mainly Rural Health Unit. The total population of Leeds, Grenville and Lanark was 162 990 with a population density per square kilometre of 26.9 in 2007. The geographic area covers 6 329 square kilometres. Local government consists of 2 Counties and 21 Municipalities with multiple small towns and hamlets. The largest urban area is the City of Brockville, population 21 957 (2006 census). There is a 3.7% Francophone population, zero First Nations bands, and a 7.6% immigrant population.



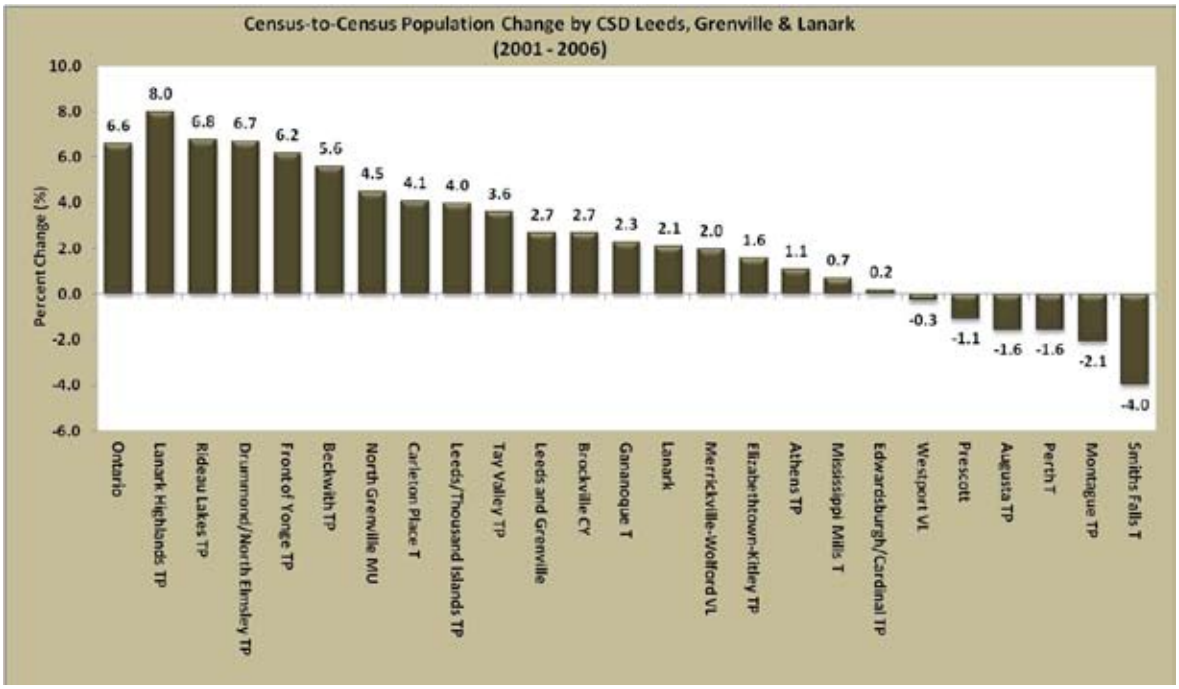
Source: 2001 and 2006 Census of Canada. Statistics Canada



Source: 2001 and 2006 Census of Canada. Statistics Canada

The population of LGL increased by 2.4% between the 2001 and 2006 censuses; the greatest positive rate of population change occurred in the 55+ age groups and the greatest decrease in population occurred in the 0-4 and 5-14 year age groups. As the population pyramids below illustrate, the projected population of Leeds-Grenville and Lanark will shift towards an older age cohort over the next 14 years.

58% of residents in LGL live in a rural environment compared with 16% for Ontario overall. Average family incomes in Lanark and in Leeds-Grenville are similar: $78 333 and $74 422, respectively. The unemployment rate for the period of October 10, 2010 to November 6, 2010 is 8.3%[1], and 9.4% of families are below the Low-Income Cut-Off (LICO). In terms of family structure, 74.0% of residents are married couple families, 12.9% are common law families, and 13.1% are single parent families. 54.1% of residents have completed post-secondary education and 18.4% have completed less than secondary school.



Source: 2001 and 2006 Census of Canada. Statistics Canada

When comparing the income and education levels of LGL, several characteristics are noteworthy. The town of Prescott has the lowest median income level, and the lowest proportion of the population without a certificate, diploma or degree (i.e. low education). The town of Smiths Falls follows closely behind Prescott and has the second lowest median income level and second lowest education level. Beckwith Township has the highest median income level and highest education levels, followed by Mississippi Mills and North Grenville. Income and social status along with education and literacy are two of the key determinants of health, with health status improving at each step up the income hierarchy and with increasing levels of education[2].

1 Human Resources and Skills Development Canada. "EI Economic Region of Eastern Ontario (2000)." http://srv129.services.gc.ca/eiregions/eng/eastont.aspx?rates=1&period=262 (Accessed 13 October 2010).

2 Public Health Agency of Canada. "What Makes Canadians Healthy or Unhealthy?" http://www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php (Accessed 13 October 2010).

3.0 Methodology

The data in this report are primarily from Statistics Canada (the Census), the Canadian Community Health Survey (CCHS), the Rapid Risk Factor Surveillance Survey (RRFSS) and the Ontario Student Drug Use and Health Survey (OSDUHS).

The CCHS provides cross-sectional estimates of health determinants, health status and health system utilization for 133 health regions across Canada, plus the territories. The target population is household residents ages 12 and over. CCHS data can be analyzed specifically for Leeds-Grenville and Lanark and compared to the province. Appendix 1 (p.41) provides details about the CCHS variables analyzed for this report.

The RRFSS is an ongoing telephone survey used to gather surveillance data, monitor public opinion on key public health issues, and collect information on emerging issues of importance to public health in Ontario. Local data for Leeds-Grenville and Lanark are collected and analyzed on an ongoing basis for adults ages 18 and older.

The OSDUHS is a population survey of Ontario students in grades 7 to 12. This self-administered, anonymous survey is conducted across the province every two years with the purpose of identifying epidemiological trends in student drug use, mental health, physical activity, and risk behaviour, as well as identifying risk and protective factors. Typically, the OSDUHS surveys thousands of students in over 150 elementary and secondary schools across Ontario. For the 2009 survey OSDUHS incorporated six Ontario public health units, including the Leeds-Grenville and Lanark District Health Unit, as regional strata to provide better regional estimates for these health units. This provides local data for LGL students which can be compared to other students in the province who completed the survey.

Data analyses were conducted using SPSS software (SPSS Inc., Chicago, IL, Version 18). Microsoft Excel spreadsheet software was used to produce charts and graphics (Excel; Microsoft Inc., Redmond, WA, Version 2007). The descriptive analysis focussed on calculation of percentages and associated 95% confidence intervals (95% C.I.) (See following paragraphs for a description of confidence intervals).

What is a confidence interval?

A confidence interval is a range of values that is normally used to describe the uncertainty, or alternately, the precision around a point estimate (%) of a quantity. The confidence interval is dependent on the sample of data on which it is calculated. Therefore we describe a 95% confidence interval as having a 95% probability of covering the true value, rather than saying that there is a 95% probability that the true value falls within the confidence interval.

Confidence intervals as statistical tests

When comparing two rates to determine if they are statistically significantly different, we use confidence intervals to see if the observed rates are different from each other beyond what would be expected by sampling error (chance) alone. Confidence intervals can allow for the quick determination of these differences if they exist.

If two rates from the same overall population have confidence limits that overlap then they are said to be not statistically significantly different. However, if two confidence intervals do not overlap, a comparable statistical test would always indicate a statistically significant difference.

Note: point estimates accompanied by an "*" have a high sampling variability and should be interpreted with caution.

4.0 Data: Healthy Communities Priority Areas

Highlights:

60.9% of LGL residents report having less than 5 daily servings of fruit and vegetables

40.8% of LGL residents report being 'moderately active' to 'active' based on average daily energy expenditure – this is significantly lower than the provincial average

Falls are the leading external cause of emergency department visits for LGL residents age 0-9 and age 65+

23.6% of LGL residents report smoking cigarettes daily or occasionally and 45.5% of grade 12 students in LGL report lifetime use of tobacco

12.5% of secondary students in LGL report alcohol use once a week or more in the past 12 months and 18.4% of LGL secondary students report using cannabis 10+ times in the past 12 months

21.7% of LGL residents (ages 12+) report 'quite a bit' to 'extreme' life stress and 8.7% of LGL students (grades 7-12) report that they 'seldom/never' feel good about themselves

59.9% of LGL residents are overweight or obese

4.1 Healthy Eating

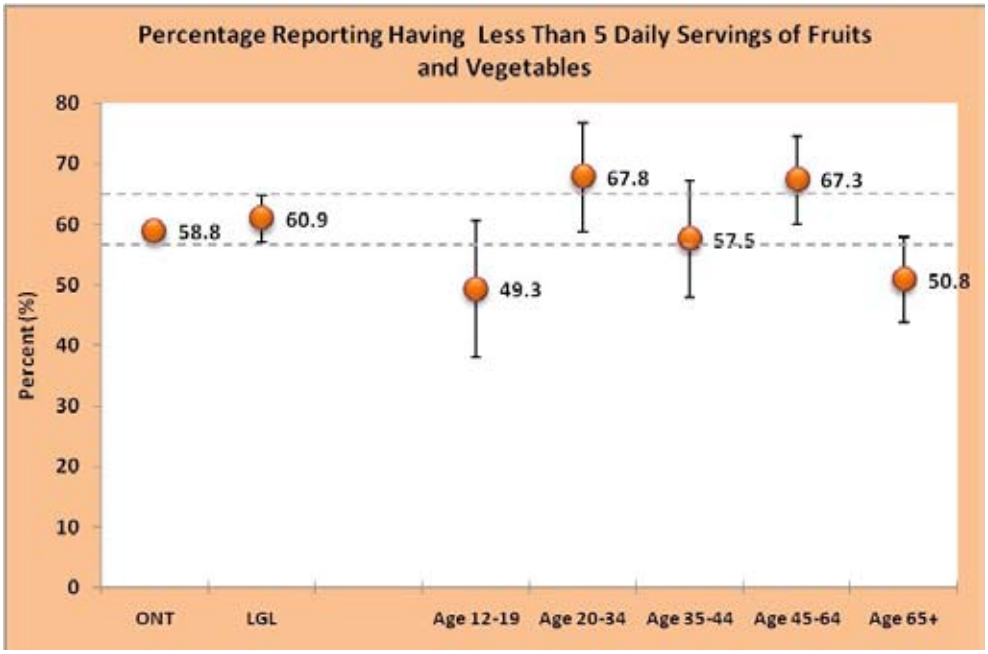
Canada's Food Guide outlines recommendations for amounts and types of food based on a person's age and sex. For vegetables and fruit servings, Canada's Food Guide recommends the following:

Canada's Food Guide: Vegetables and Fruit Serving Recommendations

Age 2-3	**4 servings**
Age 4-8	5 servings
Age 9-13	6 servings
Female age 14-18	7 servings
Male age 14-18	8 servings
Female age 19-50	7-8 servings
Male age 19-50	8-10 servings
Age 51+	7 servings

Fruit & Vegetable Consumption by Age Group

The percentage having less than 5 daily servings of fruit and vegetables in LGL is not significantly different than the rates for Ontario. The youngest (age 12-19) and oldest (age 65+) age groups appear to consume more fruits and vegetable servings.



Source: Canadian Community Health Survey 2007/2008. Statistics Canada

- The 2004 CCHS: Nutrition survey found that over one-quarter (25.4%) of Canadians ages 19 or older and 24.8% of youth ages 4-18 had eaten 'at least some fast food' in the past 24 hours[1]
- The majority of Canadians in all age groups (including children, youth, adults and older adults) reported usual sodium intake above the tolerable upper intake level: in the 19-30 age group 98.8% of males exceeded the upper intake level and 76.3% of females exceeded the upper intake level (CCHS: Nutrition 2004)[2]
- A Canadian study of children's eating behaviours (grades 4-8) found that only 60.1% of girls and 70.0% of boys ate breakfast every day; that girls were less likely to eat breakfast everyday compared to boys; and that fewer students ate breakfast as grade increased[3]

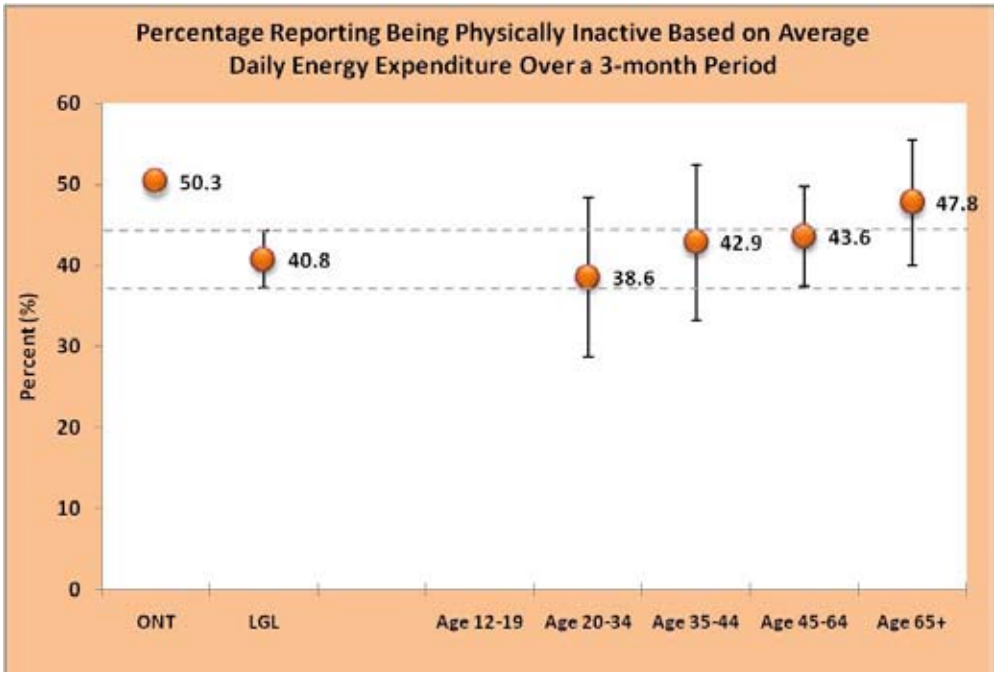
1 Garriguet, D. "Overview of Canadians Eating Habits 2004". Statistics Canada, July 2006.
2 Garriguet. D. "Sodium Consumption at All Ages". Health Reports 18 (2): May 2007.
3 Evers S et al. "Eating and Smoking Behaviours of School Children in Southwestern Ontario and Charlottetown, PEI". Canadian Journal of Public Health 92, 6 (2001): 433-436.

4.2 Physical Activity, Sport and Recreation

Canada's Physical Activity Guide to Healthy Active Living provides recommendations for Canadians. The guide recommends daily physical activity based on the intensity of the activity: 60 minutes of light effort; 30-60 minutes of moderate effort; or 20-30 minutes of vigorous effort.

Physically Inactive by Age Group

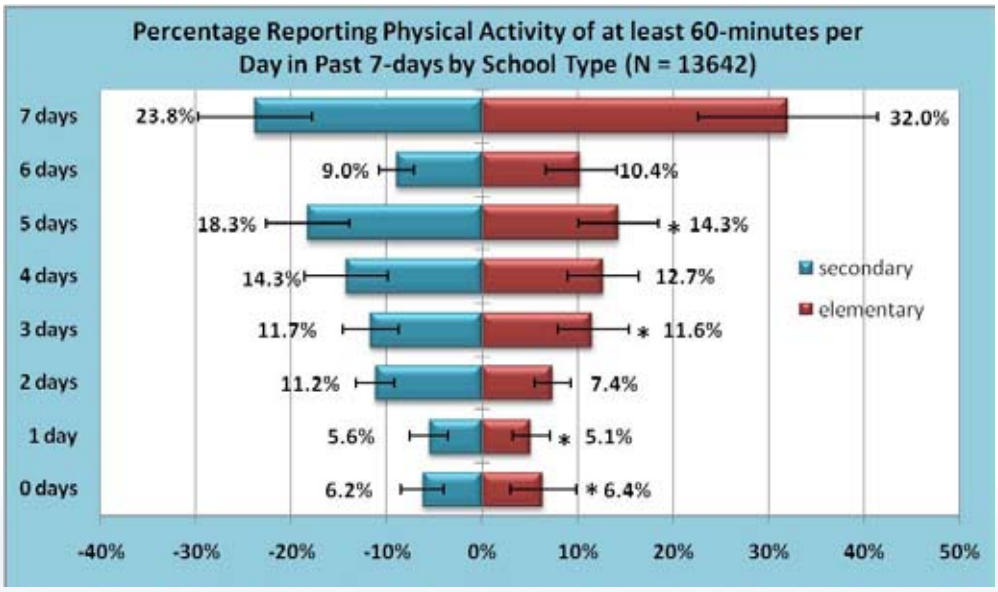
The proportion of LGL residents who are physically inactive is significantly lower than Ontario. Physical activity levels appear to decrease with age in LGL, although not significantly.



Source: Canadian Community Health Survey 2007/2008. Statistics Canada

Physical Activity by School

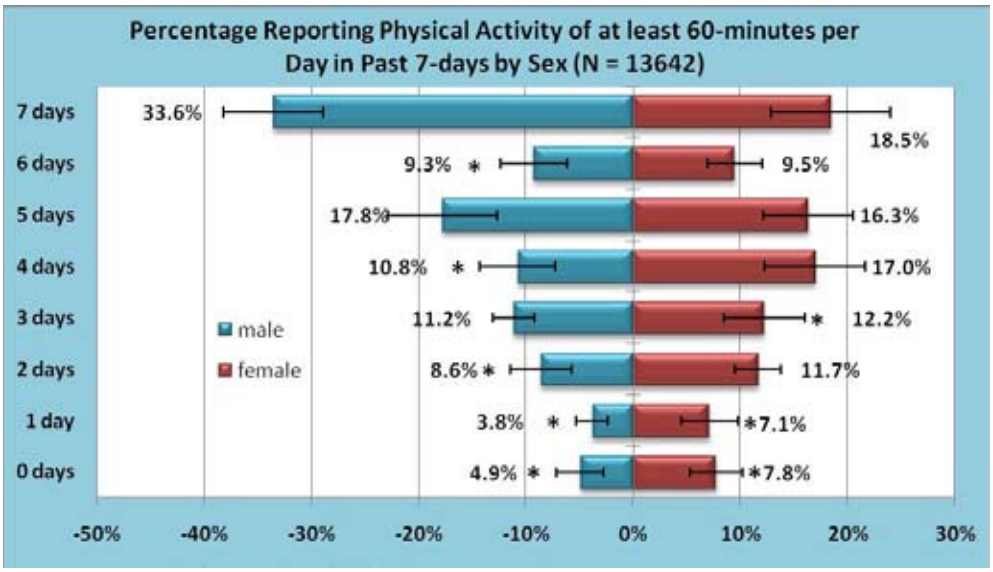
More elementary students in LGL (grade 7 and 8) are active for 60 minutes a day, 7 days a week compared to secondary students.



Source: Ontario Student Drug Use and Health Survey. CAMH 2009

Physical Activity by Sex

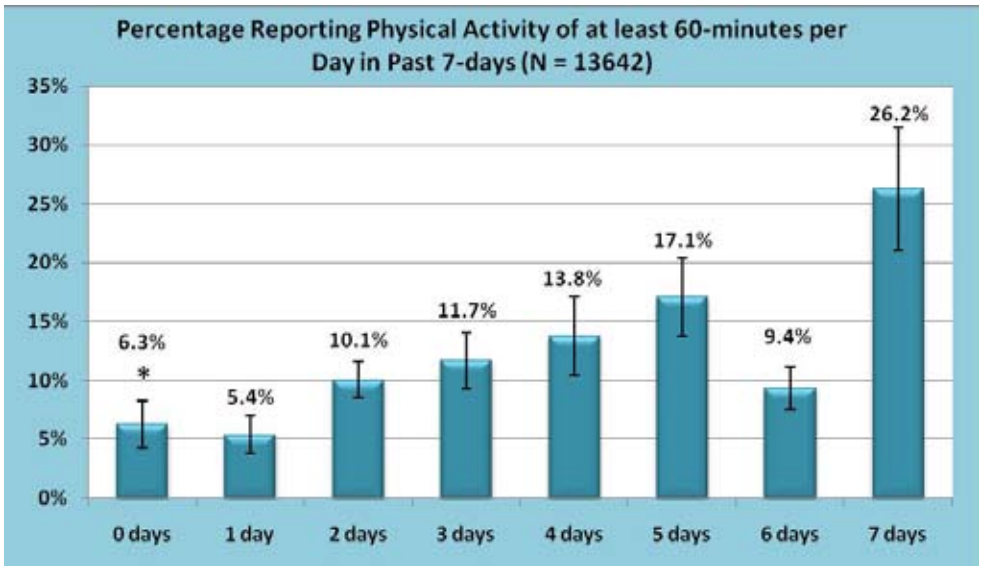
Male students in LGL are significantly more active for 60 minutes a day, 7 days a week compared to female students.



Source: Ontario Student Drug Use and Health Survey. CAMH 2009

Physical Activity Overall

52.7% of students in LGL are active for at least 60 minutes a day, 5 or more days per week.

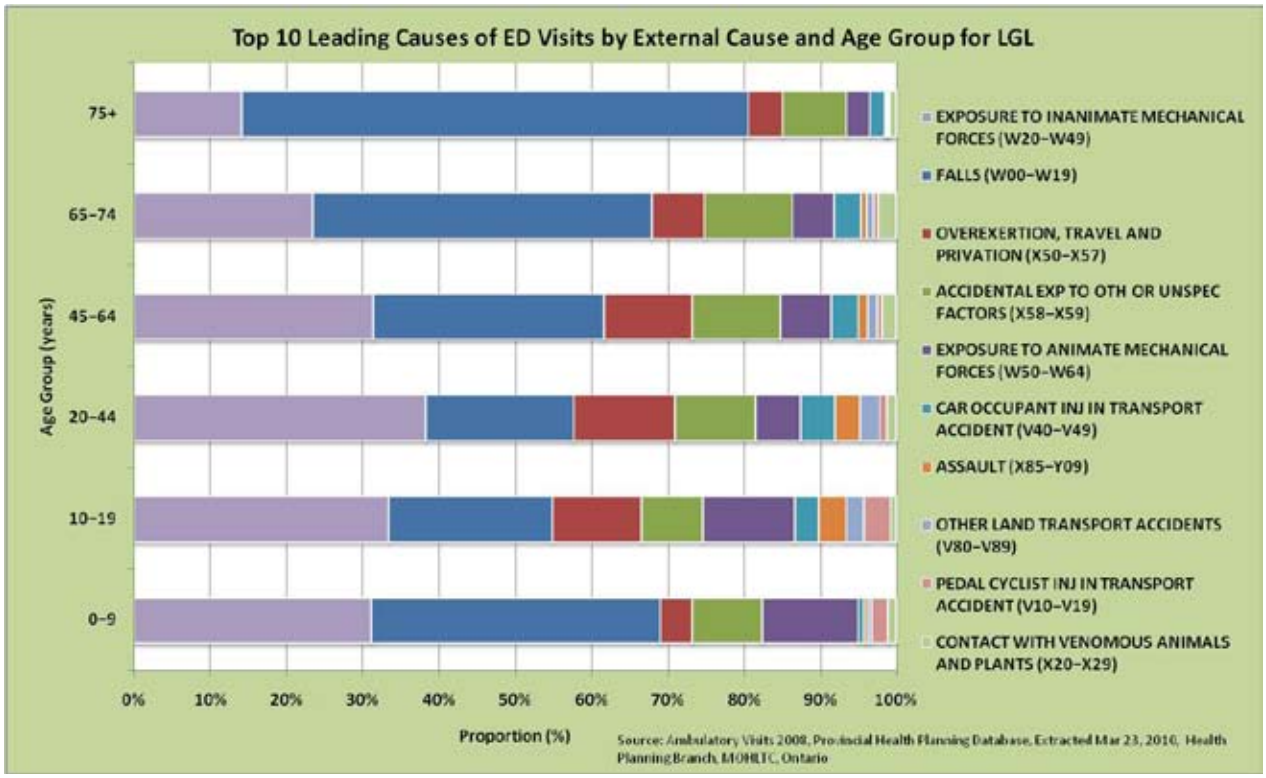


Source: Ontario Student Drug Use and Health Survey. CAMH 2009

- Youth (ages 12-19) in LGL have an average of 19.7 hours of screen time in a typical week (hours of computer use, watching television or watching videos)[4]

4 Canada Fitness and Lifestyle Research Institute. "Rating Canada's Regional Health: Which Region Accumulates the Most Screen Time?" http://www.cflri.ca/eng/regionalhealth/index.php (Accessed 27 Sept 2010).

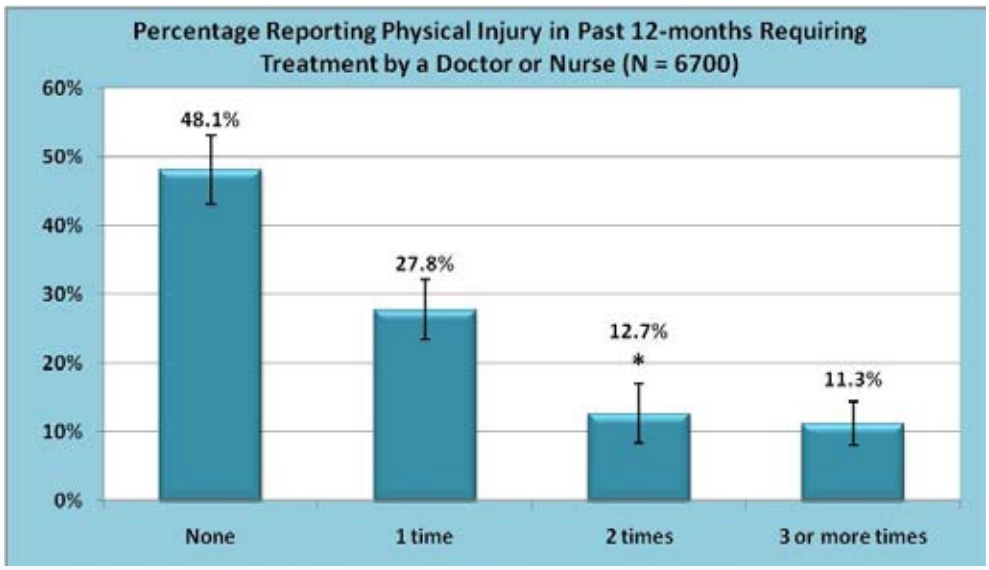
4.3 Injury Prevention



Falls are the leading cause of emergency department visits in the youngest (age 0-9) and oldest (age 65+) age groups.

Injury Overall

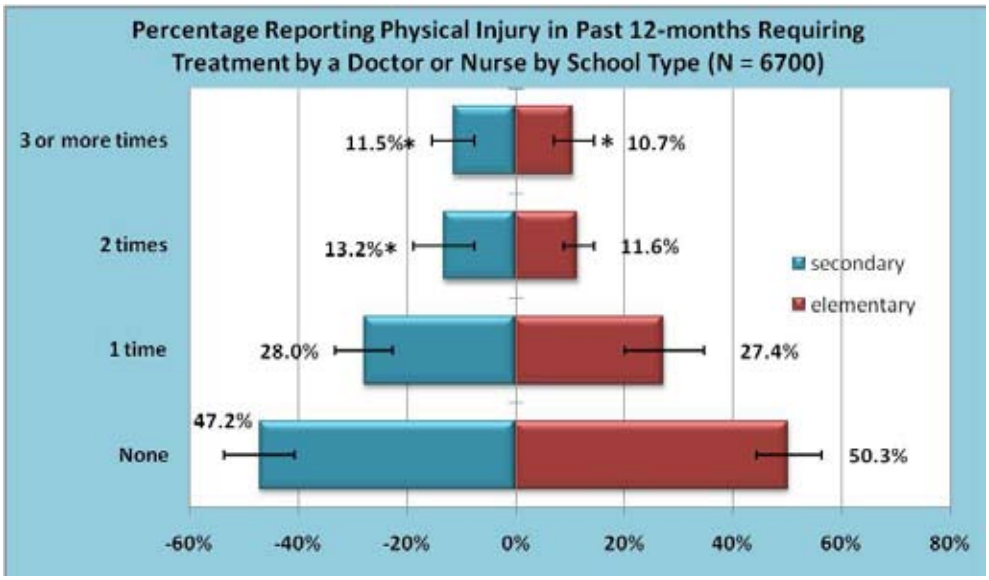
51.8% of students in LGL reported a physical injury in the past 12 months requiring treatment by a doctor or nurse one or more times.



Source: Ontario Student Drug Use and Health Survey. CAMH 2009

Injury by School

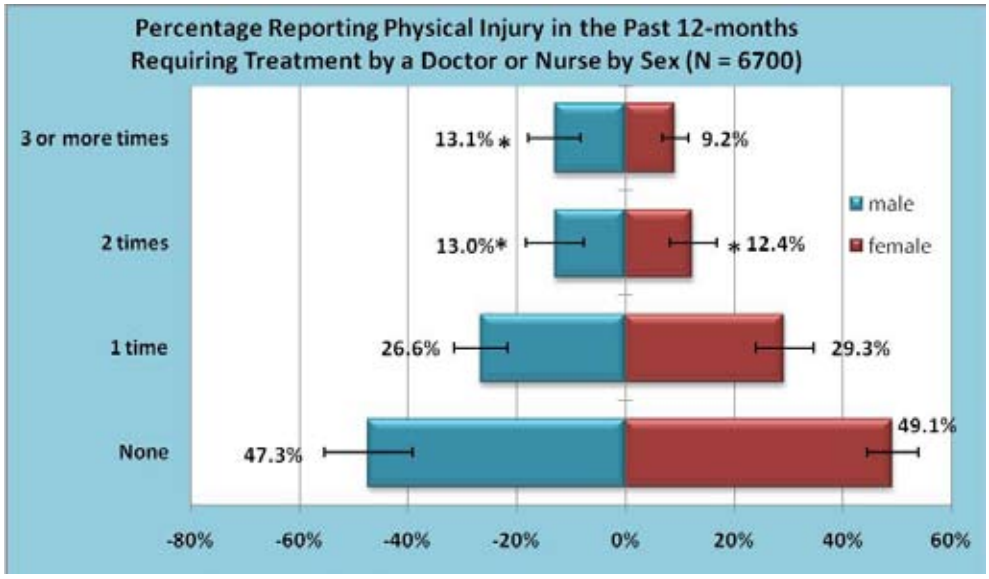
The proportions of elementary and secondary students in LGL reporting physical injuries in the past 12 months requiring treatment by a doctor or nurse are similar.



Source: Ontario Student Drug Use and Health Survey. CAMH 2009

Injury by Sex

The proportions of male and female students in LGL reporting physical injuries in the past 12 months requiring treatment by a doctor or nurse are similar.

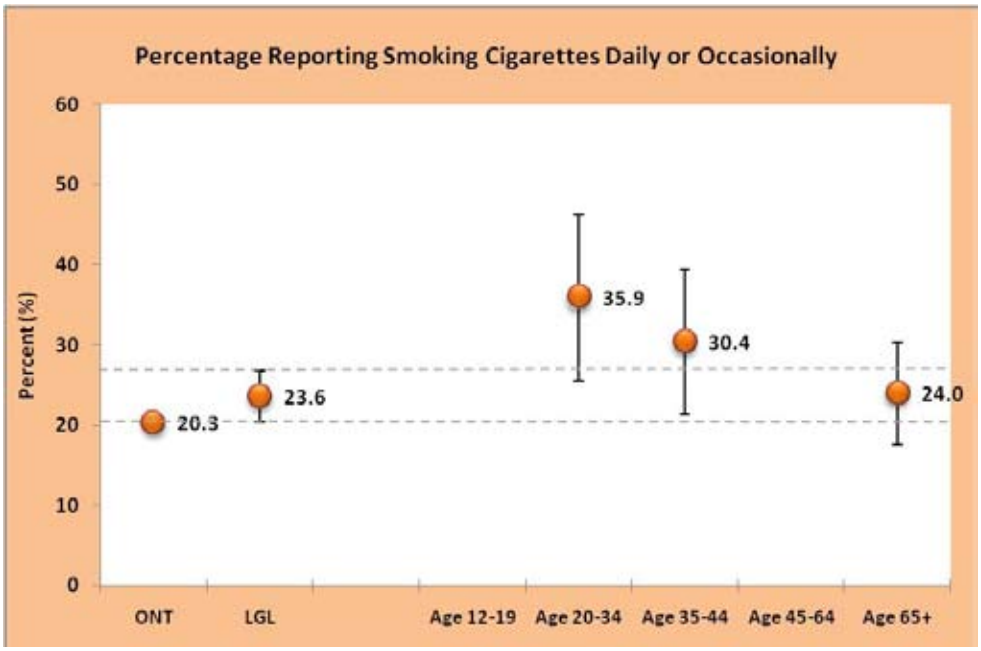


Source: Ontario Student Drug Use and Health Survey. CAMH 2009

4.4 Tobacco use/Exposure

Tobacco by Age Group

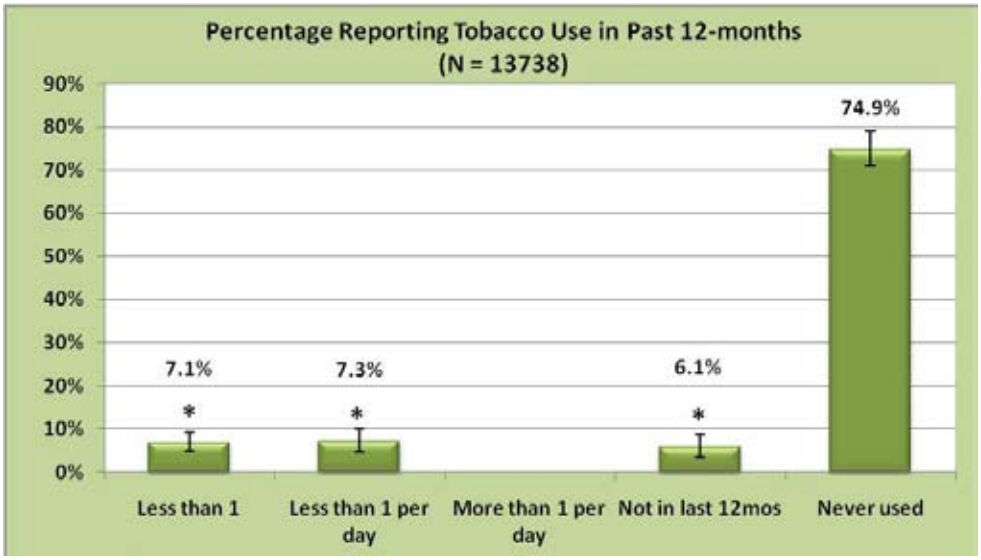
The percentage of LGL residents who report smoking cigarettes daily or occasionally is slightly higher than the provincial average. Daily or occasional cigarette smoking among LGL residents decreases with age, although not significantly.



Source: Canadian Community Health Survey 2007/2008. Statistics Canada

Tobacco Overall

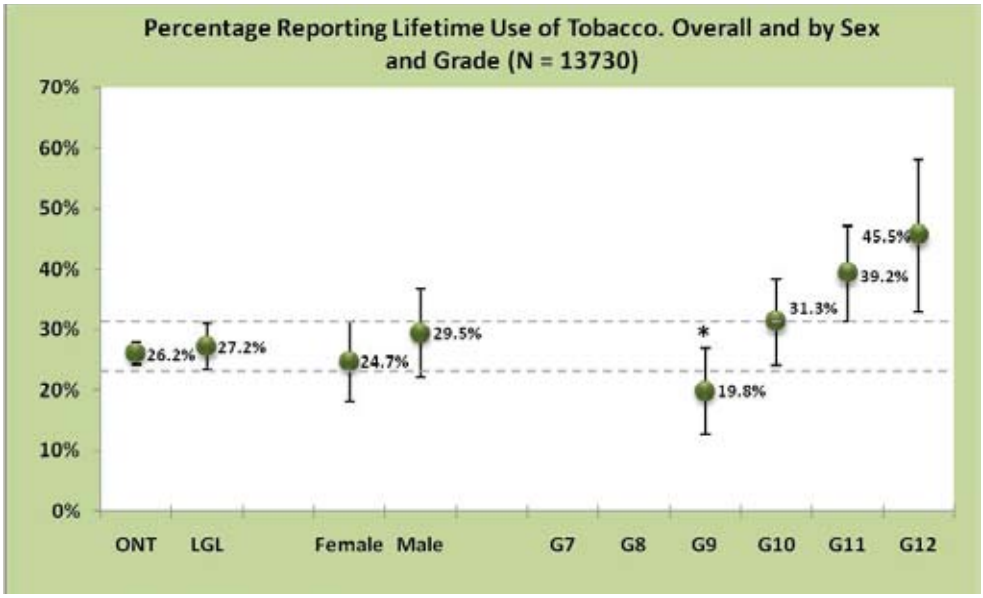
Overall, close to three-quarters of students in LGL (74.9%) report that they have never used tobacco in the past 12 months, while 6.1% report using tobacco but not in the past 12 months, and slightly over 7% report smoking less than 1 whole cigarette or smoking less than 1 cigarette per day.



Source: Ontario Student Drug Use and Health Survey. CAMH 2009

Tobacco Lifetime

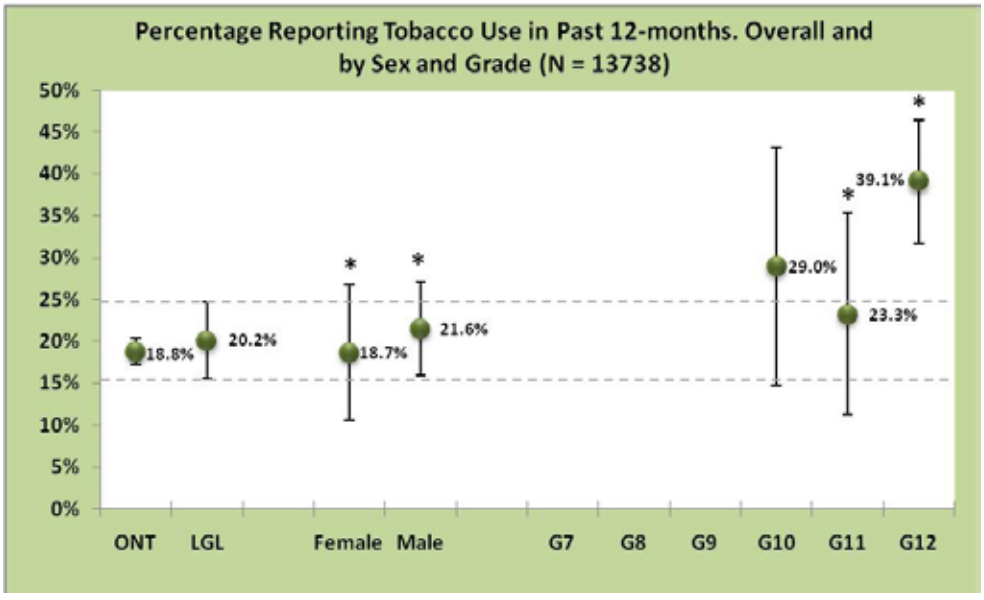
The percentage of LGL students reporting lifetime use of tobacco increases with grade, such that the percentage reporting lifetime use by grade 12 is significantly higher than grade 9. As well, male lifetime tobacco use is slightly higher than female lifetime tobacco use, although not significantly.



Source: Ontario Student Drug Use and Health Survey. CAMH 2009

Tobacco by Past Year

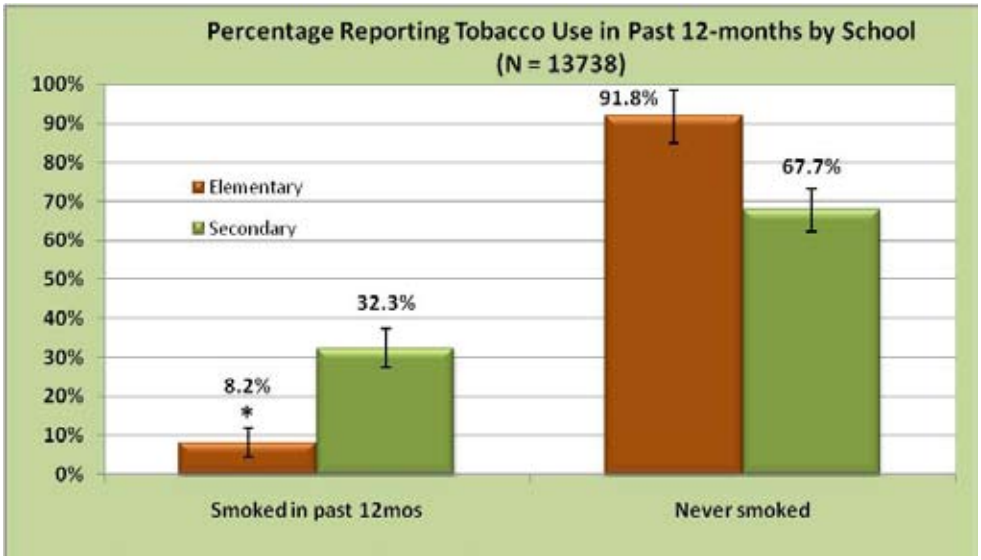
More male LGL students reported tobacco use in the past year than female students, although not significantly. As well, the percentage of LGL students reporting tobacco use in the past year is slightly higher than the provincial average, but again, not significantly.



Source: Ontario Student Drug Use and Health Survey. CAMH 2009

Tobacco by School

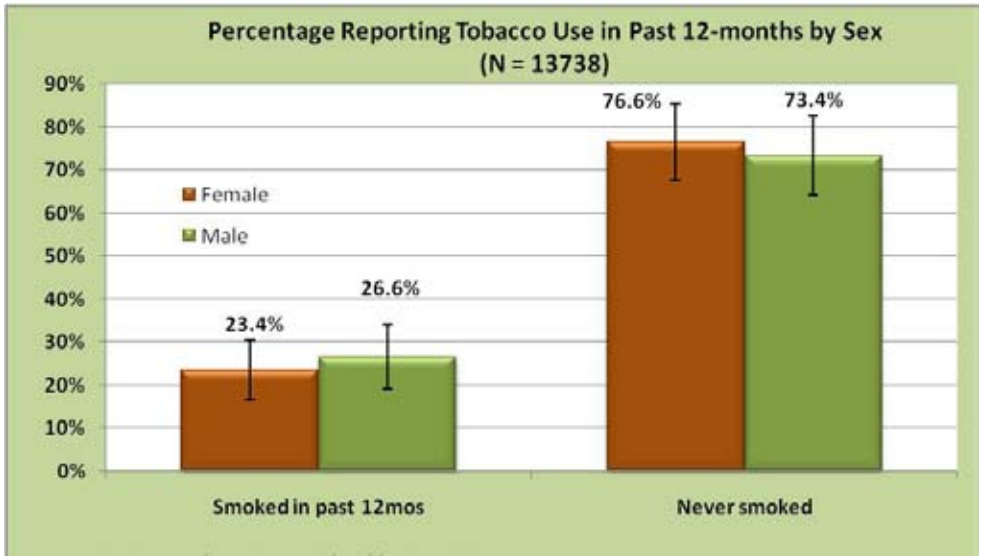
The percentage of LGL secondary students who report smoking in the past 12 months is significantly higher than LGL elementary students. As well, the percentage of LGL elementary students reporting to have never smoked is significantly higher than LGL secondary students.



Source: Ontario Student Drug Use and Health Survey. CAMH 2009

Tobacco by Sex

There are no significant differences between tobacco use in the past year for male and female students in LGL. 23.4% of female students and 26.6% of male students report tobacco use in the past 12 months.



Source: Ontario Student Drug Use and Health Survey. CAMH 2009

- 16.9%* of LGL residents reside in a home where someone smokes cigarettes regularly and 18.1%* of LGL residents are exposed to second-hand smoke everyday (RRFSS 2008 and RRFSS 2007; *data have high variability and should be interpreted with caution).

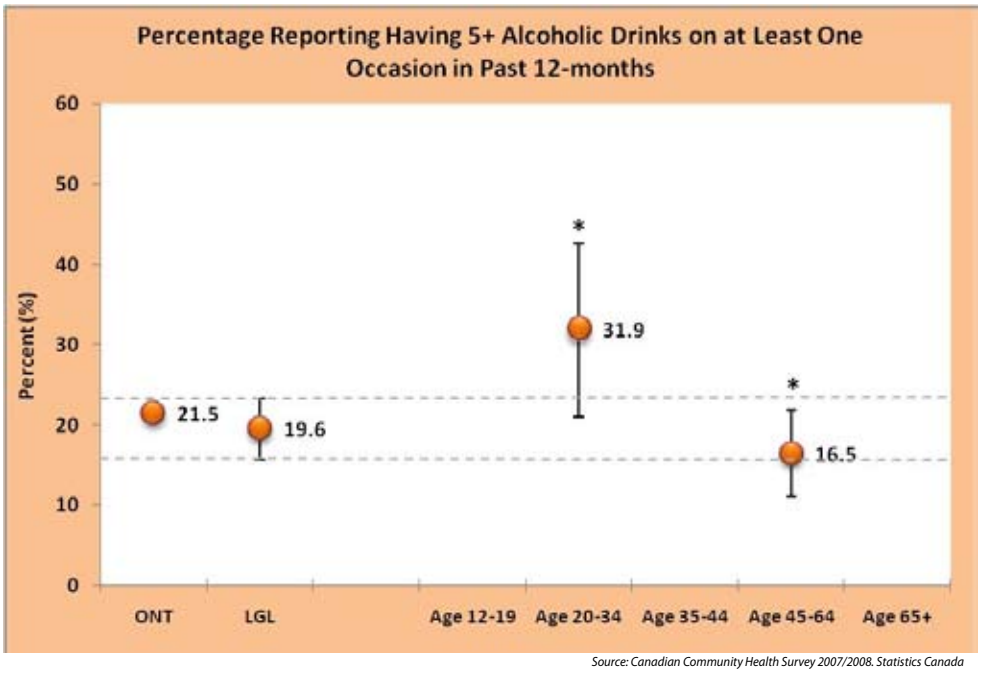
4.5 Substance Misuse/Alcohol Misuse

The Centre for Addiction and Mental Health has established low-risk drinking guidelines for Canadians of legal drinking age. The guidelines state:

0 drinks	Lowest risk of an alcohol-related problem
2 drinks	No more than 2 standard drinks on any one day
9 drinks	Women: Up to 9 standard drinks a week
14 drinks	Men: Up to 14 standard drinks a week

Alcohol by Age Group

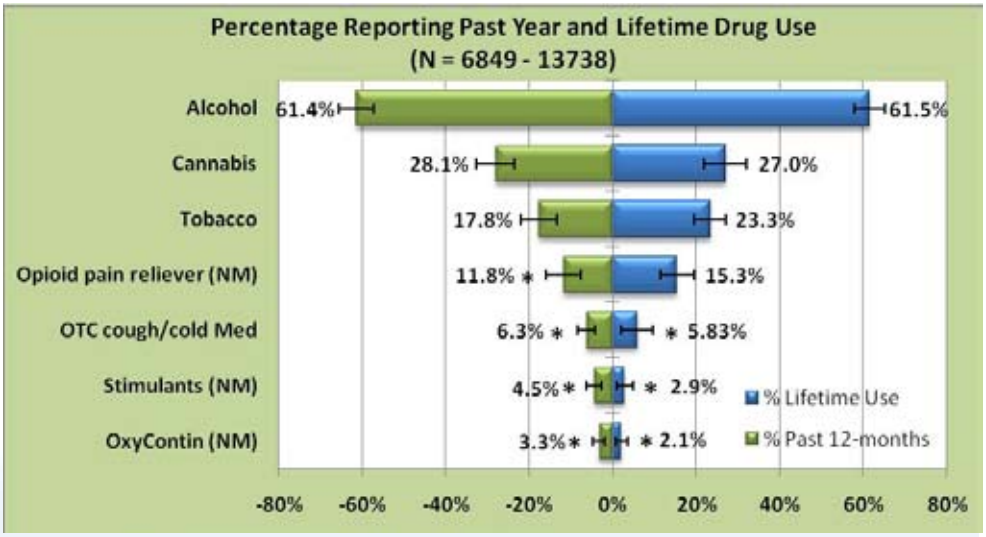
Close to 1 in 5 LGL residents (19.6%) report having 5+ drinks on at least one occasion in the past 12 months.



Source: Canadian Community Health Survey 2007/2008. Statistics Canada

Past Year vs. Lifetime Drug Use

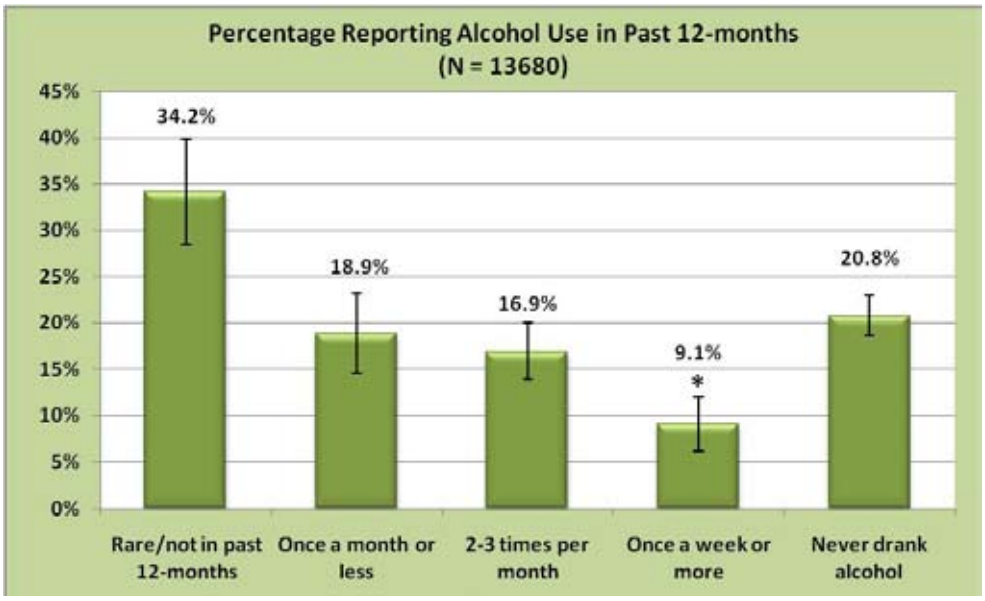
Alcohol is the most commonly used drug by students in LGL followed by cannabis and tobacco. The proportions of LGL students reporting drug use in the past 12 months and lifetime use are similar.



Source: Ontario Student Drug Use and Health Survey. CAMH 2009

Alcohol Overall

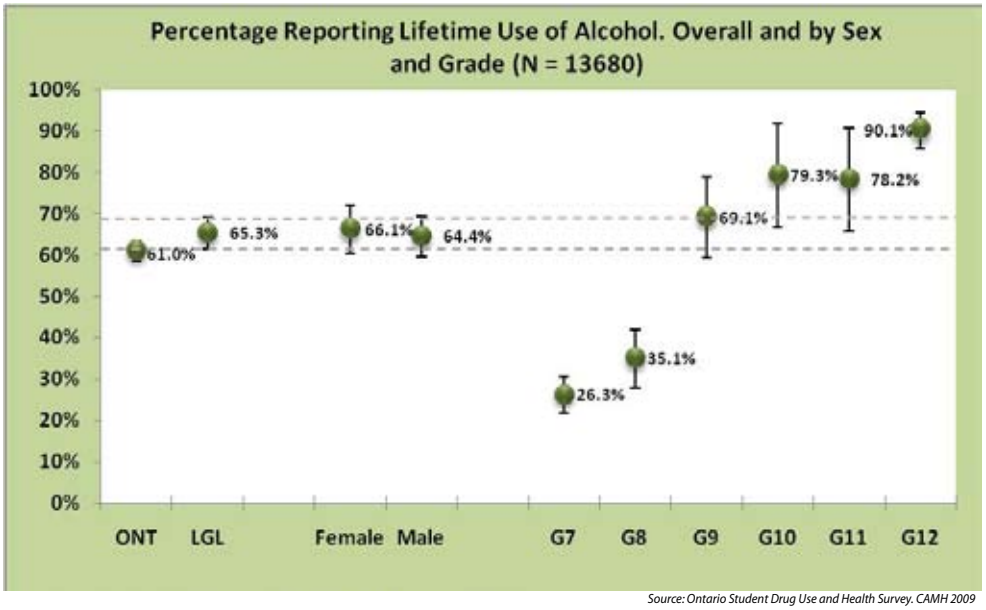
16.9% of LGL students report drinking alcohol 2-3 times per month and 9.1% report drinking alcohol once a week or more.



Source: Ontario Student Drug Use and Health Survey. CAMH 2009

Alcohol Lifetime

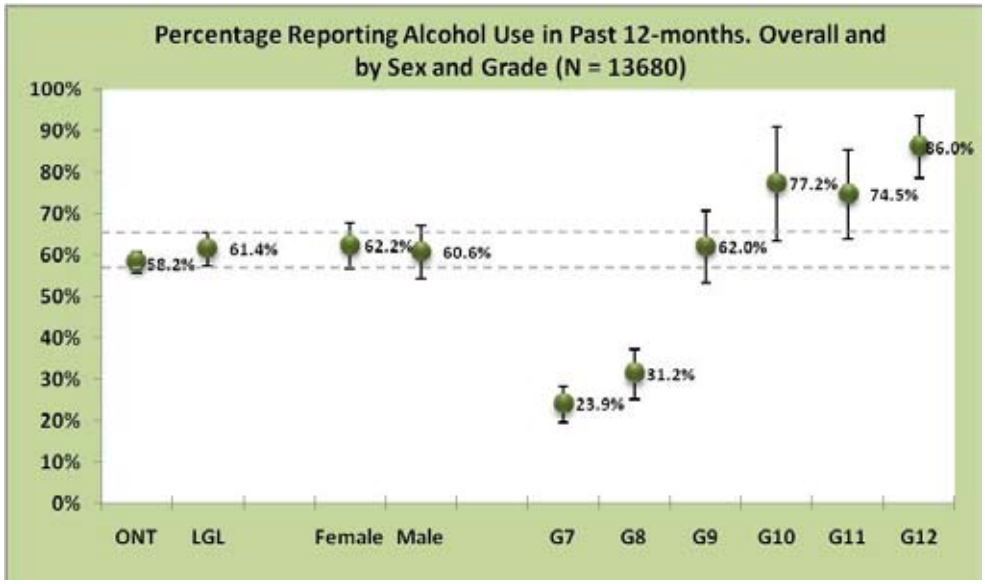
Although the percentage of LGL students who report lifetime use of alcohol is higher than Ontario, it is not a significant difference. Lifetime use among male and female LGL students is very similar, and lifetime use increases as grade increases, with lifetime use by secondary students significantly higher than lifetime use by elementary students.



Source: Ontario Student Drug Use and Health Survey. CAMH 2009

Alcohol Past Year

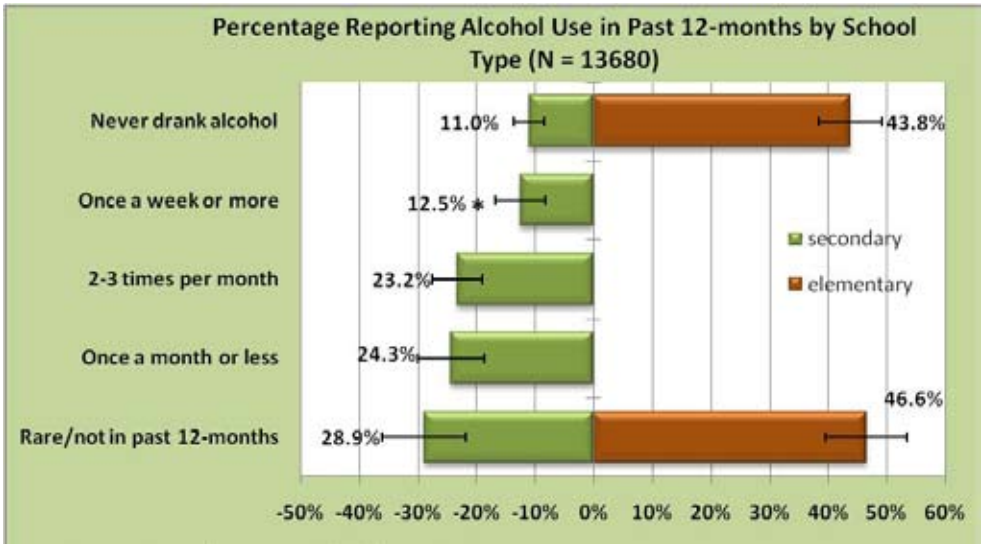
Although the percentage of LGL students who report use of alcohol in the past year is higher than Ontario, it is not a significant difference. Alcohol use in the past year among male and female LGL students is very similar, and alcohol use increases as grade increases, with alcohol use by secondary students significantly higher than alcohol use by elementary students.



Source: Ontario Student Drug Use and Health Survey. CAMH 2009

Alcohol by School

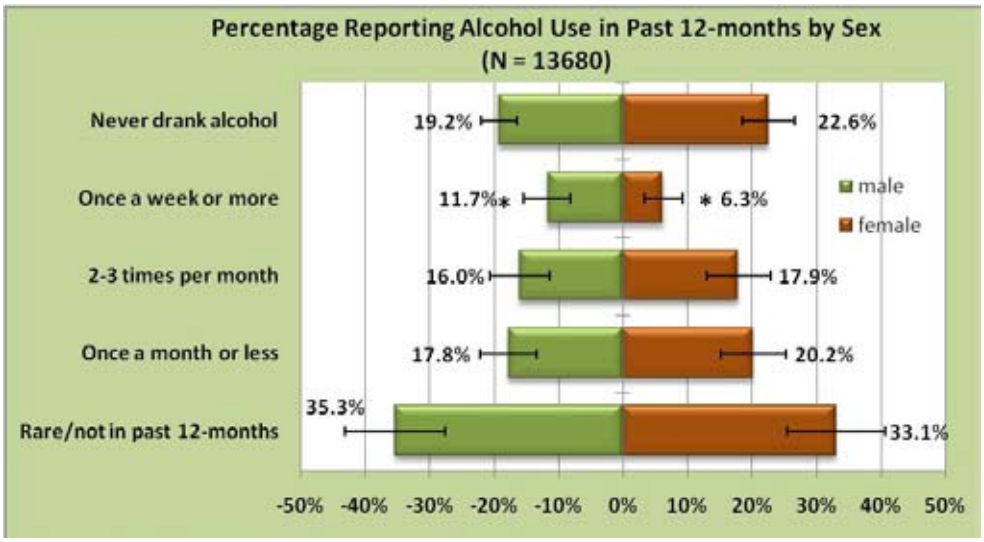
The percentage of LGL elementary students who have never drank alcohol is significantly higher than the percentage of LGL secondary students who have never drank alcohol.



Source: Ontario Student Drug Use and Health Survey. CAMH 2009

Alcohol by Sex

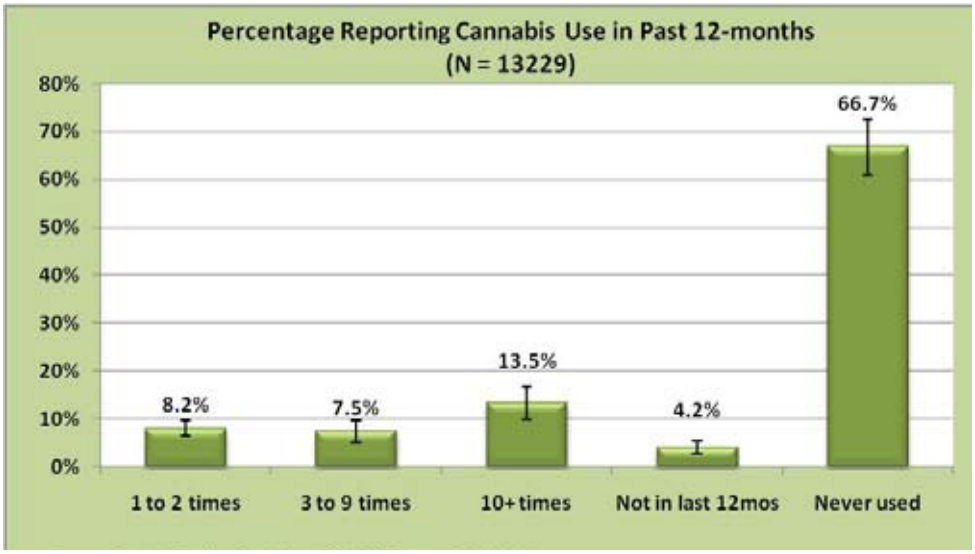
Alcohol use among male and female LGL students is quite similar with no significant differences.



Source: Ontario Student Drug Use and Health Survey. CAMH 2009

Cannabis Overall

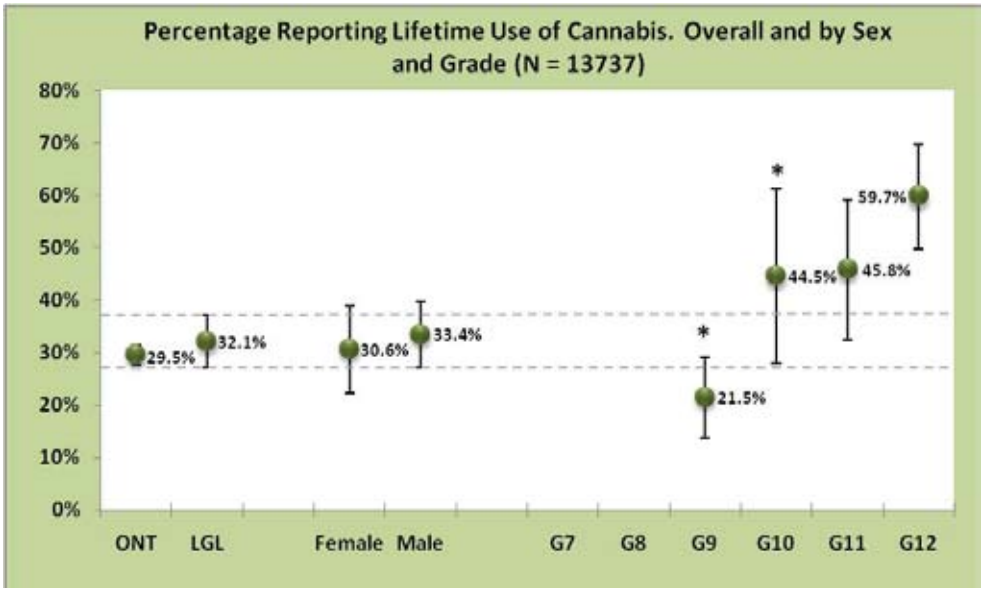
Overall, 21.0% of LGL students report that they have used cannabis 3 or more times in the past 12 months.



Source: Ontario Student Drug Use and Health Survey. CAMH 2009

Cannabis Lifetime

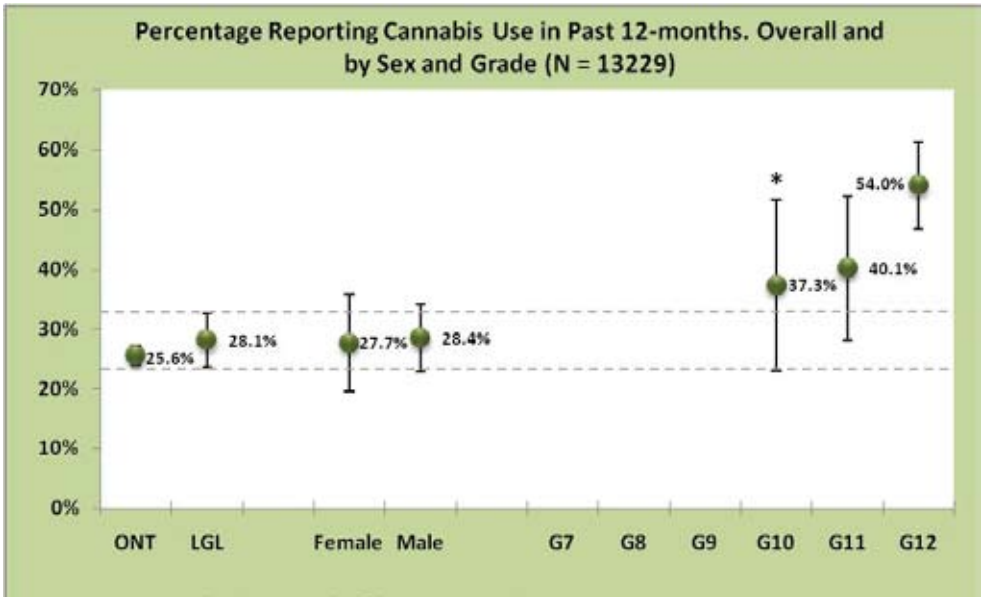
Lifetime use of cannabis increases with grade, with 59.7% of grade 12 students reporting lifetime use compared to 21.5% of grade 9 students.



Source: Ontario Student Drug Use and Health Survey. CAMH 2009

Cannabis Past Year

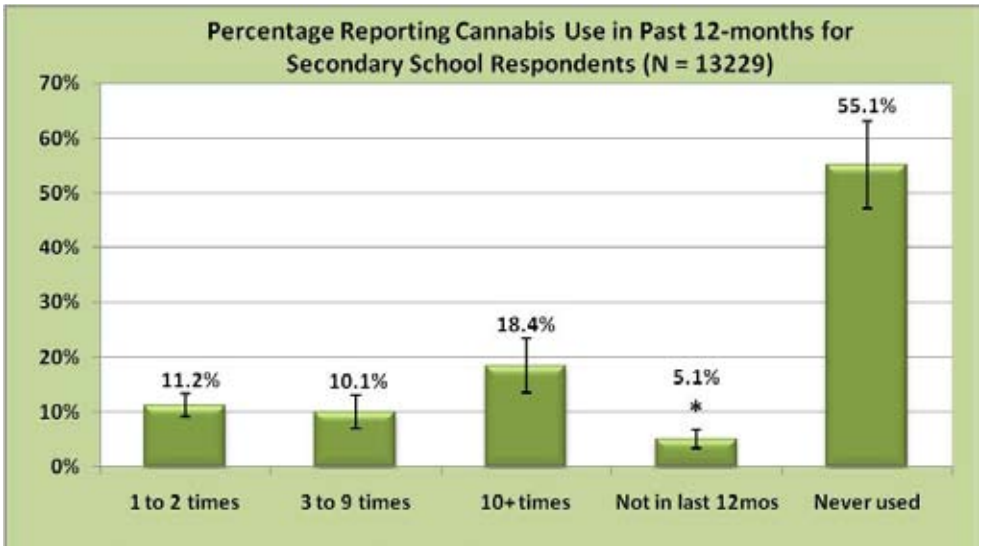
Although the percentage of LGL students reporting cannabis use in the past 12 months is higher than Ontario, it is not a significant difference. Male and female use is very similar, and cannabis use increases with grade.



Source: Ontario Student Drug Use and Health Survey. CAMH 2009

Cannabis by School

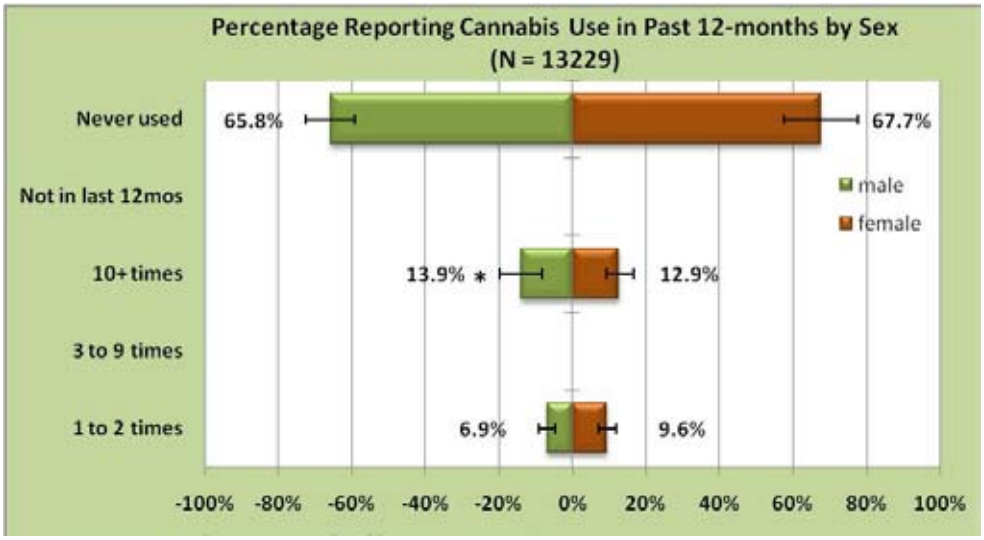
18.4% of secondary school students in LGL reported using cannabis 10+ times in the past 12 months.



Source: Ontario Student Drug Use and Health Survey. CAMH 2009

Cannabis by Sex

The proportions of male and female LGL students who report using cannabis are similar without any significant differences.

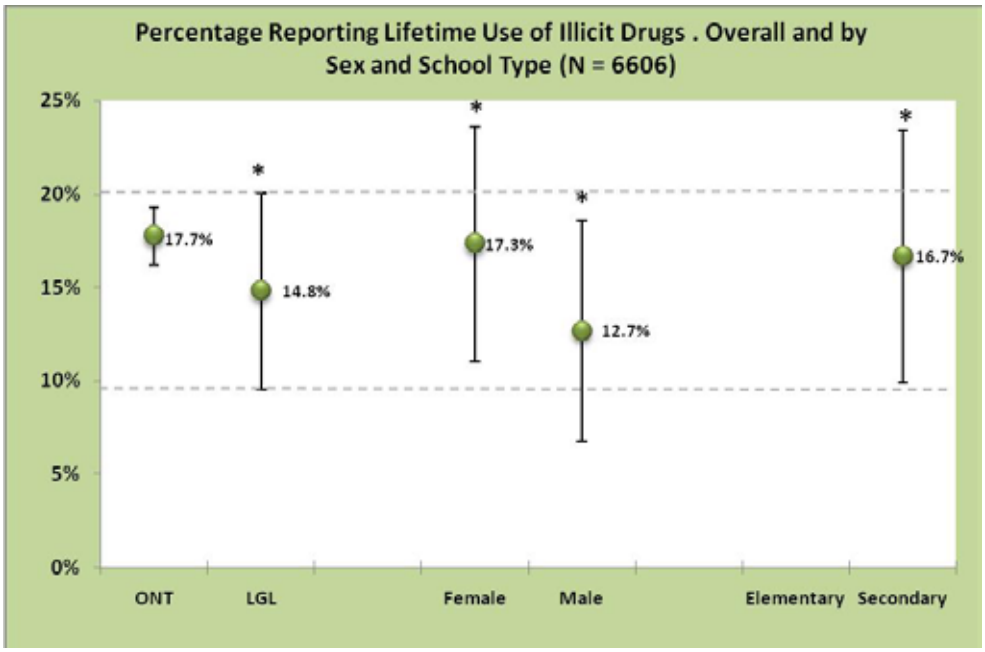


Source: Ontario Student Drug Use and Health Survey. CAMH 2009

Illicit drugs lifetime

The OSDUHS defines the illicit drug use variable as "derived from the combination of the following: sniffing of glue or solvents, heroin, methamphetamines, crystal meth, LSD, PCP, crack, cocaine, ecstasy, GHB, rohypnol, ketamine, jimson weed, and salvia divinorum, but excludes cannabis and non-medical prescription drug use".

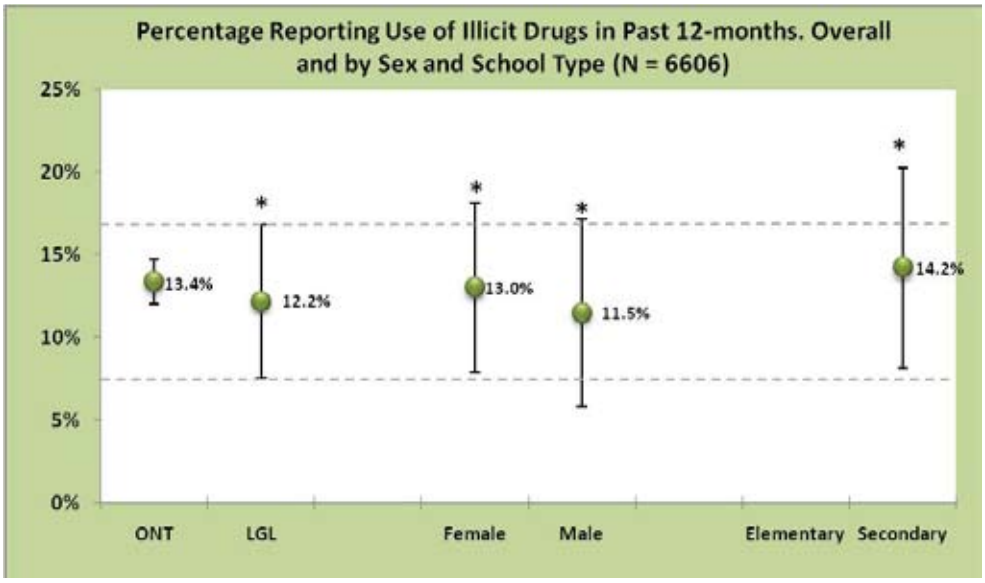
There are no significant differences in lifetime use of illicit drugs between LGL students and Ontario. As well, there are no significant differences between males and females (although females report higher lifetime use).



Source: Ontario Student Drug Use and Health Survey. CAMH 2009

Illicit Drugs Past Year

There are no significant differences in use of illicit drugs in the past year between male and female students in LGL or between students in LGL and students in Ontario.

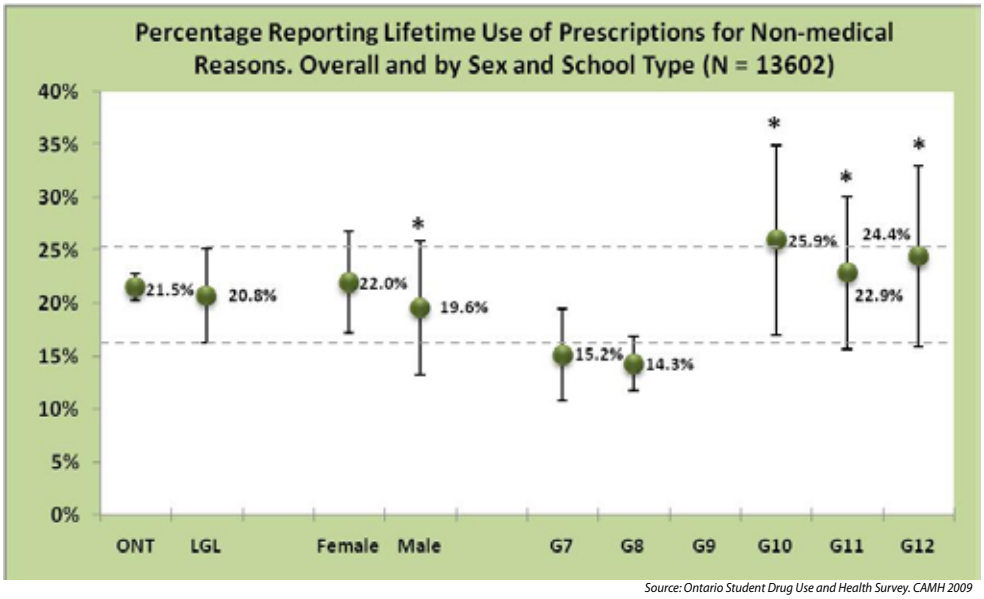


Source: Ontario Student Drug Use and Health Survey. CAMH 2009

Non-Medical Prescription Use Lifetime

The OSDUHS defines the non-medical prescription use variable as "derived from the combination of the non-medical use of: opioid pain relievers, oxycontin, ADHD drugs and sedatives/tranquilizers".

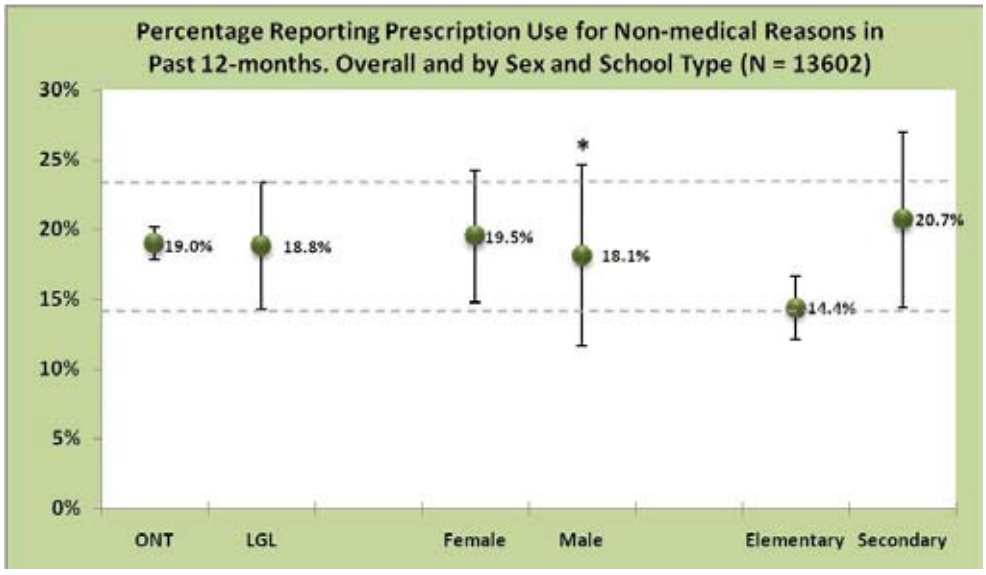
There are no significant differences in lifetime use of prescriptions for non-medical reasons between male and female students in LGL or between students in LGL and students in Ontario.



Source: Ontario Student Drug Use and Health Survey. CAMH 2009

Non-Medical Prescription Use Past Year

Use of prescription drugs for non-medical reasons in the past 12 months is higher among secondary students in LGL than elementary students. There are no significant differences between students in LGL and students in Ontario, or between male and female students in LGL.

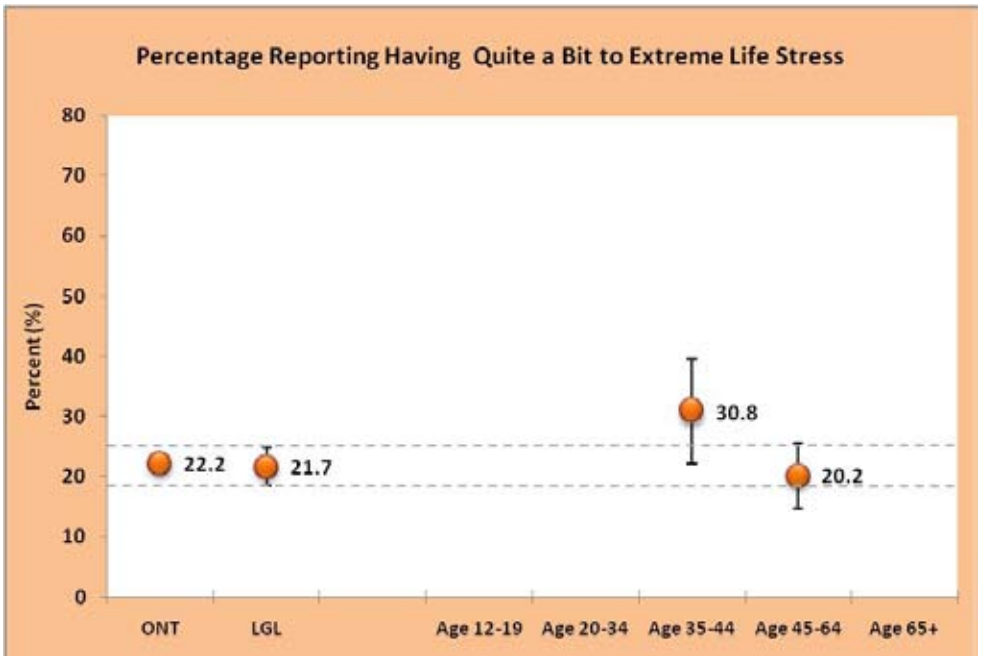


Source: Ontario Student Drug Use and Health Survey. CAMH 2009

4.6 Mental Health

Stress by Age Group

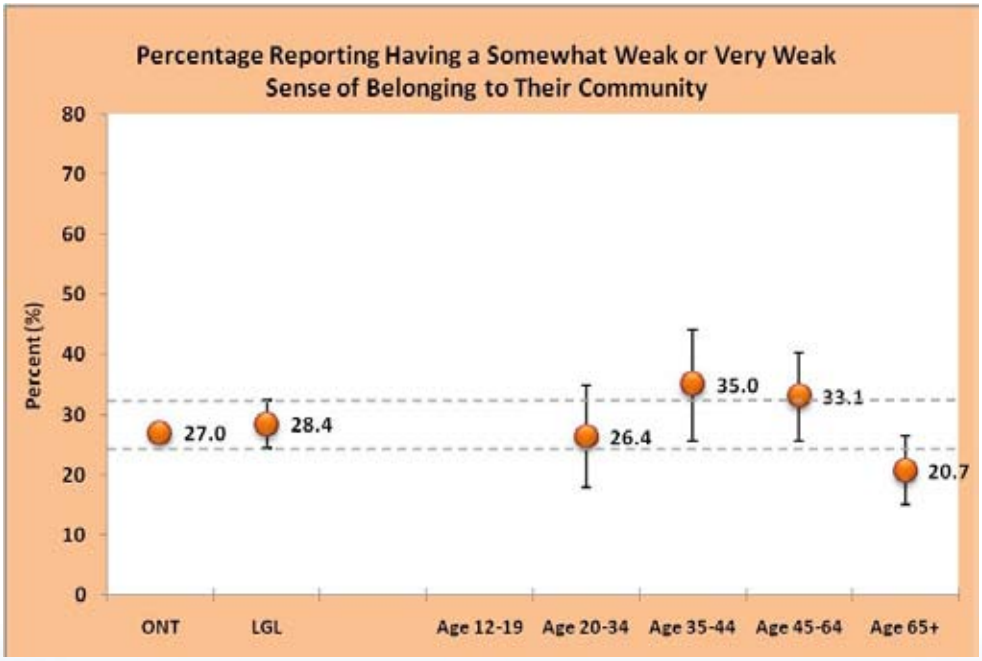
Overall, 21.7% of LGL residents (ages 12+) report 'quite a bit' to 'extreme' life stress, which is similar to the Ontario average.



Source: Canadian Community Health Survey 2007/2008. Statistics Canada

Community Belonging by Age Group

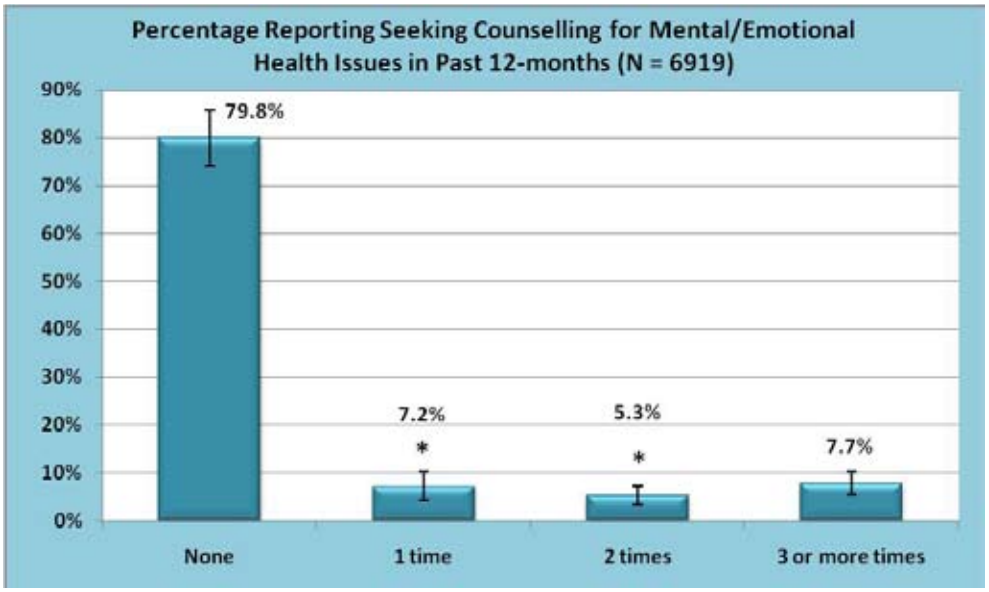
Overall, 28.4% of LGL residents report a 'somewhat weak' or 'very weak' sense of belonging to their community. Younger LGL residents (age 20-34) and older LGL residents (age 65+) appear to feel a greater sense of belonging than residents in the middle age groups (age 35-44 and age 45-64).



Source: Canadian Community Health Survey 2007/2008. Statistics Canada

Mental Health Overall

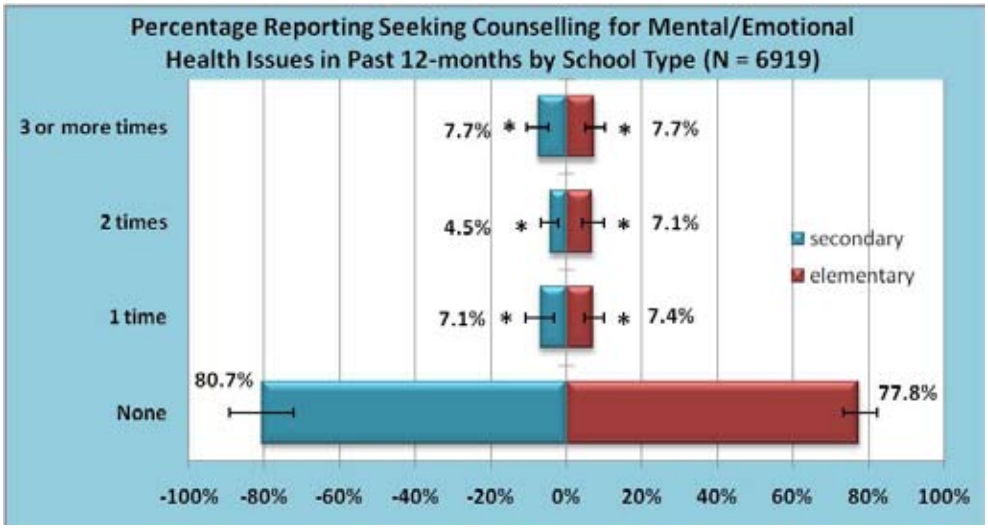
Overall, 20.2% of students in LGL have sought counselling for mental/emotional health issues in the past 12 months.



Source: Ontario Student Drug Use and Health Survey. CAMH 2009

Mental Health by School

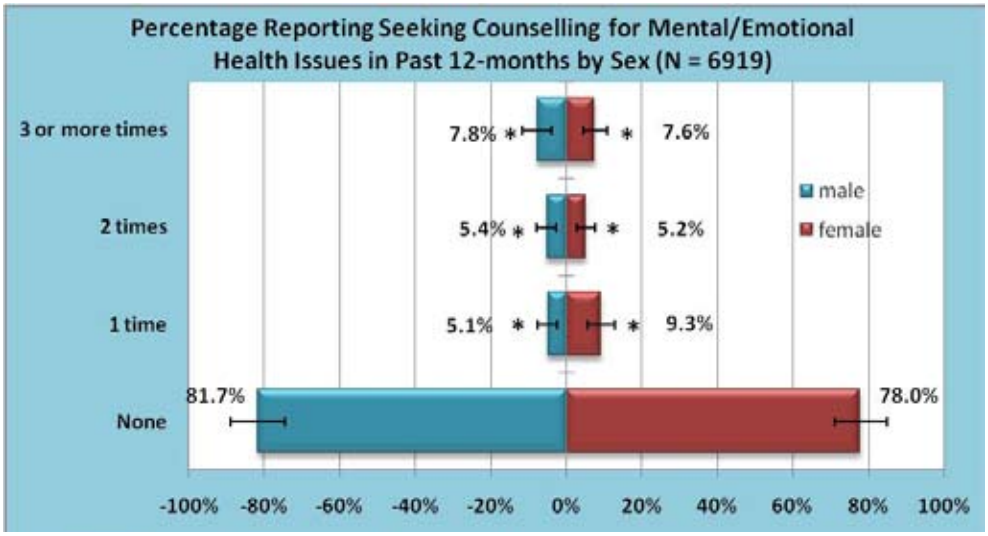
There are no significant differences in the percentages of students who seek counselling for mental/ emotional health issues between elementary and secondary students in LGL.



Source: Ontario Student Drug Use and Health Survey. CAMH 2009

Mental Health by Sex

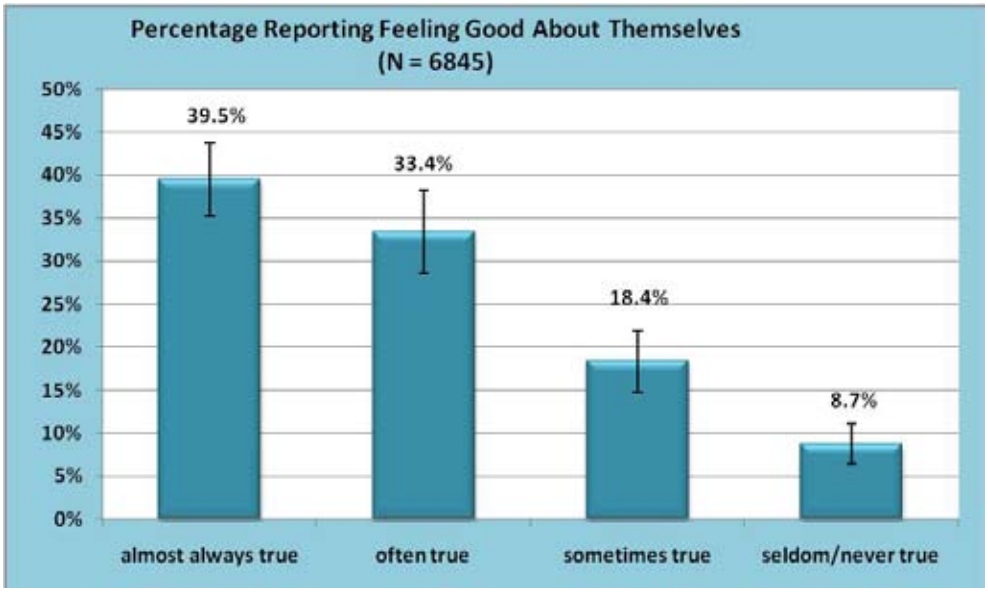
Similar proportions of male and female students in LGL report seeking counselling for mental/emotional health issues in the past 12 months. Overall, close to 1 in 5 students reports seeking counselling for mental/emotional health issues at least once in the past year.



Source: Ontario Student Drug Use and Health Survey. CAMH 2009

Self Esteem Overall

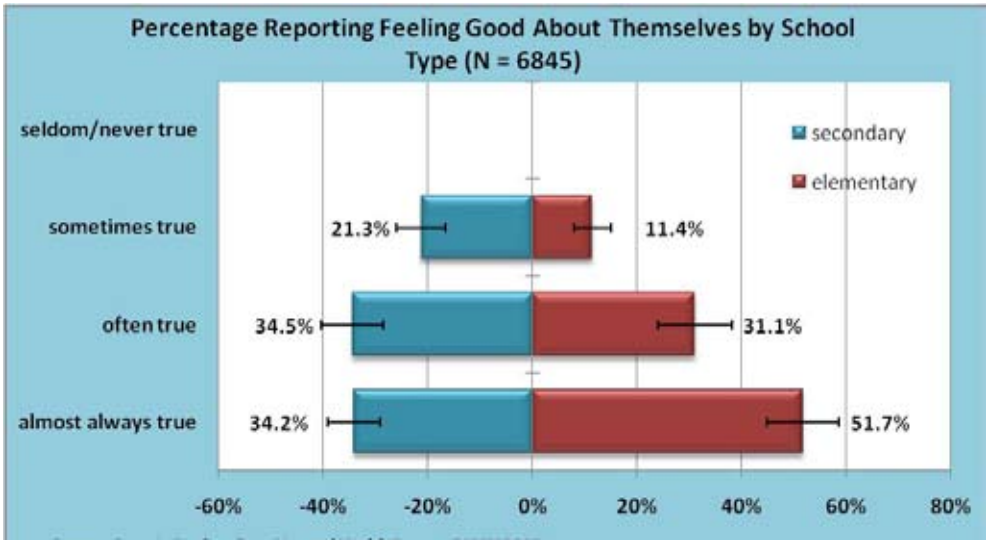
Overall, 8.7% of students report that they 'seldom/never' feel good about themselves.



Source: Ontario Student Drug Use and Health Survey. CAMH 2009

Self Esteem by School

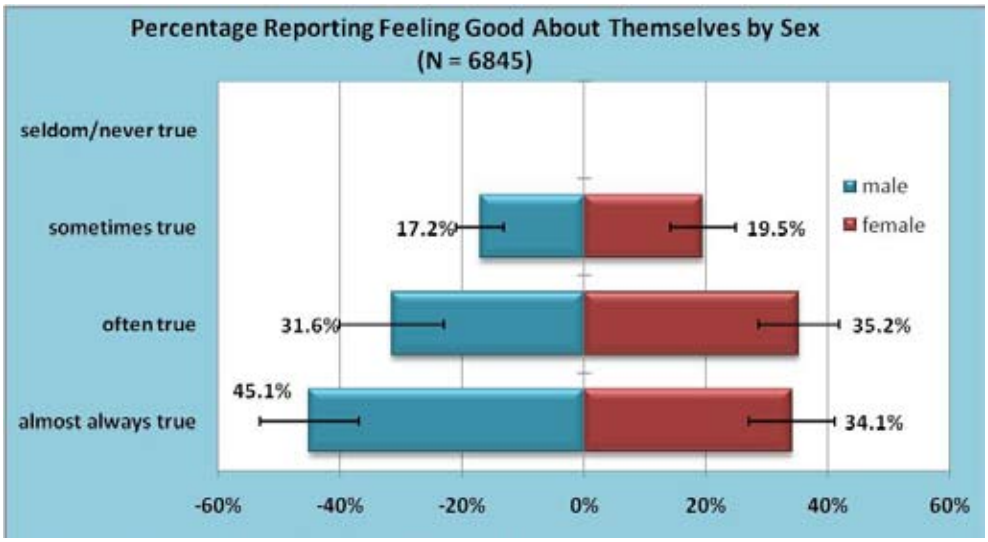
More elementary students in LGL report feeling good about themselves 'almost always' compared to secondary students.



Source: Ontario Student Drug Use and Health Survey. CAMH 2009

Self Esteem by Sex

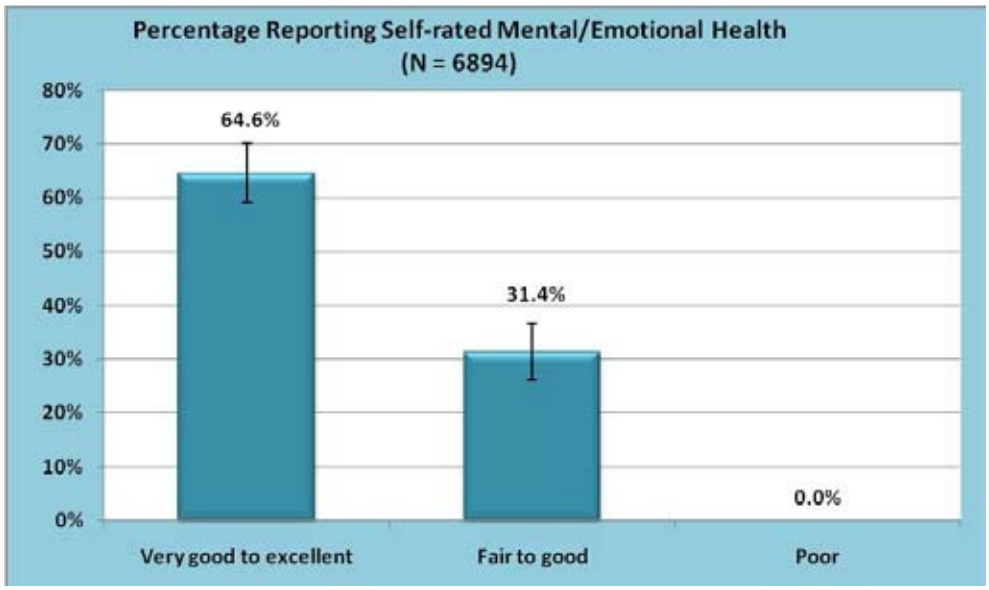
More male students in LGL report feeling good about themselves 'almost always' compared to female students in LGL.



Source: Ontario Student Drug Use and Health Survey. CAMH 2009

Self-rated Mental Health Overall

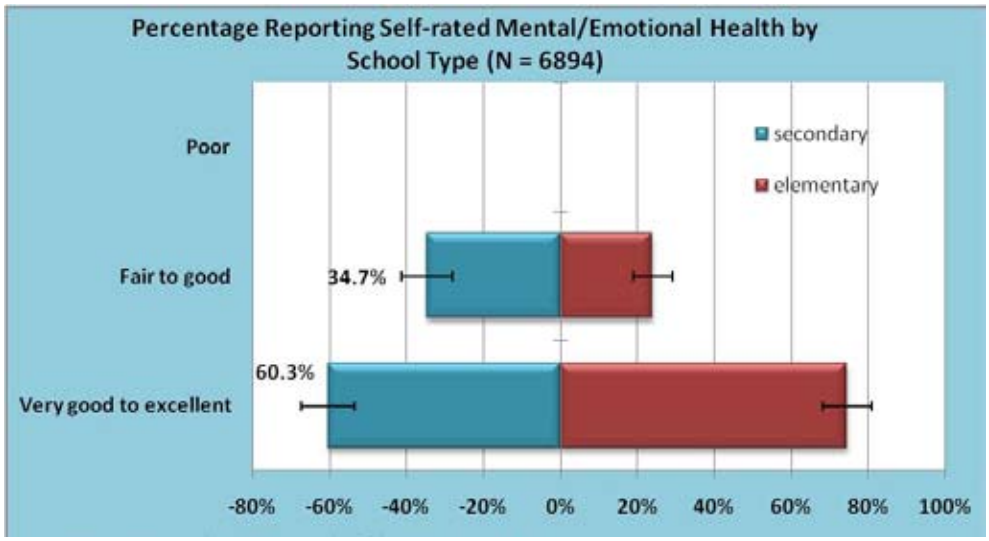
Overall, 31.4% of students in LGL self-rate their mental/ emotional health as 'fair to good' and over two-thirds rate their mental/emotional health as 'very good to excellent'.



Source: Ontario Student Drug Use and Health Survey. CAMH 2009

Self-rated Mental Health by School

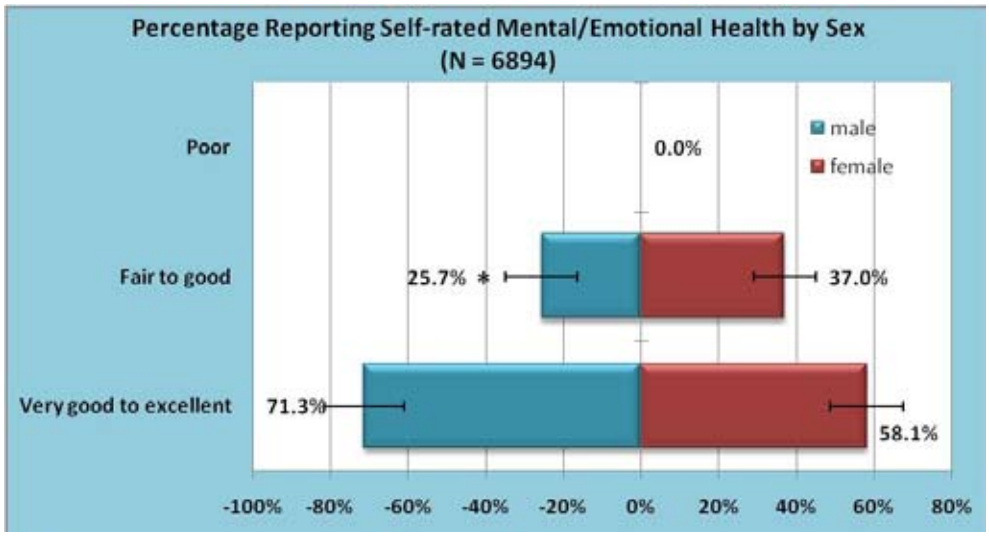
A greater proportion of elementary students in LGL rate their mental/emotional health as 'very good to excellent' compared to secondary students in LGL.



Source: Ontario Student Drug Use and Health Survey. CAMH 2009

Self-rated Mental Health by Sex

More male students in LGL rate their mental health as 'very good to excellent' compared to female students in LGL.



Source: Ontario Student Drug Use and Health Survey. CAMH 2009

5.0 Focus on Income

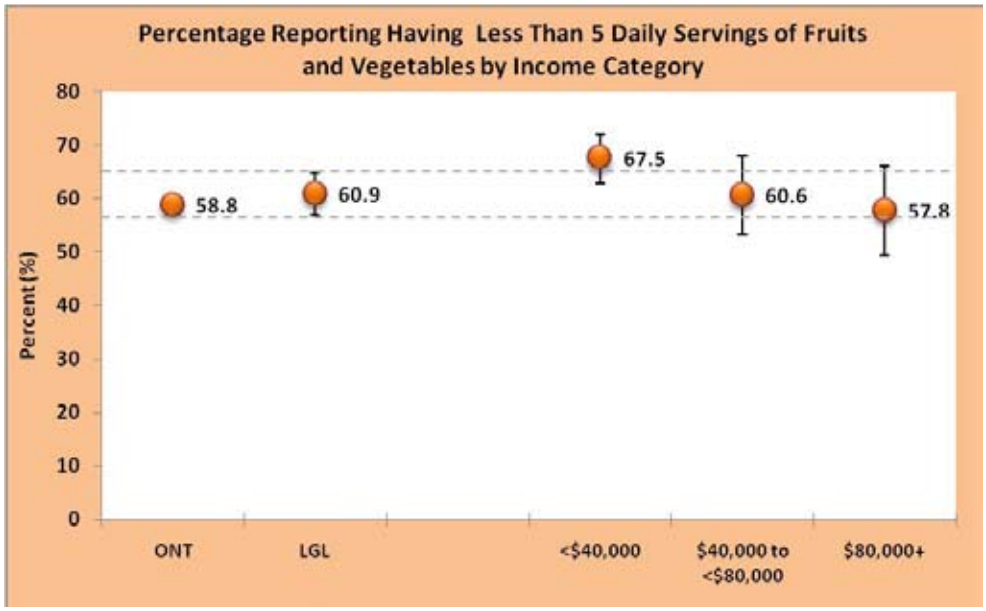
According to the Public Health Agency of Canada, income and social status are recognized as the most important determinants of health and these two factors have a tremendous influence on population health. The relationship between income and health is incredibly complex. In many cases, individuals with lower incomes may lack knowledge about healthy behaviours, lack access to healthy foods, which are often more expensive, lack access to safe recreation opportunities, and experience high levels of stress, which combined with a lack of resources, skills and social support, may lead to unhealthy coping behaviours.[1] So encouraging healthy behaviours is not simply a matter of telling people what is good for them. We also need to address the underlying barriers to a healthy lifestyle.

Both national and local data are presented here. Due to smaller sample sizes, local data cannot be broken down into the lowest income levels as the data become too unstable. The local data give a perspective on how we relate to national data.

1 Public Health Agency of Canada. "2009 Tracking Heart Disease and Stroke in Canada" www.phac-aspc.gc.ca (accessed 6 October 2010)

Fruit & Vegetable Consumption by Income

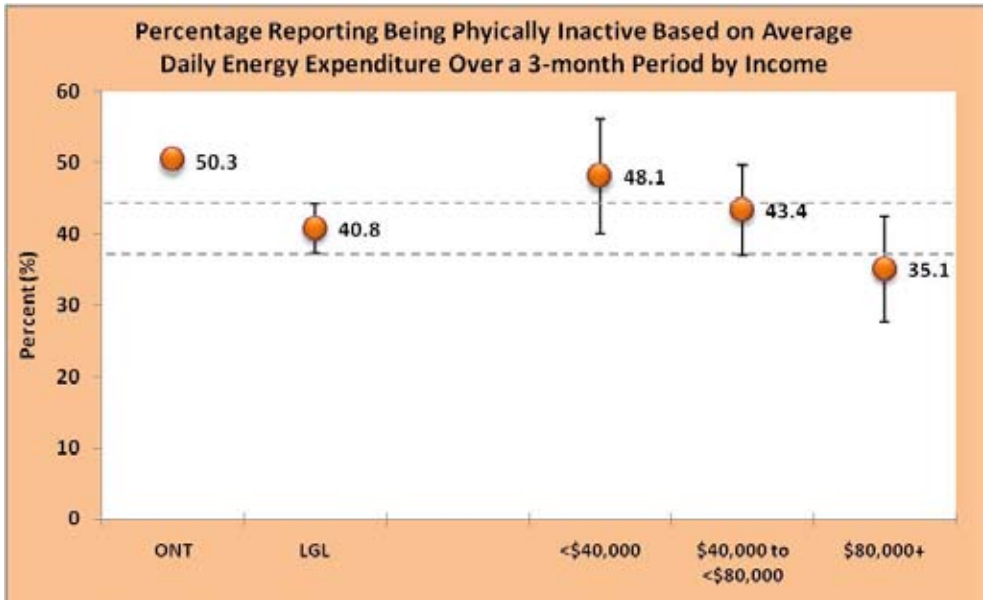
Nationally, 10% more Canadians in the lowest income quintile reported inadequate consumption of vegetables and fruit compared to those in the highest income quintile. This pattern is similar to the local data shown here.



Source: Canadian Community Health Survey 2007/2008. Statistics Canada

Physically Inactive by Income

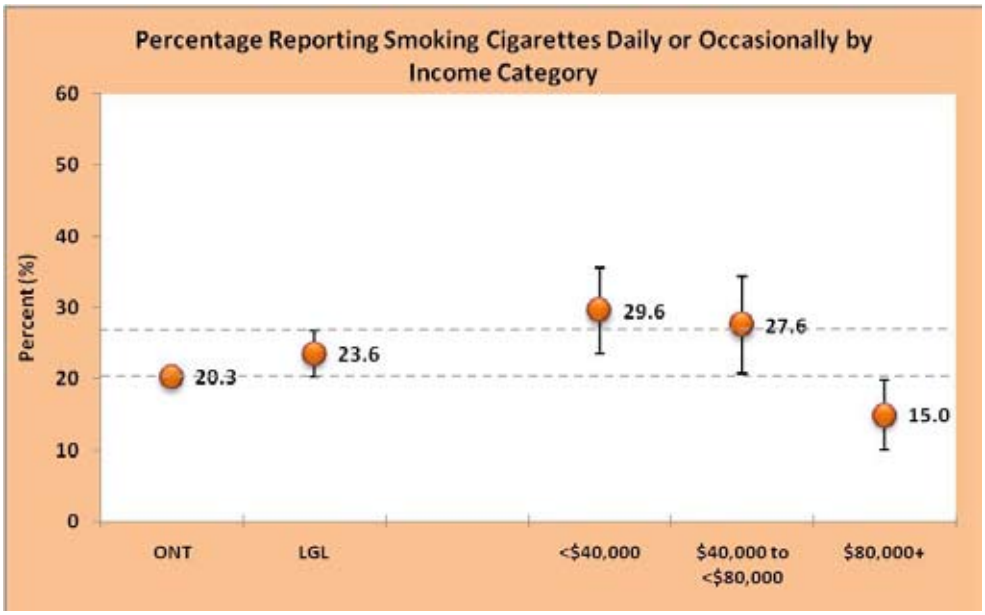
National data shows a similar pattern as fruits and vegetable consumption - rates of physical inactivity are 1/3 higher among Canadians in the lowest income quintile. This is consistent with local data shown here.



Source: Canadian Community Health Survey 2007/2008. Statistics Canada

Smoking by Income

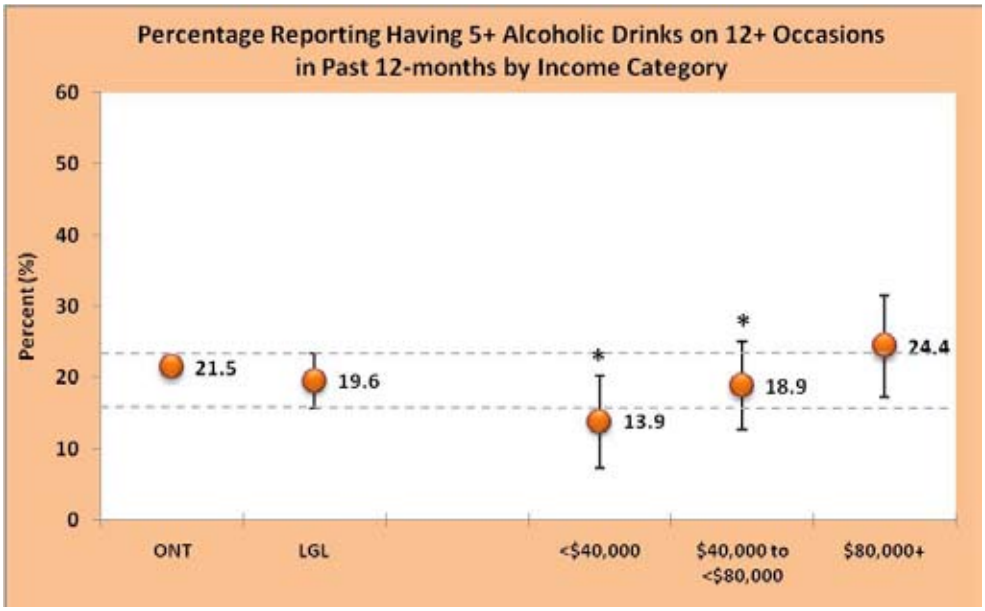
Rates of daily and occasional smoking decrease significantly as income level increases. Nationally, individuals in the lowest income quintile are almost twice as likely to report daily tobacco smoking than those in the highest income quintile. Local data, shown here, supports this trend.



Source: Canadian Community Health Survey 2007/2008. Statistics Canada

Alcohol Use by Income

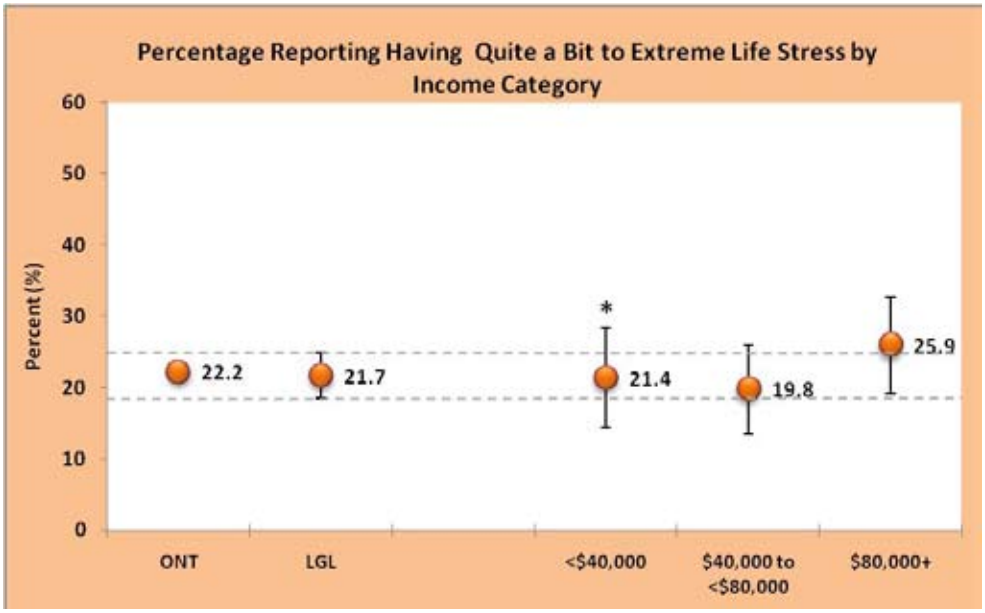
As income increases, the number of residents reporting having 5+ drinks on 12+ occasions in the past 12 months also increases.



Source: Canadian Community Health Survey 2007/2008. Statistics Canada

Life Stress by Income

National data shows a u-shaped pattern for stress by income: individuals in the lowest and highest income quintiles experience the highest levels of stress, while Canadians in the middle income quintiles experience lower levels of stress. Locally we are not able to assess stress levels among the individuals with the lowest level of income but it is likely to be the same. The sources of stress are likely to be different among the lowest and highest levels of income.



Source: Canadian Community Health Survey 2007/2008. Statistics Canada

6.0 Local Causes of Morbidity and Mortality

The risk factors associated with the six priority areas described in Section 4.0 are important because they can lead to morbidity and mortality. The tables below illustrate the leading causes of morbidity and mortality for LGL residents as indicated by hospital in-patient discharges and mortality database records. Cardio vascular disease was the leading cause of in-patient discharges for residents of LGL in 2007. Diseases of the heart, lungs and vascular system were the leading causes of death in 2005.

Leading Causes of Morbidity by In-patient Discharge LGL 2007 (source: PHPDB)	
Lead Cause Group (ISHMT)	**# Dschg**
Chronic Disease - Cardio Vascular Disease	2,330
Reproductive Health - Live Born Infants (Adult)	1,328
Injury Prevention - Falls (Adult)	646
Chronic Disease - Chronic Obstructive Respiratory Disease (COPD)	488
Infectious Diseases - Pneumonia	326
Cancer - Colorectal	129
Cancer - Lung	90
Neonatal Morbidity - Low Birth weight	89
Reproductive Health - Pregnancy Induced Hypertension	83
Neonatal Morbidity - Preterm Labour/Birth	76

Age Adjusted Leading Causes of Mortality LGL 2005 (source: PHPDB)		
Cause	**Rate**	**Count**
Diseases of Heart	144.1	373
Cancer of Lung and Bronchus	59.9	141
Cerebrovascular Diseases	45.2	121
Chronic Obstructive Pulmonary Disease	29.6	76
Accidents and Adverse Effects	28.1	56
Cancer of Colon and Rectum	25.0	58
Diabetes Mellitus	23.7	61
Pneumonia and Influenza	20.0	53
Alzheimer's	15.5	43
Cancer of Breast	13.8	34

**Rates are per 100,000 population and age-adjusted to the 1991 Canadian standard population.*

7.0 Assets

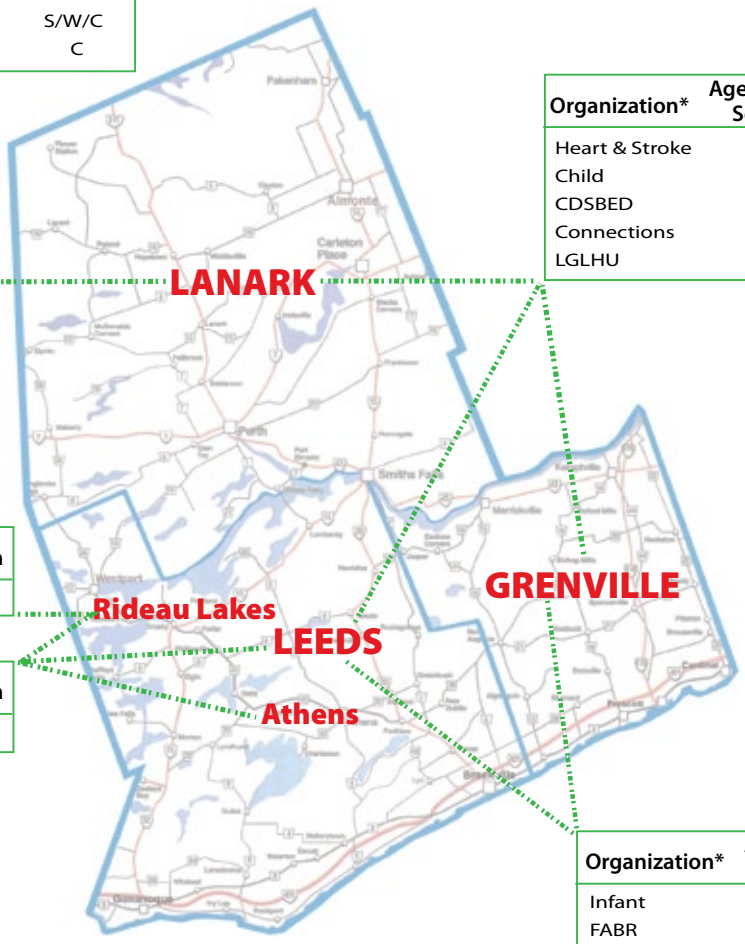
An important part of the local community picture is identifying the assets that currently exist. To better understand local assets, the Healthy Communities Partnership developed an electronic survey for stakeholders to complete. The survey collected information about the geographic area that stakeholders serve, populations served, priority areas addressed, social determinants of health addressed and interest in being involved in the Healthy Communities Partnership. A total of 30 stakeholders completed the survey and the information has been used to produce a map (below) which visually identifies which organizations are working where, and with whom. As well, two tables (below) have been developed identifying which organizations are working on which priority areas, and on which determinants of health. These documents help to identify the existing community assets as well as some gaps in the community. Please note, the data in the map and tables are current as of September 30th.

7.1 Asset map

* The Legend below applies to the map on pg 33 as well as the Tables in section 7.2 and 7.3

LEGEND	
ASK	Active Seniors Koalition
Assault	Assault Response and Care Centre
BBBS-L	Big Brothers Big Sisters of Lanark County
Best Start	Best Start Working Group (Lanark County)
CDSBEO	Catholic District School Board of Eastern Ontario
CHC	Country Roads Community Health Centre
Child	Child Development Centre
Connections	Connections CAPC/CPNP
CROW	Children's Resources on Wheels/Ontario Early Years Centre
Doors	Open Doors for Lanark Children and Youth
Employ	The Employment & Education Centre
FABR	Frontenac Arch Biosphere Reserve
Girls Inc	Girls Incorporated of Upper Canada
Heart & Stroke	Heart & Stroke Foundation of Ontario
Infant	Infant and Child Development Program, Leeds and Grenville
L-G	United Counties of Leeds and Grenville Human Service Division
LGLDHU	Leeds-Grenville and Lanark District Health Unit
MDS	Lanark County and the Town of Smiths Falls Municipal Drug Strategy
REAL	Rideau Environmental Action League
Rehab	Leeds-Grenville Rehabilitation and Counselling Service
Safe	Safe Communities Coalition of Brockville, Leeds and Grenville

Organization*	Age Group Served	Location
Best Start	0-6	S/W/C
CROW	0-6	C
Doors	0-19	S/C
ASK	35+	C
BBBS-L	0-65+	S/W/C
MDS	0-65+	C



Organization*	Age Group Served	Location
Heart & Stroke	0-19	S/C
Child	0-19	S/C
CDSBED	0-19	S
Connections	0-54	C
LGLHU	0-65+	S/W/C

Organization*	Age Group Served	Location
CHC	0-65+	S/C

Organization	Age Group Served	Location
Rehab	20-65+	W/C

Organization*	Age Group Served	Location
Infant	0-6	C
FABR	7+	S/W/C
Girls Inc.	7-19	S/C
Assault	7-65+	S/W/C
Employ	13-64	S/W/C
LG	0-64	C
Safe	0-65+	S/W/C

Legend

S = School
W = Workplace
C = Community

*See full organization names on pg 32

7.2 Table of work being done on priorities

	Awareness	Skill Building	Supportive Environments	Policy
Nutrition/access to nutritious food	BBBS-L CDSBEO CHC Connections CROW Employ FABR Heart & Stroke L-G LGLDHU	BBBS-L CDSBEO CHC Connections CROW FABR Heart & Stroke LGLDHU	ASK BBBS-L CDSBEO CHC Connections FABR Heart & Stroke LGLDHU REAL	CHC Heart & Stroke LGLDHU
Build environment/ active transportation	BBBS-L Employ FABR Heart & Stroke LGLDHU Rehab	BBBS-L Employ FABR Heart & Stroke LGLDHU	Employ FABR Heart & Stroke L-G LGLDHU Rehab	Employ Heart & Stroke LGLDHU
Recreation/ Sport and physical activity	ASK BBBS-L CHC CROW Employ FABR Heart & Stroke L-G LGLDHU Rehab Safe	BBBS-L CHC CROW FABR Heart & Stroke LGLDHU Safe	ASK BBBS-L CHC FABR Heart & Stroke L-G LGLDHU REAL Rehab	CHC Heart & Stroke LGLDHU
Prevention of tobacco use/ exposure	BBBS-L CDSBEO CHC Connections Employ Heart & Stroke LGLDHU MDS	BBBS-L CDSBEO CHC Connections LGLDHU MDS	BBBS-L CDSBEO CHC Connections LGLDHU MDS	CDSBEO CHC Heart & Stroke LGLDHU MDS

	Awareness	Skill Building	Supportive Environments	Policy
Prevention of alcohol/ drug misuse	BBBS-L CDSBEO CHC Connections Employ L-G LGLDHU MDS	BBBS-L CDSBEO CHC Connections LGLDHU MDS	BBBS-L CDSBEO Connections L-G LGLDHU MDS	LGLDHU MDS
Injury prevention	ASK BBBS-L CDSBEO Connections CROW Employ LGLDHU MDS Safe	BBBS-L CDSBEO Connections Employ LGLDHU MDS Safe	ASK BBBS-L CDSBEO LGLDHU MDS Safe	CDSBEO LGLDHU MDS Safe
Mental health	Assault BBBS-L CDSBEO CHC Connections CROW Doors Employ L-G LGLDHU MDS Rehab Safe	Assault BBBS-L CDSBEO CHC Connections CROW Doors Employ MDS Rehab	ASK Assault BBBS-L CDSBEO CHC L-G MDS Rehab	Assault BBBS-L CHC MDS

7.3 Table of work being done on determinants of health

	Income & social status	Social support networks	Education & literacy	Employment / working conditions	Social environments	Physical environments	Personal health practices & coping skills	Healthy child development	Health services
ASK		x			x	x			
Assault	x	x	x	x	x	x	x	x	x
BBBS-L		x	x		x		x	x	
Best Start			x					x	
CHC	x	x	x	x	x	x	x	x	x
Child	x	x			x	x	x	x	x
Connections	x	x	x	x	x	x	x	x	x
CROW			x		x		x		
Employ	x	x	x	x	x		x	x	
Heart & Stroke	x	x			x	x	x	x	x
Infant								x	
L-G	x	x	x	x			x	x	
LGLDHU	x	x	x	x	x	x	x	x	x
MDS					x	x	x		
Open Doors		x			x			x	x
REAL						x			
Rehab	x	x	x	x	x	x	x		
Safe					x	x	x		
	9	**12**	**10**	**7**	**14**	**11**	**13**	**12**	**7**

This information will be supplemented by the completion of a 'Network Map.' Health Nexus (the organization completing the Network Mapping) explains that the Network Map will collect data from multiple individuals with emphasis on the relationship as the unit of analysis. This information will then be translated into visual maps that can assist in building and sustaining strong networks of collaboration for healthy communities and help to enable partnerships to see and act on opportunities to collaborate and connect.

In addition to identifying the work being done by stakeholders, several scans identifying local assets have been completed:

Environmental Scan of Health Promotion Policies in Champlain District School-based Settings (2007)

- Most commonly identified policies were:
  - Elementary Schools: daily physical activity and Healthy Choices in Vending Machines
  - Secondary Schools: Healthy eating options in cafeterias, mandatory credit of physical education, participation in 'Eat Smart' cafeteria certification program
- No board has an active transportation policy or procedure in place (as of 2007)

Ontario Heart Health Network Collaborative Policy Scan (2009)

- Existing policies identified in LGL were:
  - Policy supporting establishment of Farmers Markets
  - Policy supporting welfare supplements being used to purchase nutritious foods
  - Healthy food access maps promoted
  - Regional/district/county/municipality Interim Land Use Policies to address lack of open spaces for recreation in apartment complexes and other multi-unit dwellings and Vacant Lots Policy to establish guidelines for public use of private land and city-owned vacant lots
  - Existence of a regional/district/county/municipality Parks Master Plan, Recreation Master Plan, and an Official Plan
  - Existence of a regional/district/county/municipality public transportation system
  - Municipal Alcohol Policy, policy that supports Safer Bars training, policies to reduce/prevent service to minors or to intoxicated patrons (above provincial requirements)
  - Policy that bans tobacco use within designated distance of public entrances and exits to regional/district/county/municipality buildings providing local government services

Community Gardens Inventory (2010)

- Identifies 5 established community gardens and 2 in the process of getting organized in LGL

Food Access Inventory (2010)

- Identifies 17 emergency food programs, 3 food action and skill development programs, and 12 food support programs in LGL

Municipal Recreation Inventory (2010)

- Identifies local recreation opportunities in LGL

Community Services Inventory (2010)

- Identifies food and nutrition-related programs for seniors, exercise programs for seniors and home support programs in Lanark and in Leeds-Grenville

Appendix 2: Community & Organizational Focus Group Script

Time	Activity/Purpose	Facilitator Speaking Notes	Notes for Facilitators
0 min	**Sign-In** (Optional: participants sign in and prepare name tags)	• Encourage people as they arrive to make name tags (unless you and the participants already know each other by name). • Ask participants if they would like to be kept informed of the HCP's activities. If so, ask them to sign the sign-in sheet.	**Set-Up** • Sign-in sheet, pens, name tags, markers
5 min	**Welcome** (**Facilitator** welcomes participants and explains the purpose of the Focus Group)	• Welcome participants and thank them for coming. • **Explain the Purpose of the Focus Group:** The Lanark, Leeds and Grenville Healthy Communities Partnership (HCP) wants to hear what you think needs to be done to make it easier to live active, healthy lives. This will help us set priorities and make sure that funding from the Ministry of Health Promotion and Sport is spent on the programs and services that community members feel are most important. • **I'm going to ask you three basic questions today**. For each question I'm going to go around the room (or table) and give each and every one of you a chance to share your thoughts. If you have more than one idea, please hold it until we've made it all the way around the group. This will give everyone a chance to be heard.	**Set-Up** • NA
5 min	**Healthy Community** (In a **Go-Around**, participants identify the key ingredients of a Healthy Community)	**Explanation of Activity** • I'd like to start off today by going around the room (or table) and asking each of you to share: - Your name - The organization you are affiliated with (if any) - ***One thing* that comes to mind when you think of a healthy community - *one thing* you consider to be a key ingredient of a healthy community.** • I'm really just looking for the first thing that comes to mind here. I would like to hear from all of you, so one idea each please! You can "pass" after introducing yourself if you want. **Top-Up After Activity** • I want to share a few thoughts with you about health and healthy communities. When *I* think about health, I think about physical, emotional, mental *and* spiritual aspects of health. When I think of healthy communities, I think of Social, Economic *and* Environmental factors (such as having friends, a job, clean water). Just some food for thought.	**Set-Up** • Flip chart, markers, masking tape **Facilitation Notes:** • Please make sure that every sheet generated in this activity is labeled "Healthy Community". • When finished, post the flip chart sheet(s) on the wall. • **Note:** Encourage participants to make only **one comment each**. Once everyone has spoken, please move on to the next activity. This is mostly an ice-breaker, and you will lose precious time if you invite discussion.

5 min	**Strengths** (In a **Go-Around,** participants identify "strengths and successes" or "what is already working well" in their community)	**Explanation of Activity:** • For our second question, I'd like to go around the room in the opposite direction, and ask each of you to share "one thing your community is already doing well" to make it easier for you to live an active, healthy life. • What strengths or successes would you like your community to build on for the future? This could include events, services, programs, organizations, people, facilities or policies. • One idea each, please! If you have more than one idea, please hold it until everyone else has had a chance to speak. **Note for Facilitators:** • Please move on to the next activity once everyone has spoken. You will lose precious time if you invite discussion. The final question on "Burning Issues" is arguably the most important.	**Set-Up** • Flip chart, markers, masking tape **Facilitation Notes** • Set up a flip chart and label it "Strengths". • Please make sure that every flip chart sheet generated in this activity is labeled "Strengths". • When finished, post the sheets on the wall (space permitting).
15 min	**Burning Issues** (In a **Go-Around**, participants identify what they consider to be the "Burning Issues" that need to be addressed in their community) (A brief discussion can follow, time permitting)	**Explanation of Activity** • For our last question, I'd like to know what each of you thinks is the one "Burning Issue" that needs to be addressed in your community to make it easier for you and others to live an active, healthy life. • Please keep it to one comment each. If you have more than one idea, please hold it until everyone else has spoken. We will have time to add and discuss ideas once we've heard from everyone. • Before we start, I want to share with you what the MHPS considers to be the 6 main issues. It's not necessary for you to cover these six areas, but I thought it might get you thinking. **Discussion (after the Go-Around, time permitting)** • Does anyone have a "Burning Issue" they would like to add to the list? Have we missed something important?	**Set-Up** • Post a list of the MHPS 6 Priority Areas on the wall: Physical activity, sport & recreation; Injury prevention; Healthy eating; Tobacco use & exposure; Substance & alcohol misuse; Mental health • Record comments on flip chart paper. • Label every flip chart sheet completed in this activity with the heading "Burning Issues".
5 min	**Reflection**	**If time permits, facilitate a brief discussion on the following:** • "Are you surprised by what did or didn't come up as priorities in the 6 Priority Areas?" Have we missed anything important?	• Refer to the flip charts from the Burning Issues activity.
0 min	**Thank you**	• Please let me know if you want to be kept informed. I could return at a later date with an update, or you could sign the contact sheet and we'll keep you informed. • Feel free to call me within three days if you want to add anything. • Thank you. I appreciate you taking time out of your busy lives.	

Appendix 3: Partnership Development & Asset Mapping Taskforce Terms of Reference

Goal

To develop a Healthy Communities Partnership and to develop an asset map for Lanark, Leeds & Grenville which, will be used in the development of a Healthy Communities Plan.

Objectives

- To recruit new partners to the HC Partnership
- To collect data
- To determine gaps in data
- To develop a baseline for the evaluation of the Healthy communities plan
- To map the assets of Lanark, Leeds & Grenville as relates to the 6 priority areas identified by the Ministry of Health Promotion

Deliverables

- HC Partnership will be a Network of Networks with representation from across Lanark, Leeds & Grenville and across the six risk factor areas.
- Community assets and capacities identified
- Collect and analyze data
- The map of the assets of Lanark, Leeds & Grenville as relates to the 6 priority areas identified by the Ministry of Health Promotion will be compiled and ready for distribution for the October 21 2010 Healthy Communities Partner Day.

Membership

- The working group will be established in May 2010 and will continue working until the group has accomplished their objectives.
  Membership consists of representatives who have volunteered to be part of the task force.
- A chair/co-chair will be identified
- The working group will consist of a minimum of 3 members.
- If a partner is no longer able to be part of the task force, they will inform the coordinator, who will advise the group.
- Other partners may be invited to join the task force or attend meetings by group invitation.

Decision making

Members will share responsibility for decision making. Decisions will be made by consensus. Each partner has equal representation. A minimum of two partners to represent quorum on decision making. If consensus cannot be reached, then disagreement is noted.

Each member to identify any potential conflict of interest to the group when they feel one might exist with regard to the position they hold outside of this working group.

Accountability

The task force will report to the Lanark, Leeds & Grenville Healthy Communities Partnership.

Meetings
Meetings will be scheduled by task force members or by the call of the chair. Meetings will be face to face and when needed by teleconference.

Roles and Responsibilities

Chair
The position of chair/co-chair will function as a facilitator for working group meetings, as determined by working group members. This will be on a rotating basis.

Recorder
Working group members will have a designated Recorder (supplied by Health unit). The recorder will record meeting highlights and decisions and circulate to members in a timely manner.

All members
All members will contribute to meeting discussion, decisions and communications in a positive and professional manner.

Administrative Duties
All members will share miscellaneous tasks that may arise (administrative duties).

Resources

Travel and meeting costs to participate/attend working group meetings will be absorbed by the member/ respective employer. Teleconference costs will be provided by the Health Unit.

Terms of Reference

Approved Terms of Reference will be reviewed upon extension of working group time frame.

Appendix 4: Healthy Communities Partnership Day Agenda

Healthy Communities Partnership Day
October 21, 2010, 8:30 am - 3:00 pm
AGENDA

8:30 am	Registration, Refreshments	
9:00 am	Welcome & Introductory Remarks Setting the Context Icebreaker	Dr. Paula Stewart Kim Hodgson
9:25 am	Healthy Communities Overview	Lois Dewey Susan Hreljac
9:45 am	Network Map Survey	Lois Dewey
10:05 am	Community Profile	John Cunningham Katie Jackson Mona Wynn Martha Duncan Myers Susan Turnbull
11:15 am	BREAK	
11:30 am	Small Group Discussion	Kim Hodgson
12:30 pm	LUNCH	
1:30 pm	Visioning Exercise	Kim Hodgson
2:30 pm	Next Steps for our Healthy Communities Partnership Website Stakeholder Wheel	Lois Dewey Jenna Earle
2:45 pm	Review of What We Have Accomplished Evaluation Name Tag Line Exercise	Kim Hodgson Lois Dewey

Appendix 5: Structure & Governance Day Agenda

Lanark, Leeds & Grenville Healthy Communities Partnership
December 10, 2010, 9:00 am - 3:30 pm
AGENDA

9:00 am ***Refreshments & Networking***

9:30 am **Welcoming Remarks - Lois**
1. Purpose of the Session
2. Introduce Facilitator, Nancy Dubois, The Health Communication Unit

9:45 am **Introduction to the Session - Nancy Dubois**
- Overview of the Process
- Group Introductions
- Difference between Approaches
- Outputs:
  - 1-2 Recommended Actions per Topic
  - Priority Policy Options across 6 Topics
- Inputs: Community Picture

10:00 am **Recommended Actions**
- Proposed Format – Topic, Approach, Population, Setting
- Examples
- Factors to consider in setting priorities
  - Examples: Need, Impact, Capacity, Opportunity for Partnerships & Collaborations
  - Draft to share
  - Others?

10:45 am ***BREAK***

11:00 am **Recommended Actions (cont'd)**
- Weighting of Criteria / Need & Nice to Have's?
- Priority Setting Methods – present the 4 methods from THCU with associated pros and cons
- Determine one or more methods

12:15 pm ***Lunch (provided)***

1:00 pm **Setting Policy Priorities**
- Factors to consider in setting policy priorities – any differences from Recommended Actions?
- Weighting of Criteria / Need & Nice to Have's?
- Priority Setting Methods – present the 4 methods from THCU with associated pros and cons
- Determine one or more methods

2:30 pm **Generating the Options for Consideration**
- How to generate the list from which priorities will be selected

3:10 pm **Next Steps**
- January meeting to identify priorities
- January consultations for community input on draft recommended actions and priorities

3:20 pm **Reflections**
- Process, product, pace

3:25 pm **Closing Remarks – Lois**

Appendix 6: Stakeholder Wheel - Core and Peripheral Members

HCP: LLG Stewardship Group and Partners - February 2011

HCP: LLG Stewardship Group:

Government Sector:

- Ministry of Health Promotion & Sport: Regional Advisor
- Municipal :
  - Beckwith Township
  - Town of Smiths Falls

Health-Related Sector:

- Child Development Centre
- Country Roads Community Health Centre
- Community and Primary Health Centre
- Lanark Mental Health Services
- Leeds Grenville and Lanark District Health Unit
- Merrickville and District Community Health Centre - Smiths Falls site
- North Lanark Community Health Centre
- Heart and Stroke Foundation
- Rideau Valley Diabetes Services
- French Language Health Services Network

Non-Health Services Sector:

- Brockville & Area YMCA
- Every Kid in Our Communities of Leeds and Grenville
- Lanark Planning Council for Children and Youth
- Upper Canada District School Board

Community/Grass Roots Sector:

- Brockville & Area Community Foundation
- Brockville Ministerial Association
- Communities ALIVE
- S.A.I.L. Services to Assist Independent Living
- Safe Communities Centre of Leeds and Grenville

HCP: LLG Partners (stakeholders who are frequently consulted and kept informed of the work of the partnership):

Government Sector:

- 24 Municipal elected officials including:
  - Reeves/Mayors
  - Deputy Reeves
  - Councilors
- 30 Municipal staff including:
  - Chief Administrative Officers
  - Administrators
  - Clerks
  - Sport and Recreational Directors
  - Planners
- 3 Ministry representatives:
  - Ministry of Child and Youth Services

Health-related Sector:

- 30 organizations including:
  - Addiction services
  - Ambulance
  - Arts for Health and Learning
  - Child development
  - Community Health Centers
  - Community Primary Health Care
  - Health Unit
  - Home support
  - Mental health
  - Non-government organizations
  - Rehabilitative services
  - Seniors support
  - Tobacco Control Area Network

Non-Health Services Sector:

- 35 organizations including:

  Best Start networks
  Big Brothers Big Sisters
  Children's Aid
  Children's planning networks
  Community justice programs
  Fire departments
  Food banks/community dinners
  Girls INC
  Libraries
  Ministerial Associations
  Ontario Early Years Centers
  Ontario Students Against Impaired Driving
  Police services
  Safe Communities
  School boards/individual school representatives
  United Way
  Victim Crisis services
  Youth centers
  Youth employment and education
  YMCA

Community/Grass Roots Sector:

- 7 organizations including:

  Environmental
  Physical activity (programs, trails, cycling)
  Community Support

- 16 individual community members

Appendix 7: Stewardship Committee - Terms of Reference

Governance Model

The Lanark, Leeds, and Grenville (LLG) Healthy Communities Partnership has decided to use the Constellation Model to guide its approach to governance of the partnership work in the following six action areas: to promote mental health, healthy eating and regular physical activity, and to prevent injuries, tobacco use, and alcohol and drugs misuse in Lanark, Leeds and Grenville.

> "The Constellation model is a complexity-inspired governance framework for multi-organization collaboration." [1]

> "A Stewardship group sets strategic direction, monitors the partnership's overall health, and aligns constellations with the partnership's purpose. Small self-organizing action teams of partners work together on a particular task or issue within the partnership. "[2]

This approach makes sense within Lanark, Leeds and Grenville because several existing networks and coalitions already exist. The Constellation model will allow these existing organizations to find a place for themselves within the partnership by focusing on a priority recommended action that fits within their existing mandate. In addition, many organizations are interested in participating but they have varied interests. They will be able to self-select to a particular constellation that attracts them or create a new constellation to respond to an issue they want to address. Finally, Lanark, Leeds and Grenville is a large geographic area, mostly rural with towns and small hamlets, and people identify with their own geographic area. Constellations can form that are specific to a geographic area if the interest is there.

Several of our municipalities are currently developing Integrated Community Sustainability Plans (ICSP). The LLG Healthy Communities Partnership sees direct relevance between this work and ours as the ICSP plan must include a social component that includes health and well-being with an obvious link to the six action areas. This governance model will encourage the municipalities to be part of the partnership as a constellation identifying how to address the social needs of their communities, and this will facilitate links to other activities going on in the community.

Responsibilities of Stewardship Group

The Stewardship Group will have the following responsibilities:[3]

- Develop vision for the community and a broad framework for their work together (This includes the Francophone community under the provisions of the French Language Services Act);
- Ongoing assessment of the current assets, successes, gaps and needs in the community for the six action areas;
- Management oversight of specific projects e.g. priority policy action area
- Partner asset mapping – how each partner wants to relate to the partnership
- Engage organizations and individuals in the work of the partnership as part of a constellation action group
- Scoping the nature of how and why the partners can work together
- Communication among partnership members and others

Values of the Stewardship Group

- Openness and transparency
- Sharing of power
- Innovation

1 Surman, T. Constellation Collaboration: A model for multi-organizational partnership. Centre for Social Innovation, http://s.socialinnovation.ca/files/Constellation%20Model%20Description%20June%209'06.pdf

2 Surman T, suramn M. Listening to the Stars: The Constellation Model of Collaborative Change. http://www.lcsi.smu.edu.sg/downloads/MarkSurman Final Aug-2.pdf

3 Based on T. Surman, Constellation Collabortion: A model for multi-organizational partnership, CSI

Principles of the Stewardship Group

- Community participation
- Focus on areas where there is willingness to move forward
- Activities respond to a community need
- Evidence-based approaches
- On-going evaluation
- Dynamic response to community issues
- Builds on community assets
- Addressing root contributors to wellness
- On-going leadership development within community
- Shared decision-making, leadership moves among the partners on a project by project basis

Membership

The following networks, organizations and individuals have agreed to be members of the Stewardship Group for 2011. Others will be welcomed as they become aware of the partnership and decide to participate in it.

- Brockville & Area YMCA
- Brockville & Area Community Foundation
- Brockville Ministerial Association
- Child Development Centre
- Communities ALIVE
- Community and Primary Health Centre
- Country Roads Community Health Centre
- Every Kid in Our Communities of Leeds and Grenville
- French Language Health Services Network
- Lanark Mental Health Services
- Lanark Planning Council for Children and Youth
- Leeds Grenville and Lanark District Health Unit
- Municipal :
  Beckwith Township
  Town of Smiths Falls
- Merrickville and District Community Health Centre - Smiths Falls site
- North Lanark Community Health Centre
- Upper Canada District School Board
- Heart and Stroke Foundation
- Rideau Valley Diabetes Services
- S.A.I.L. Services to Assist Independent Living
- Safe Communities Centre of Leeds and Grenville
- Ministry of Health Promotion & Sport: Regional Advisor

All members will contribute to meeting discussion, decisions and communications in a positive and professional manner. Travel and meeting costs to participate/attend working group meetings will be provided by the member/respective employer.

Decision making

Members will share responsibility for decision making. Decisions will be made by consensus as much as possible. If consensus cannot be reached, then disagreement will be noted. Each member will identify any potential conflict of interest to the group when they feel one might exist with regard to the position they hold outside of this working group.

Accountability

The Stewardship Committee is accountable to the community members of the Lanark, Leeds & Grenville Counties. The Leeds, Grenville and Lanark District Health Unit has administrative responsibility for the funding, and reports in this capacity to the Ministry of Health Promotion and Sport.

Meetings

Meetings will be held monthly for the first 6 months and then quarterly or by the call of the chair/facilitator. Teleconferencing will be available at every meeting. Smaller task specific meetings may be held as agreed upon by the larger working group.

Chair/Facilitator

The Chair will be chosen through consensus by the Stewardship Group members for a one year term. The chair will function as a facilitator for working group meetings, as determined by working group members. He/she will also be the spokesperson for the Leeds, Grenville and Lanark Community Health Partnership.

Resources

The Stewardship Group will be supported by the Healthy Communities Coordinator. He/she will receive direction from the Stewardship Group to support the work of the partnership. The LGL District health Unit is providing this in-kind contribution to the partnership to support its work.

It is expected that all partners will also contribute in kind resources to support the work of the Stewardship Group as they are able.

Appendix 8: Priority Setting Workshop Agenda

Healthy Communities Partnership – Lanark, Leeds and Grenville Core Committee
January 6, 2011, 9:00 am - 3:30 pm
AGENDA

9:00 am	Refreshments and Networking	
9:30 am	Welcome and Review Agenda	Jeff Kohl Lois Dewey
9:45 am	Review resources/tools for today's meeting	Lois and Jeff
10:00 am	Introduction to Asset Based Community Development and Appreciative Inquiry	Jeff
10:15 am	Small Group Activity (Part 1)	Jeff
11:30 am	Small Group Reports	
12:00 pm	LUNCH/ Networking/Walk	
12:45 pm	Small Group Activity (Part 2)	
1:30 pm	Small Group Reports	
2:00 pm	Whole Group Review of Recommended Actions Identify Policy/Overarching Issue focus for HCP LLG	Jeff
3:00 pm	Next Steps	Lois
3:30 pm	Adjourn	

For more information on the Lanark, Leeds & Grenville Healthy Communities Partnership please contact:

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