Parkdale
Community
Health Centre

parkdale today

ANNUAL REPORT 2014–2015

Shirley Roberts
Executive Director, Interim

Anu Radha Verma
President, Board of Directors

Joint message from Executive Director and Board President

At this time last year we paused to reflect on Parkdale CHC's thirty year history of health care service delivery in the community. This year we are taking the opportunity to reflect on Parkdale CHC today within the context of Parkdale and the many changes that are impacting our community. Neighbourhood demographics are quickly being affected by the growth of condominium developments, rising incomes of new residents, the proliferation of restaurants and a vibrant night-life which welcomes people from many parts of Toronto into the neighbourhood. However, many residents remain at the edges of this growing prosperity and risk increased marginalization as economic and employment opportunities remain elusive. In the midst of these changes Parkdale CHC is a constant in the provision of health and social services to people who have called Parkdale home for decades. Income disparities have long been linked to poorer health outcomes in populations. We are proud to serve communities who are most marginalized and most at risk for illness.

The old adage that "change is the only constant" was never truer today as the health care system grapples with rising costs and shrinking resources to serve complex communities. A number of health care system initiatives have focused on putting the client at the centre of care with more emphasis on better access to primary health care and better coordination of care particularly for those who risk falling through the cracks in a complicated and often hard to navigate

system. At Parkdale CHC we are proud to contribute to these initiatives that work in partnership with our hospital, community partners and our clients to improve access and coordination. We understand that barriers to good health outcomes include more than access to effective treatments. We work with our partners to remove the barriers that make health care inaccessible to many.

Good health outcomes are the cornerstone to any health care service delivery model and they are front and centre in our work. We have embraced the Quality Improvement agenda and we have made "quality" an integral part of our work. Incremental changes to the way that we do the work has contributed to improved efficiencies and accountability to improving outcomes.

Our responsiveness to the community is made possible by our diverse and dedicated staff who consistently bring a can-do spirit to their work. Their understanding of the impact of social and political changes on their clients' ability to meet the most basic of their health care needs has led to many changes in the way that they approach program and service delivery. Staffs' ability to adapt to what the client needs in the moment and their willingness to try new things imbues a spirit of possibility and hopefulness.

In the current climate of fiscal restraint we are optimistic about Parkdale CHC's capacity to respond, and in fact to lead system changes. However, we face mounting challenges to our ability to seize new opportunities for growth. Over the past year our Board of Directors has embarked on an exploration of opportunities for PCHC to increase its sustainability and systems leadership role. The goal is to build on the collaborative work that is already taking place to better support access, coordination of care and improved health outcomes.

As we focus on Parkdale CHC today, we are heartened by our many accomplishments, which will be highlighted in the next few pages. We are also grateful for the support of the many individuals, staff, volunteers, students and partners who have contributed to our success. We are excited and inspired by the possibilities that can be generated by our shared vision today for a sustainable system that supports healthy communities tomorrow.

MISSION STATEMENT

Strong community. Better lives.

VISION STATEMENT

All members of our diverse community will have access to integrated primary health care services to improve their quality of life.

VALUES STATEMENT

The Parkdale Community Health Centre's work is integrated within a framework that expresses our core values, articulates our vision for the Parkdale Community, and is aligned with the CHC Model of Care which focuses on five service areas, including primary care, illness prevention, health promotion, community capacity building and service integration. **At Parkdale Community Health Centre our work is driven by our core values of:**

ACCESS

Health services and supports when and where they are needed.

EQUITY

Ensuring everyone is treated according to their needs.

CLIENT-CENTERED

Working together with the client who shares in the decision-making.

DIGNITY & RESPECT

Acknowledging that every person has value and recognizing diversity as an asset.

SOCIAL JUSTICE

Supporting individual and collective rights so that everyone can fully take part in society.

ENDS

The Parkdale CHC Board uses a policy governance model to fulfill its mandate. In keeping with this framework, the Board defines ENDS statements to reflect the strategic objectives of the organization. The ENDS statements articulate the reason the organization exists and describe the impact we want to have in the community. The ENDS are reviewed regularly to ensure that they remain as relevant as possible. In the past year the Parkdale CHC Board reviewed and revised the ENDS statements, adding a fourth END that reflects broader health system priorities.

Parkdale Community Health Centre acknowledges that all ENDS hold equal importance, are interconnected and that progress towards their achievement occurs concurrently.

PROMOTE HEALTH AND WELL BEING
Provide access to knowledge and resources that support healthy lives

IMPROVE COMMUNITY HEALTH
Improve health outcomes with a focus on priority populations
Address the social determinants of health to reduce barriers

ADVOCATE FOR HEALTHY PUBLIC POLICY
Collaborate broadly to ensure advocacy efforts reflect community needs

ADAPT TO CHANGE RESPONSIBLY
Demonstrate accountability and efficiency
Plan for sustainability
Demonstrate leadership in the community and in an integrated health system

Programs and services offered in the past year

Primary Care:

Family medicine

Same day medical drop-in

Infant Hearing Screening

Flu shot clinic

Physiotherapy

Chiropody

Healthy Smiles Dental Clinic

West End Oral Health Clinic

Naturopathy

Healthy child screenings

Ophthalmology screening

Hepatitis C nursing support

Chronic Disease Management:

Living Life Well with Diabetes

Insulin Management Support Group

Plan Well, Budget Smart, Be Healthy (for individuals with diabetes)

Living Well Lunch Club (for individuals with diabetes)

Diabetes and Weight Management

Sorauren Farmers' Market Tour (for individuals with diabetes)

Steps Across Parkdale (walking group for individuals with diabetes)

Soup Making Workshop (for individuals with diabetes)

Granola Making Workshop (for individuals with diabetes)

Afternoon Stroll and Tea (for individuals with diabetes)

Cherry Blossom Walk in High Park (for individuals with diabetes)

Gentle Exercise Class

Asthma education

Support to Quit (smoking cessation)

Harm Reduction:

Anonymous HIV testing

KAPOW

Kit Making Group

Needle Exchange

ID Clinic

Naloxone Training

Harm Reduction Community Advisory Group

Mental Health:

Psychiatry

Individual and group counselling support

Men's Mental Health Advisory Group

Anger Management Program

Health Promotion:

Nobody's Perfect (parenting group for newcomers)

Roma Health and Well Being

Child Minding Training

Peer Nutrition Program

Portuguese Group

Seniors Wellness Drop-In

Seniors Drumming Circle

Seniors English Conversation Class

Seniors Leadership and Advocacy Group

Seniors Actively Socializing Walking Club

Information Session for Male Seniors on Prostate Health

Mental Fitness for Older Adults

Healthy Living: A Chronic Disease Self-Management Workshop

Wellness Workshop

Parkdale Caregivers Support Group

Living Healthier to Live Longer

Women's Connection:

Individual and Group Counselling for Women

Prenatal Nutrition and Support

Baby and Me

Mom and Baby Circle

Women's Expressive Arts Group

The Language of Parenting

Fatherhood 101: Dads Drop-In

Postpartum Mood Disorders Support Group

Acupuncture Drop-In

Building Skills: Peer Learning and Empowerment Program for Women

Tamil Women's Group

Yoga and Mindfulness for Moms

Trauma 101: Healing from the Effects of Abuse and Trauma

Yoga by the Lake and Acupuncture

Food Security and Nutrition:

Guys Can Cook

Good Food Box

Gardening Drop-In

Organic Gardening 101 Workshop

Special Events and Community Development:

30th Annual AGM

Elder Abuse Community Walk

Community Worker Training on Diabetes Management

World Diabetes Day

Income Tax Clinic

PAVE's International Women's Day Celebration

One Stop Shop on Cancer Awareness

Parkdale CHC Information Sessions

Holiday Food and Craft Sale

Housing Worker from West End Housing Help

Seniors Month

Foot Health Month

Department of Public Memory (Harm Reduction advocacy and sign unveiling)

Parkdale Community Crisis Response Network (PCCRN)

Population Health and Community Engagement

The uniqueness of any community health centre is embedded in their explicit work to address health disparities that make it difficult for many residents to achieve optimum health. We know that unemployment, poor housing, discrimination, racism, homophobia, transphobia and poverty contribute to poorer health outcomes in our community. In fact low income, rather than lifestyle, is the single most predictive factor in the development of heart disease, hypertension, diabetes and cancer.

Seniors standing up for safety

Parkdale residents experience higher rates of chronic health problems such as diabetes and cancer relative to other City of Toronto neighbourhoods. Despite these health issues they also experience lower rates of screening and treatment. In partnership with community agencies and resident advisory groups our population health team works hard to address these barriers through creative programming that focuses on outreach, individual and group counselling, community development, health promotion and harm reduction.

Program achievements

Some of these programs focused on specific **outreach and health education to the Hungarian Roma community** who identified priority health issues that they wanted to address. Despite a loss of our harm reduction funding we were able to provide stability to this program which saw an **increase in successful harm reduction activities**. For example, almost as many syringes distributed through this program were returned for safe disposal. Our health promotion team worked with our Toronto Central LHIN partners and newcomer communities to determine ways to generate **improved participation in cancer screening activities**. Recommendations will be implemented this year. Our **Women's Connection program** continues to serve women in a "women's own" space at our satellite site. There, our counselling, community development and **5P's (Parkdale Parents Primary Prevention Program)** programs address a myriad of issues that women and children face across life's ages and stages.

Our population health and community engagement team is increasingly integrating their activities with our primary health care services, collaborating on a **weekly acupuncture program and centralized access to mental health and addiction services**. In addition, a client support worker role was developed to work more closely with clinical staff to assist with system navigation and solid linkages to community resources.

Working together for healthy communities

Primary Health Care:

Improving quality of care through comprehensive chronic disease management

According to the recent data, in Ontario, almost 80% of people over the age of 45 suffer from two or more chronic diseases. If these conditions are left untreated or managed poorly, they could significantly impact quality of life, and potentially lead to the development of other chronic conditions. Improving quality of care for our clients, including those with multiple health problems, has always been one of our top priorities, and a central focus at Parkdale CHC.

Our Primary Health Care team

During the past year, our clinical team has been working tirelessly to provide access to integrated, high quality primary health care to our clients so that they can get the right care from the right provider at the right time. Our inter-disciplinary team is comprised of physicians, nurse practitioners, registered nurses, Certified Diabetes Educators (CDE), medical secretaries, chiropodists, physiotherapists, registered dietitians, mental health counsellors, social and client support workers, and psychiatrists. All work closely together to provide proactive, comprehensive care to clients residing in our community. They strive to work holistically to address clients' various health and social needs.

Illness prevention is a key component of our work and many of our programs focus on empowering individuals to play a greater role in managing their health, and to become an integral partner with their care teams. This is accomplished through providing individual consultations, as well as organizing group educational sessions where participants have a chance to obtain practical skills in order to self-manage their conditions on a daily basis.

Mental health management

The majority of people affected by chronic health conditions are at a higher risk for developing a mental illness. To improve access to mental health counselling services, we have piloted a new centralized way of connecting people to mental health supports. Through our Access Program our mental health counsellors are available, within two business days, for prompt assessment, brief counselling, and/or referrals to specialized mental health services. This innovative approach has helped us eliminate our waiting list making sure that clients are connected with appropriate services in a timely way.

New CCAC partnership

In order to ensure the continuity and coordination of care across the care continuum and to facilitate seamless transition between primary and home care, we have established a partnership with the Toronto Central Community Care Access Centre (TC CCAC). A CCAC care coordinator regularly meets with our clinical team to problem solve around shared patients. Our staff are using the new TC CCAC Primary Care dedicated phone line to get immediate updates and/or share urgent information on the status of their clients. This closer collaboration with the Toronto Central CCAC is enhancing our ability to deliver quality care to our patients.

South Toronto Health Link

To address the needs of our most complex clients, Parkdale CHC has been actively involved in the work of the South Toronto Health Link. As part of this initiative, hospitals, primary care providers, specialists, long-term care facilities, community agencies and others work as a team so that patients with multiple, complex conditions receive better, more coordinated care and support. These providers develop effective solutions that address each patient's specific needs by designing individualized, coordinated care plans, and working together with patients and their families to ensure they receive the care that they need.

Serving people with mental illness and diabetes

People living with mental health issues are at higher risk of a shorter life expectancy

This is because mental illness increases the risk of chronic physical medical conditions such as diabetes, hypertension and cardiovascular, and respiratory problems. The medical conditions experienced by this group are associated with preventable risk factors, such as smoking, physical inactivity, obesity, and side effects of psychiatric medication.

People with severe mental health conditions are also more likely to receive lower quality health and social care than the general population. One of the central issues around healthcare access for people with a severe mental disorders is the stigma and discrimination associated with mental illness. Strategies to improve health and life expectancy must focus not only on modifying individual risk factors but also on improving access to quality health care, eliminating the stigma associated with mental illness and addressing the social factors that get in the way of good health outcomes.

Food security, access, and social inclusion impact people who live in shelters and boarding homes. Prevalence of diabetes in people with schizophrenia or bipolar illness (10 – 15%) is two to three times that of the general population (3.5 – 5%) (Holt et al, 2005).

In addition to the side effects of antipsychotic medications for people living in boarding homes and shelters, the risk of obesity and metabolic illness may be compounded by meal quality, lack of control over portion size, inability to time meals and medication, and lifestyle habits.

Bailey House: a pilot project success

Our Diabetes Education Program (a registered nurse and a registered dietitian), working with COTA Health (a community mental health organization) and Habitat services (a community housing provider) embarked on a journey to tackle some of the above challenges. What started as a pilot project eight years ago at Bailey House to provide direct support to residents with diabetes, has evolved to include training of boarding home staff, education and support for residents living in the home and better coordination of care. Meals have increased from one to three meals a day plus snacks. The cook is supported by the diabetes dietitian to provide healthier food choices as well as modifying diets according to residents' specific dietary needs.

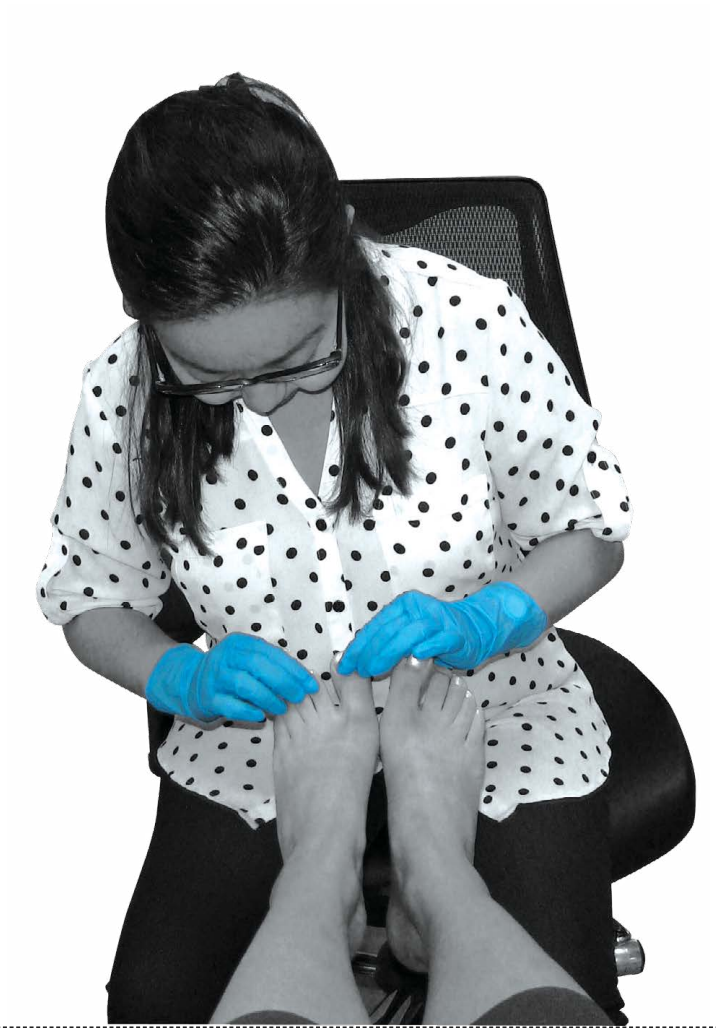
The model of care at Bailey House has facilitated positive changes for residents living there. Over time Bailey House has seen a decrease in hospital emergency visits and an increase in the number of complex clients coming to live in the home. Just this year two of the residents have moved out into the community into independent housing.

One of the team's key learnings has been that the promotion of healthier outcomes over time, is a slow and steady process of collaboration with residents and staff to provide support and practical information. The goal is to build on small successes, laying the foundation for residents to improve their quality of life.

> **"I love the way you guys treat us", "Bailey house is security to me—it keeps all the bad guys away so I can make a future for myself while I feel safe." "You talk to us and you are always there for support."**
>
> – Bailey House residents

The Chiropody (Foot) Clinic

The Chiropody (Foot) Clinic began servicing seniors and those who have diabetes full time from Monday to Friday since 2005.



Chiropodists/Foot Specialists are primary care professionals practicing podiatric medicine whom specialize in the assessment, management and prevention of diseases, disorders and dysfunctions of the foot. Their role is to maintain and improve patient mobility, alleviate foot pain, provide health education and thereby improve quality of life.

As well as providing one to one appointment based patient care, the Chiropodist/Foot Specialist provides foot health education to programs at the Centre including the Seniors Program, Diabetes Education Program, The West Neighbourhood House (formerly known as St. Christopher House), South Asian's Women's Group, and KAPOW. Since 2011, Foot Health Month is celebrated every May by putting up a display, and providing foot health information through handouts, and the TV's in the waiting areas.

"I have been able to use many of the services at PCHC, including the naturopaths, food clinics, counselling services, smoking cessation programs, acupuncture, family physicians, psychiatric counselling and assessments, and others. All have been a great benefit to me and my continuing health concerns."

– 2015 survey respondent

Spotlight on **mindfulness**

Mindfulness is the act of purposely paying attention to the moment in a non-judgemental way and is a practice that is increasingly being offered to a variety of populations as a means for enhancing overall health and wellbeing.

Mindfulness and its principle of self-compassion are fundamental components of Women's Connection wellness programs. It may be used to work with clients with a history of trauma and a real need to connect with the strong feelings they are experiencing. It may also be included as part of a yoga program that promotes relaxation and self-compassion among women navigating the challenging transition to motherhood.

In counselling, mindfulness allows individuals to increase their ability to bring patience and acceptance to a variety of difficult states that may be a source of struggle for them.

This may involve focusing on breath, sounds, and sensations within the body and it often involves focusing on truly experiencing emotions. It serves as a useful tool to reframe negative thoughts about emotions, especially anger and sadness, allowing for the person to learn to embrace the usefulness of these states. The use of mindfulness aims to support individuals to connect with their body, mind and spirit, and with internal resources that strengthen positive coping strategies.

Mindfulness partnership

Parkdale CHC has recently joined a Toronto Central LHIN funded collaboration amongst five agencies that will bring expanded mindfulness based mental health services to our communities. Led by St. Joseph's Health Centre and the Centre for Mindfulness Studies, this program will build local capacity to deal more effectively with mental health issues through mindfulness based interventions.

What our clients have to say

Every year we ask our clients to share their experience of the care and services they receive from us. This is what they told us this past year.

Access

87%

say they can get an appointment when they need one

89%

say they can get service in a language of their choice

90%

say staff members explain things in a way that is easy to understand

Impact

96%

agree that programs and services offered at PCHC help them to improve their health and well-being

92%

agree that PCHC has a positive impact on the health of the community

I can't imagine Parkdale without your services!

Equity

93%

say they always feel comfortable and welcome at PCHC

What we're doing well

Non-judgmental and consistent care

Accessible services to a diversity of clients

I can see staff when I need to

Prompt and responsive services

Variety of services provided

Holistic approach to care

Compassion, respect, integrating info from specialists, addressing the whole patient (emotional, mental, physical)

Team approach

Wonderful to be able to see different health care providers such as a dietitian, physiotherapist, or naturopath if needed

Staff are polite, courteous, open and honest

The place is always warm and friendly

Very caring doctors and nurses

Lots of information, brochures, condoms, connections to get health services done for people on a budget

The place is well maintained, clean

More feedback from clients

Clients tell us they want to see

- Less waiting time to see a doctor
- Improved telephone access
- longer hours for the Harm Reduction program every day of the week
- More children's programs
- Additional drop-in hours
- More evening programs and appointments
- More services for the LGBTQ and Caribbean populations
- Have more food available

Postpartum mood disorders support

A client shares her experience

Immediately after my first child was born, my mother passed away. It was not a pleasant way to enter into motherhood. It became clear fairly quickly that due to these and other circumstances, I had a pretty serious bout of PPD [post-partum depression]. I was referred to the PPD support group and, in the meantime, had a few one-on-one sessions with a counsellor.

The group was wonderful—my lifeline and support for six months while I felt just terrible trying to navigate new motherhood. But, thanks to the group, I learned very valuable and important coping skills, I learned to trust my instincts and I learned, most importantly, that I could let go of my preconceived notions and simply enjoy being a mother.

Since that fateful summer four years ago, my husband and I have gone on to have two more children, and to my absolute shock, I not only enjoyed the experience more, I didn't have any PPD. I was able to understand myself, and the normal things that happen with babies and motherhood and it's made such a difference.

Because of the help I received there, I firmly believe that my life has taken a different course. The lessons I learned about myself, children and parenting empowered me to be a better person overall and has truly helped me understand myself better than anything else. I couldn't be more thankful that I was able to attend a local group that offered so much judgment-free support to women.

Our Numbers

Overall Service Utilization

5,852	Active clients
1,010	New primary care clients
24,409	Individual face-to-face encounters
8,401	Personal development/support group encounters

Illness Prevention / Chronic Disease Management

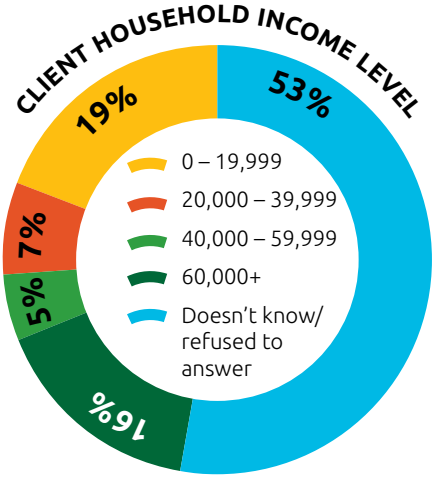
64%	Cervical cancer screening rate
61%	Colorectal cancer screening rate
64%	Breast cancer screening rate
23%	Influenza vaccination rate
79%	Rate of interprofessional care for diabetes
44%	Periodic health exam rate

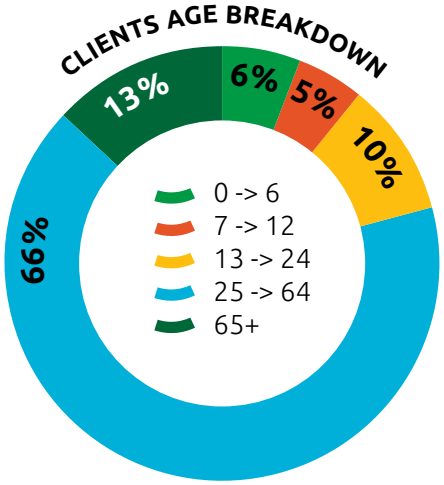
Health Equity

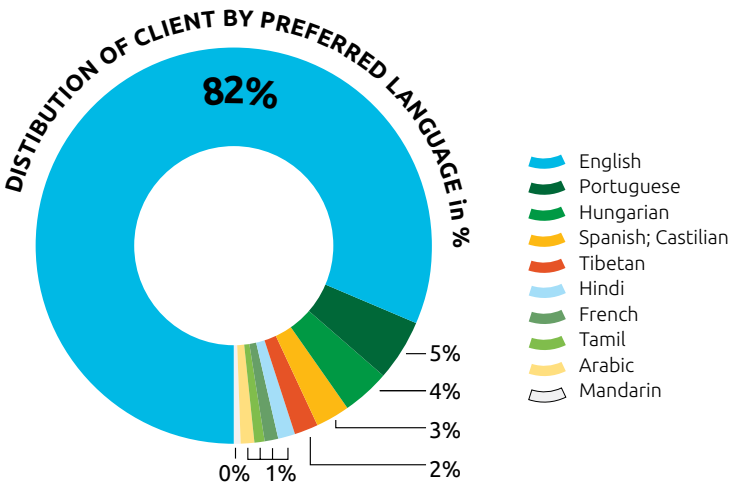
331	non-insured clients
34%	newcomers <= 5 years
280	homeless clients

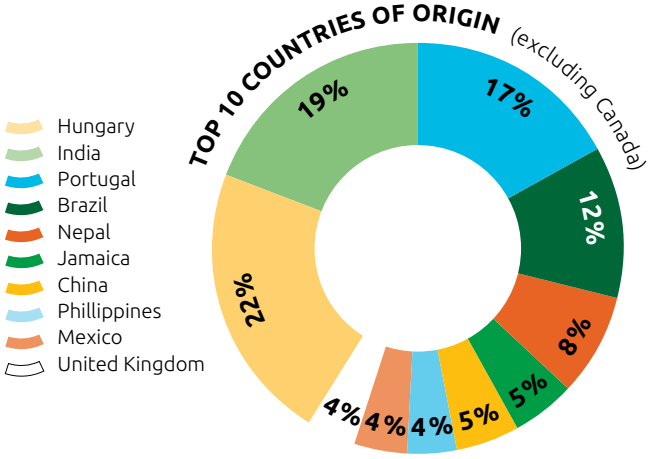
Health Promotion / Harm Reduction

1,294	Counselling hours for women









Financials

Statement of Financial Position Year ended March 31, 2015

		2015		2014
ASSETS				
Current assets	**$**	$631,839	$	724,548
Property and equipment		3,046,293		3,138,028
		3,678,132		3,862,576
LIABILITIES				
Current Liabilities		**349,195**		460,947
NET ASSETS				
Capital Assets Fund		3,046,293		3,138,028
Special Projects Funds		282,644		263,601
		3,328,937		3,401,629
		3,678,132		3,862,576

Statement of Operations Year ended March 31, 2015

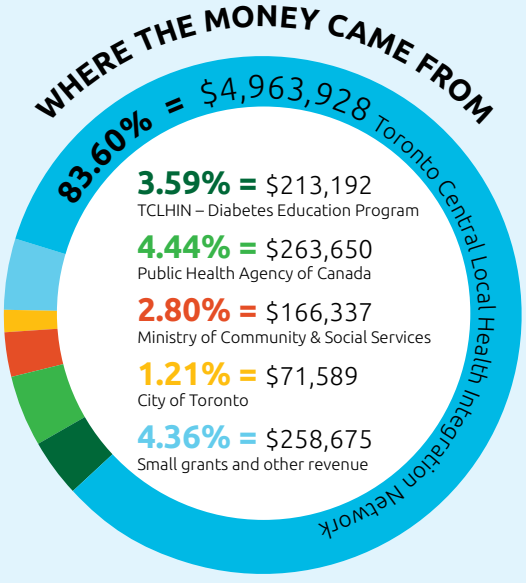
REVENUES				
Toronto Central Local Health Integration Network (TCLHIN)		4,963,928		4,984,894
Diabetes Education Program (TCLHIN)		213,192		213,198
Ministry of Community and Social Services (MCSS)		166,337		172,387
City of Toronto		71,589		126,625
Public Health Agency of Canada		263,650		263,568
Small grants and other revenue		258,675		221,889
Total revenues		**5,937,371**		5,982,561
EXPENSES				
Staffing Expenses		**4,557,225**		4,654,963
Operating				
Building occupancy		452,764		411,154
Programs & Service Expenses		685,091		613,096
Non-insured		110,724		173,779
		1,248,579		1,198,029
Non-Recurring		**64,844**		55,000
Total expenditures		**5,870,648**		5,907,992
Excess (deficiency) of revenues over expenses before the Undernoted		66,723		74,569
Amount refundable to Funders		(47,680)		(4,614)
Excess (deficiency) of revenues over expenses before amortization	**$**	**19,043**	$	69,955

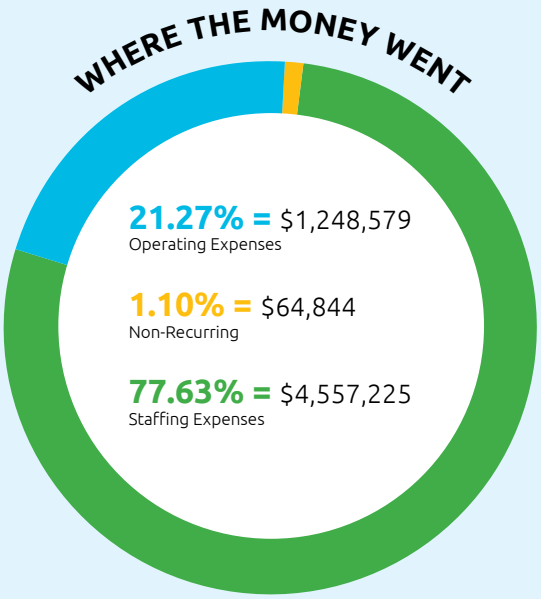
* This is a summary of the audited Financial Statements. For more information, the complete audited financial statements are available from the office of the Executive Director.

Corporate Information

PARTNERS AND FUNDERS

Access Alliance Multicultural Health and Community Services
Arrabon House
Association of Ontario Health Centres
Bailey House/COTA Health
Breakaway Addiction Services
Canadian College of Naturopathic Medicine
Canadian Hearing Society
Central Toronto Community Health Centre
Centre for Addiction & Mental Health
Child Development Institute
City of Toronto – Public Health
CultureLink
Davenport-Perth Neighbourhood and Community Health Centre
Department of Public Memory
Ecuhome Corporation
Etobicoke Children's Centre
Eva's Satellite
FoodShare
Toronto Four Villages Community Health Centre
Fred Victor
George Brown College – Assaulted Women & Children's Advocacy Program; School of Dental Health; Social Service Worker Program
Greater Toronto Community Health Centres
Network Habitat
Services Hispanic Development Council
Interval House – BESS Program
Jean Tweed Centre
JobStart
Kababayan Community Centre
LAMP Community Health Centre
Liberty Village BIA
Mennonite New Life Centre
Ministry of Community & Social Services (Ontario)
Ministry of Health & Long Term Care (Ontario)
More Than Child's Play
Oasis Centre des Femmes
Opportunity for Advancement
Parent & Child Mother Goose Program
Parkdale Activity Recreation Centre
Parkdale BIA
Parkdale Community Crisis Response Network
Parkdale Community Information Centre
Parkdale Community Legal Services
Parkdale Intercultural Association
Parkdale/High Park Ontario Early Years Centre
Parkdale LOFT Community Services
Parkdale Neighbourhood Church
Parkdale Newcomer Service Provider Network
Parkdale Project Read
Parkdale Public Library
Parkdale Public School – Family Literacy Centre
Parkdale Residents Association
Planned Parenthood Community Health Centre
Polycultural Immigrant & Community Services
Queen Victoria Public School partners for Early Learning Program
Rainbow Health Ontario
RECONNECT Mental Health Services
Regent Park Community Health Centre
Roma Community Centre
Roncesvalles/MacDonell Resident Association
Ryerson University – Nursing Program & Internationally Educated Dietitians Pre-registration Program (IDPP)
Savards Schizophrenia Society of Ontario
Scout Canada
Second Harvest Food Rescue
Seniors Pride network
Sistering SKETCH
South Riverdale Community Health Centre
South Toronto Health Link
St. Joseph's Health Centre
St. Stephen's Community House
Stonegate Community Health Centre
StreetHealth
Streets 2 Homes
Tim Horton Bus
The Arthritis Society
The Bargain Group
The Daily Bread Food Bank
The Redwood Shelter
Toronto Central Community Care Access Centre (CCAC)
Toronto Art Therapy Institute
Toronto Central Local Health Integration Network
Toronto Community Housing Corporation
Toronto Employment and Social Services
Toronto Justice Service Collaborative
Toronto Public Health – Maternal and Infant Health
Toronto Urban Health Alliance (TUHA)
West Toronto Housing Help Services
West End Food Coop (WEFC)
West End Urban Health Alliance (WEUHA)
West End Sexual Abuse Treatment
West Neighbourhood House (formerly St. Christopher House)
Women's Health In Women's Hands CHC
Woodgreen Community Services
Working Women Community Centre
Unison Health and Community Services
University of Toronto
Village Family Health Team





STAFF

Aisha Sasha John, Medical Secretary, Relief

Alison Gillies, Physician

Antoinette Hyatt, Medical Secretary, Relief

Ana Maria Navarro, Physiotherapist

Beth Wierzbicki, Corporate Executive Assistant

Bobby Jo Quigley, Nurse, Hep C Program

Bronwyn Underhill,** Director of Population Health and Community Engagement

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Charlene Holland, Medical Secretary, Relief

Choni Sangmo, Child Care Worker

Christopher Fowler, Medical Secretary, Relief

Connie Collinson, Social Worker

Cristina Fayet, Physician

Cristina Raposo, Medical Secretary

David Fabrizio, Peer Worker

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Deborah Chalmers*, Office Manager

Dennis Kussin, Psychiatrist

Edward Lee, Physician

Elen Azevedo*, Diabetes Dietitian

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Elizabeth Merlos, Harm Reduction Assistant

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Falko Schroeder, Nurse Practitioner

Fatime Khamis, Child Care Worker

Grace Landa, Program Assistant

Grażyna Mancewicz, Social Worker/Therapist

Heather R. Cadogan, Counselor/Educator

Isabel M. Andariza, Counselor/Educator

Jackie Clark, Medical Secretary, Relief

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Jennifer Chung Lim, Physiotherapist

Jenny Kim, Chiropodist

Jessa Hawkesworth, Food Room Facilitator

Jessica Brunino*, Child Care Worker

Jessica Lee, Physician

Jill Blakeney, Physician

Julie Knights, Registered Nurse

Juan Gil, IT Assistant

Karin Mary Ng,** Clinical Dietitian

Kathy Friedman, Medical Secretary, Relief

Kathy Pinheiro, Peer Worker

Kelly Ribeiro, Medical Secretary

Kendra Kusturin, Social Worker

Kevin Chopra*, Psychiatrist

Kimberly Allong,** Medical Secretary, Relief

Khalid Asad, Manager of Finance & Resources

Latreice Keen, Harm Reduction Assistant

Leesa Mae Dean*, Medical Secretary, Relief

Leslie Parker*, Community Outreach Worker

Linda Yaa Adutumwaah, Medical Secretary

Loanne Stone, Receptionist Coordinator

Loubna Bahnan, Program Assistant

Lyudmila Kukhta, Medical Secretary, Relief

Malu Santiago, Psychologist

Maria Kukhta, Medical Secretary, Relief

Maryrose MacDonald, Physician

Max McConnell*, Director of Population Health and Community Engagement, Interim

Melissa Abrams, Nurse Practitioner

Melissa Hergott, Administrative and Communications Coordinator

Million Woldemichael, Receptionist Coordinator

Minxue Michelle Lui, Diabetes Dietitian

Nadira Mahabir, Child Care Worker

Nancy Steckley, Community Development Work

Nat Bannon*, Peer Outreach Worker

Natalie Kallio, HIV/AIDS Coordinator

Neil Mentuch, Data Management Coordinator/Planner

Nicholas Durand, Chiropodist

Norma Hannant, Social Worker/Therapist

Olivia Llamas Padilla, Bookkeeper

Oxana Latycheva, Director of Primary Health Care, Interim

Patricia Ki*, Community Outreach Worker

Rakini Sivaharan, Child Care Worker

Raymond Macaraeg, Nurse Practitioner

Rebecca Lee, Office Manager

Riley Fulkerson *, Diabetes Dietitian

Rosa Ribeiro, Health Promoter

Rupinder Brar *, Physician, Locum

Samantha Cooper, Clinical Dietitian

Sandra G., Health Promoter

Sara Garnett, Peer Worker

Satha Vivekananthan*, Tamil Counselor

Simone Houghton, Food Assistant

Shawn Mattas*, Physician

Shirley Hepditch, Client Support Worker

Shirley Roberts, Executive Director, Interim

Shona MacKenzie, Nurse Practitioner

Sriram Ananth, Mental Health Coordinator

Stacia Stewart, Project Coordinator

Steven Idzi*, Peer Worker

Steven Lipari, Physician

Tricia Williams, Medical Secretary

Tysa Harris, Medical Secretary

Victoria Okazawa, Social Worker

Yohama Gonzalez, Family Support Outreach Worker

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STUDENT ACADEMIC PLACEMENT AND VOLUNTEERS

We would like to extend our Special Thank You to ALL students and volunteers who completed their work at PCHC over the year.

Your contribution and commitment to the work of PCHC was greatly appreciated!

* No longer with PCHC ** On Leave

With Gratitude...

Parkdale CHC wishes to thank all donors with special mention to:

The Zukerman Family Foundation for their generous donation to the West End Oral Health Clinic. This gift will make possible an expansion of dental services to low income adults of Parkdale. In partnership with Toronto Public Health, George Brown College and dedicated volunteer dentists, PCHC will be able to provide more dental treatment services to adults who are unable to access preventive and basic dental care through services that are only currently funded for children and seniors.

The Sprott Foundation for their generous grant in support of the Parkdale Parents Primary Prevention Project (5P's program). The grant will be used to fund our new Infant Feeding Program. This program supports new parents with food insecurity and newborn feeding challenges by providing in-home lactation supports, breast pumps, feeding supplies and peer to peer learning opportunities. The program complements 5P's other programs which include prenatal nutrition, education & support, mom & baby postnatal support programs, fatherhood drop in, a food and infant clothing bank, and early learning opportunities for children aged 0-6 years.

Parkdale Community Health Centre

Parkdale CHC (Main Site)

1229 Queen Street West
Toronto, ON M6K 1L2

Tel: 416.537.2455
Fax: (Admin) 416.537.5133
Fax: (Clinical) 416.537.3526

Hours of Operation

Monday, Tuesday & Thursday
9:00 a.m. to 8:00 p.m.

Wednesday
9:00 a.m. to 12:00 noon
3:00 p.m. to 8:00 p.m.

Friday
9:00 a.m. to 5:00 p.m.

Saturday
10:00 a.m. to 1:00 p.m.

Parkdale CHC (Satellite)

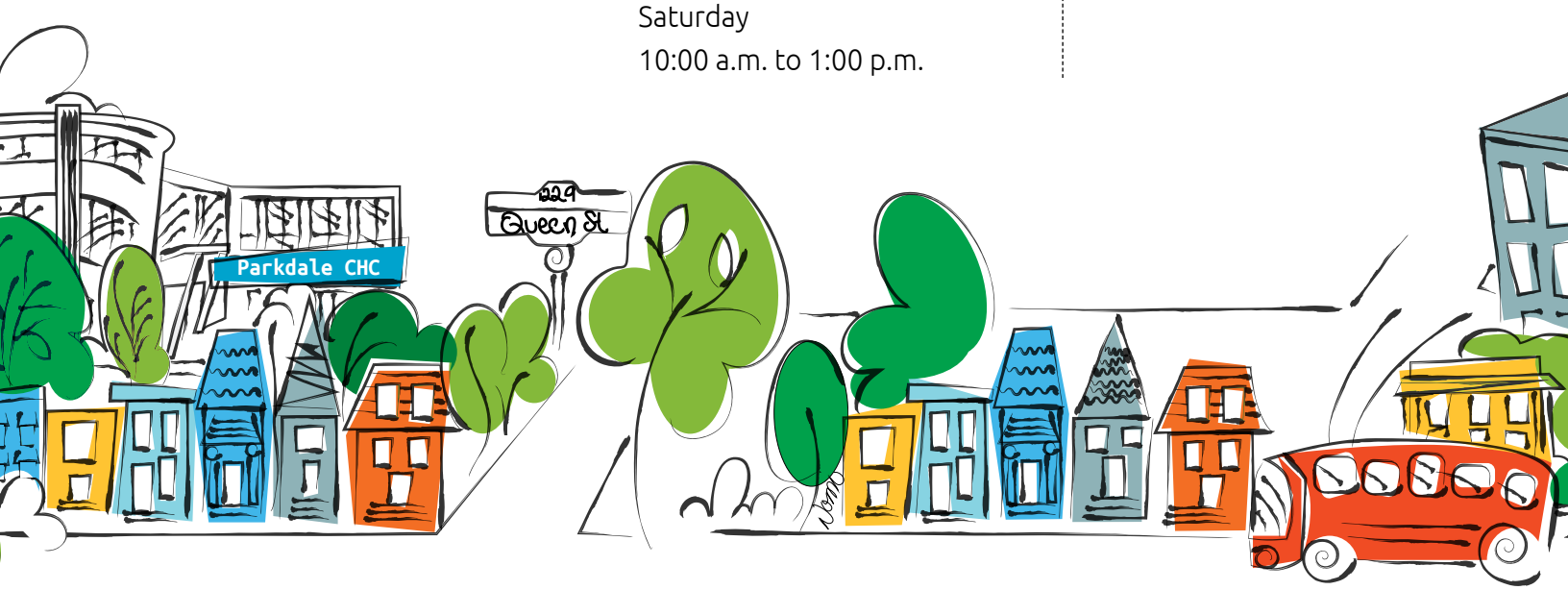
27 Roncesvalles Avenue
Suites 301/503
Toronto, ON M6R 3B2

Tel: 416.537.8222
Fax: 417.537.7714

Hours of Operation

Monday to Friday
9:00 a.m. to 5:00 p.m.

www.pchc.on.ca



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Toronto Central Local Health Integration Network

Ontario's Community Health Centres
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