



SOCIAL IMPACT REPORT 2025-2026

A DIFFERENT KIND OF HEALTHCARE



www.vaughanchc.com



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[@vaughan_chc](https://twitter.com/@vaughan_chc)



[@vaughancommunityhealthcentre](https://www.instagram.com/@vaughancommunityhealthcentre)

LAND ACKNOWLEDGEMENT

We acknowledge that we are situated on the treaty lands and territory of the Mississaugas of the Credit First Nation and the Williams Treaty First Nation. These lands have been cared for by other Indigenous peoples including Wendat and Haudenosaunee. We are grateful to the First Nation, Inuit and Metis people and we thank them for sharing this land.

VISION, MISSION, VALUES AND PRIORITIES

VISION

A Healthy, thriving community.

VALUE

Belonging – We facilitate a community where all feel welcome and safe.

Equity – We advocate for and create culturally safe, inclusive, diverse and accessible environments.

Collaboration – We develop strong, inter-disciplinary partnerships that respond to client, staff, and community needs.

Accountability – We practice the highest standards of professional services.

Excellence – We are leaders in providing exceptional community health care through continuous learning and innovation.

PRIORITIES

Organizational Vitality

Develop a healthy, innovative organization with a stable, skilled, and engaged workforce.

Inclusive Community Engagement

Provide intentional and inclusive service delivery with and for local Indigenous, Black, racialized, and other disadvantaged communities.

Innovative Partnerships

Enhance collective capacities by strengthening existing partnerships and cultivating new relationships.

MISSION

Working with our community, VCHC provides exceptional client-centered community health services that address social determinants of health, foster more equitable health outcomes, and promote health and wellbeing.



LoAn Ta-Young
Executive Director



Carin Binder
Board Chair

MESSAGE FROM EXECUTIVE DIRECTOR AND BOARD CHAIR

We are pleased to reflect on a year of progress, partnership and impact across our community.

This year, our organization continued to respond to changing community needs by providing accessible, integrated health and social services. This is exemplified by VCHC having received funding approval of \$2.6M in August 2025 from the Ministry of Health and Ontario Health to expand our primary care team and that of our partner, Mount Sinai Academic Family Health Team. Our sincere thanks to supporting partners in the proposal submission: ANCHOR Canada, Human Endeavour, and COSTI Immigrant Services/Vaughan Welcome Centre.

On November 7, 2025, the Executive Director on behalf of VCHC, was invited to the official funding announcement by Minister Stephen Lecce, MPP for King-Vaughan, in the presence of Mayor Steven Del Duca and City of Vaughan Councillors and community partners.



We remain focused on reducing barriers to care, strengthening connections and ensuring that the voices of our clients and community members inform our work. Our Community Ambassadors have been engaging community

partners and residents at local fairs, businesses, faith-based organizations, etc. to create awareness of VCHC primary care services and promote the connection of unattached individuals to health services. In addition, VCHC is partnering with the Western York Region Ontario Health Team and Mackenzie Health Cortellucci Vaughan Hospital to connect unattached individuals to primary care and allied health services.

VCHC is committed to serving our local African, Caribbean, and Black (ACB) community. We have engaged ACB community leaders and members in blood glucose screenings and education on diabetes management and other health topics. Our team has gathered feedback from the community to understand the barriers and gaps in accessing primary health care services and we are collaborating with community leaders to identify strategies to address those barriers.

The dedication of our staff, volunteers, Board, and the strong partnerships we have built across the community have made possible the successes of last year.

We extend our sincere appreciation to our clients, staff, volunteers, partners, funders and supporters for your continued trust and commitment. Together, we are building a healthier, more inclusive and connected community.

Looking ahead, we will continue to build on what we have learned, strengthen our partnerships and focus our efforts where they can make the greatest difference.

Our Board of Directors

BOARD CHAIR

**Carin
Binder**



VICE CHAIR

**Dennis
Bailey**



SECRETARY

**Gino
Caputo**



TREASURER

**Malcolm
Wong**



BOARD MEMBER

**Patrick
Clifford**



BOARD MEMBER

**Louisa
Poon**



BOARD MEMBER

**Carmela
Campanella
-Borraccia**



BOARD MEMBER

**Emmanuel
Abara**

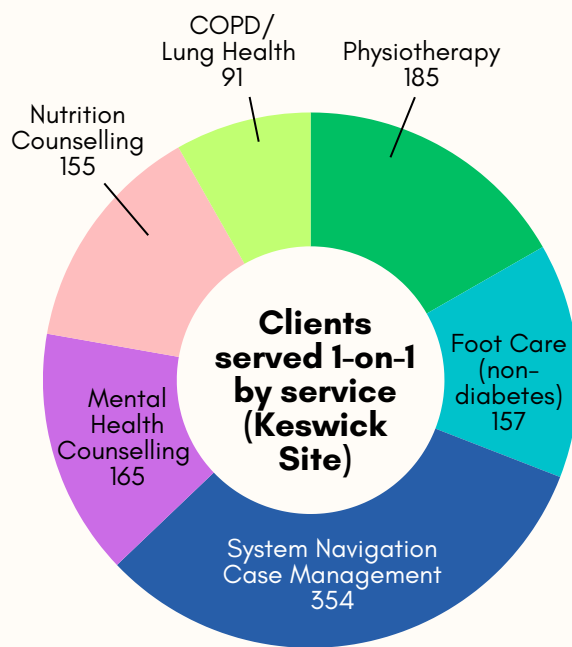
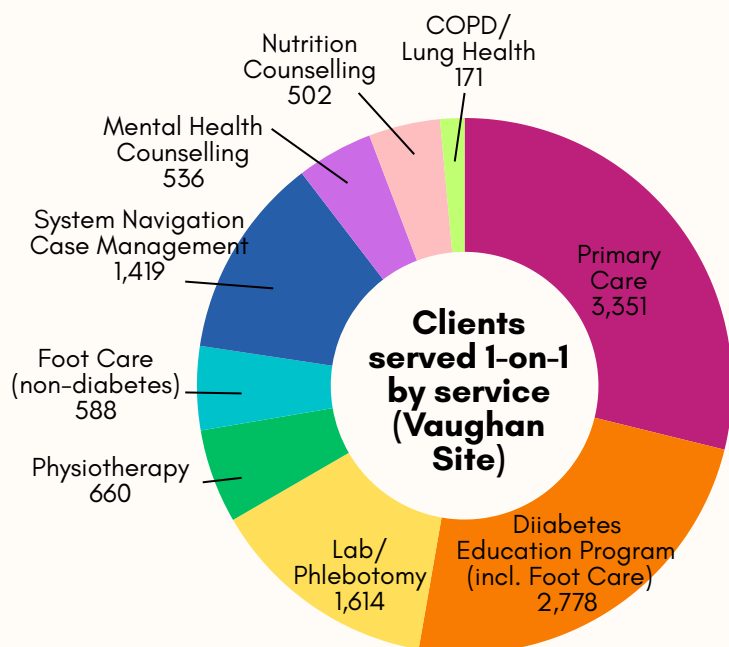


BOARD MEMBER

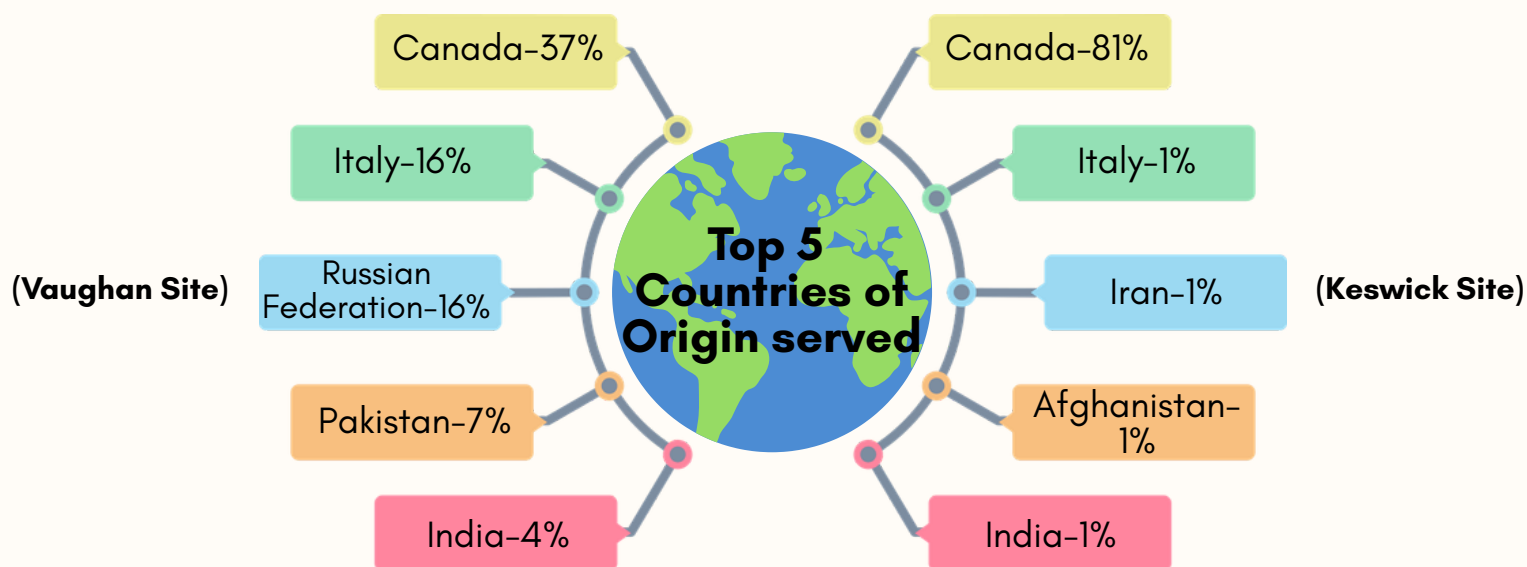
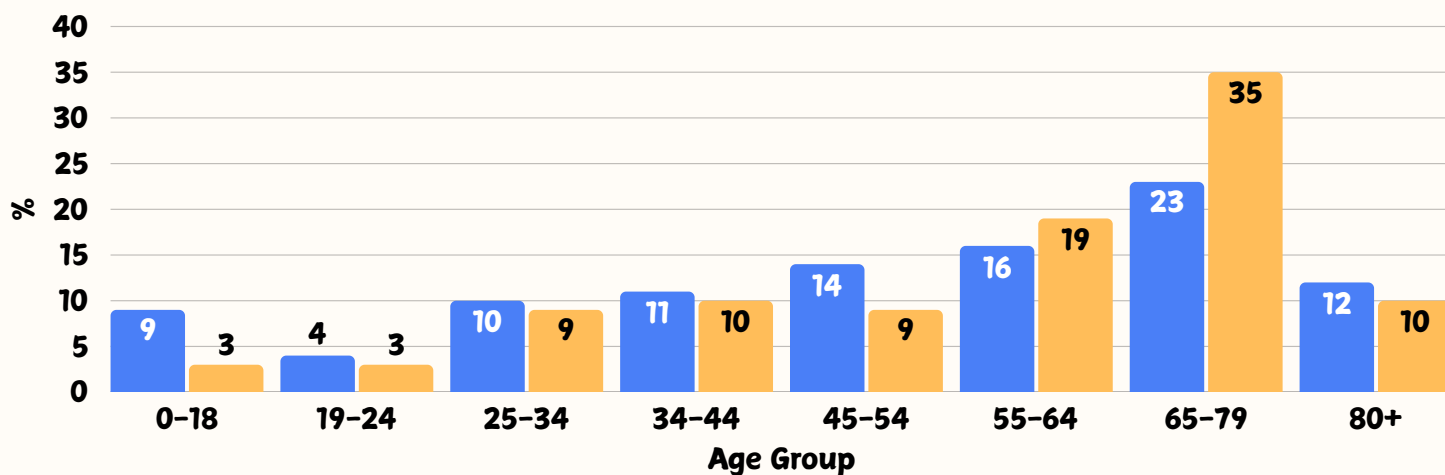
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Sehgal**



DIVERSITY OF OUR CLIENTS

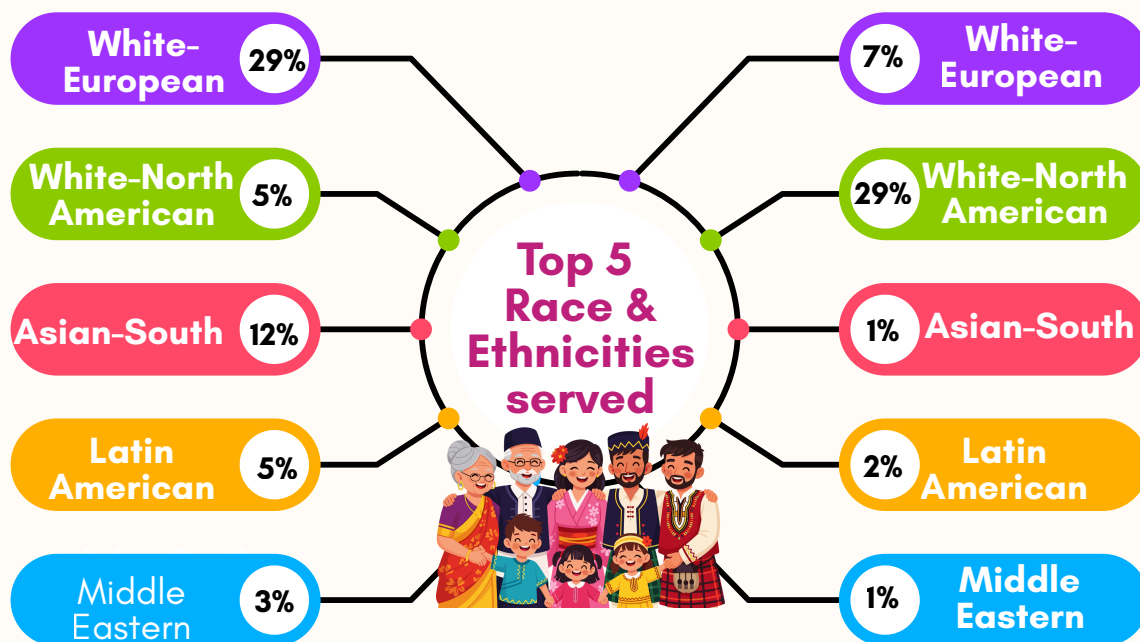


● Vaughan ● Keswick



DIVERSITY OF OUR CLIENTS

Vaughan site



Keswick site



Top Languages preferred to receive care

English

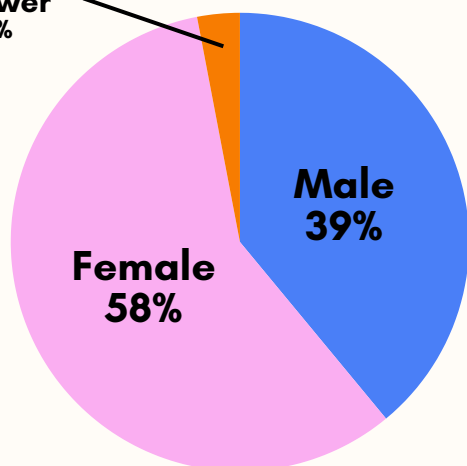
Russian

Italian

Urdu

Spanish

Prefer not to answer
3%



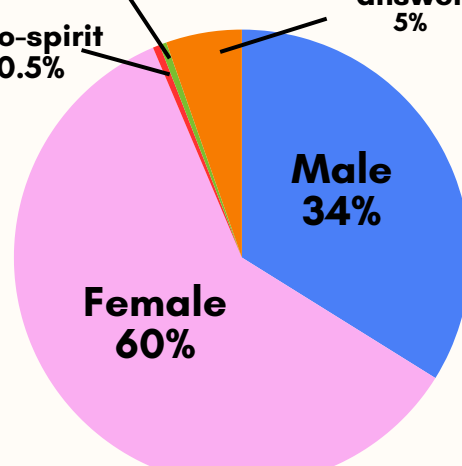
Vaughan Site

Gender Distribution

Non-Binary
0.5%

Two-spirit
0.5%

Prefer not to answer
5%



Keswick Site



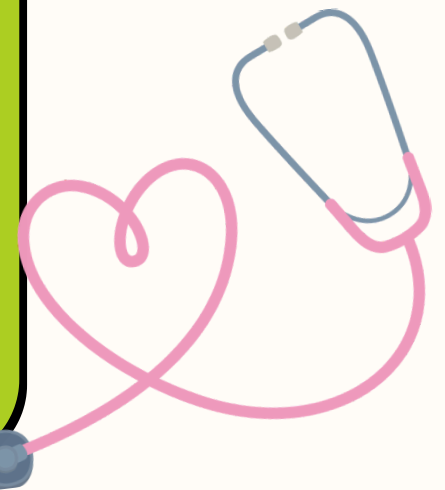
INCREASING ACCESS TO PRIMARY CARE

At the Vaughan CHC, our team of family doctors and nurse practitioners provide ongoing primary care services to our clients. The team works alongside other health care professionals to provide care that meets the needs of each person. Over the past year, we have been working on connecting more community members to a family doctor or nurse practitioner through an expansion of our services.



What does it mean to be registered with a Family Doctor or Nurse Practitioner for your ongoing care:

Your family doctor or nurse practitioner is your dedicated first point of contact for health care needs. They manage your overall health and guide you to specialists' services, when needed. Research tells us that there are many benefits to having access to a regular clinician or care team. This includes catching and preventing illnesses, management of chronic diseases, lowered risk of health crisis, less emergency department visits and or hospital admissions and decreased mortality overall.



Connecting More Community Members to Primary Care

In early 2025, the Ontario government launched the Primary Care Action Plan (PCAP) to make sure everyone in Ontario has access to their own Family Doctor or Nurse Practitioner for ongoing primary health care by **2029**. To be able to serve **more people in our community** without an existing Family Doctor or Nurse Practitioner, we submitted a proposal to Ontario Health to expand our team. By summer 2025, we were approved for more funding. Soon after, we began hiring new clinical and administrative staff, making minor renovations to our space, connecting with our community partners and promoting the availability of services to the community. Through collaboration between our primary care team, community ambassadors, administrative staff, community and system partners, we were able to ramp up our services quickly and connect our community members to a health care provider.



By April 2026, we attached over 550 new clients to a family doctor or nurse practitioner at the Vaughan CHC and provided just over 900 appointments.



INCREASING ACCESS TO PRIMARY CARE

Working with Local Community Organizations to Increase Access to Primary Care

As a key step in our expansion, it was important for us to understand the current needs of our community. Over the past year, we connected with various local community-based organizations to discuss needs and barriers of communities in accessing primary care services, so we can ensure our approach is community-centered.

Since the fall of 2025, our Community Ambassadors visited 23 community organizations such as **ANCHOR Canada, CAYR Community Connections, Catholic Community Services of York Region, Upper Thornhill Areas and Community Association and York Region Alliance of African Canadian Communities** and referred 167 people to primary care services at VCHC.

We accept new clients with or without health insurance or status who live in the Western York Region and surrounding area. Most of our new clients live in nearby towns including Maple, Woodbridge and Concord. Some travel at length to our Centre because of lack of access to care in their neighbourhood or because of positive relationships with our staff. We have a diverse team that represents the community we serve and clients come to us for culturally-sensitive and language-specific care.

Meet the Primary Care Team

The primary care team consists of family physicians, nurse practitioners, phlebotomist and registered practical nursing staff who are committed to delivering ongoing care and treatment to people of all ages.

Equipped with strong knowledge of acute and chronic illnesses prevention, management and treatment, preventative health (cancer) screening and community resources, our team aims to help clients achieve better health outcomes and live a healthier life.



Working alongside the primary care team is a dedicated group of inter-professional service providers such as system navigators, diabetes educators, mental health providers, physiotherapist, chiropodists, registered dietitians, respiratory therapist, kinesiologist and health promotion staff. The team works together to offer each client an opportunity to receive supportive and comprehensive care under one roof.

Our priority populations include people who do not have access to a regular primary care clinician, those experiencing barriers to getting the care they need, those at risk for poor health outcomes, underserved and racialized communities including the African, Caribbean, Black and Indigenous communities.

INCREASING ACCESS TO PRIMARY CARE

Our Impact in the
2025-2026 Fiscal Year

Community Health

85%

% of clients
were offered or
completed
their cervical
cancer
screening

89%

% of clients
were offered
colorectal
cancer
screening

850

appointments
provided for
health issues
requiring a
same or next
day visit

556

of new clients
attached to a
Family Doctor
or Nurse
Practitioner

15,692

of
interactions
with a
provider

Client Experience

99%

respondents
feel
comfortable
and welcome
at VCHC

91%

respondents
feel involved in
making decision
about their care

74%

clients reported
getting an
appointment on
the day they
wanted

We provide
interpretation
services in **over
100 different
languages**

Our team
speaks a variety
of languages
including English,
Russian, Farsi,
Bengali, Tagalog,
Mandarin and
more!

INCREASING ACCESS TO PRIMARY CARE

VCHC TEAM ACHIEVEMENTS Addressing the Six Primary Care Team Objectives

01

Province-Wide:

- VCHC is providing attachment to primary care and interprofessional health services onsite
- Offering primary care to individuals on the Health Care Connect waitlist
- Working with our community partners to create awareness of primary care services and maximize attachment for equity-deserving communities
- Community Ambassadors' engagement with Vaughan residents, providing them with information and referral to VCHC services

02

Connected:

- VCHC delivers a team-based approach to care and involves external services in individual's care
- Referral to VCHC's system navigators for wraparound support with social determinants of health needs
- Partnering with the Western York Region Ontario Health Team and Mackenzie Health Cortellucci Vaughan Hospital to connect individuals to primary care and allied health services

03

Convenient:

- Expanded appointment availability with evening access and on-call service outside of regular business hours
- In-person, telephone or virtual appointments
- Same-day appointments
- Shared model of care (more than 1 clinician may be available for support)

04

Digitally Integrated:

- Online sign-up and registration to ensure a smoother referral and registration process
- Client access to online booking, email appointment reminders, self-check ins for appointments and secure messaging with a primary care clinician (OCEAN)
- Staff access to digital tools such as the electronic medical record, online eReferrals and e-fax and AI Scribe for documentation to reduce administrative burden

05

Equitable:

- Ongoing engagement with community leaders, including ANCHOR Canada, Human Endeavour and the COSTI Immigrant Services/Vaughan Welcome Centre
- Tailored community engagement by Community Ambassadors who are reaching underserved populations
- Use of individual level sociodemographic data and race-based data to inform service delivery

06

Responsive:

- Ongoing collection of primary healthcare client experience surveys to understand access and experience with service
- Continuous quality improvement planning with VCHC QIP committee and primary healthcare team
- Launch of VCHC Client and Partner Advisory Council with interested community partners and primary healthcare client representatives to guide this work

INCREASING ACCESS TO PRIMARY CARE



HOW

**Examples of how we
support our clients!**

Helping individuals
without health
insurance during their
pregnancy

Following clients
through cancer
diagnosis and
treatment

Having 1:1
conversation with
individuals in the
community, listening
to their needs and
circumstance, then
connecting them to
the appropriate
service at VCHC

Linking clients to
system navigation
and case
management services
to address their
social needs

Supporting
individuals and
caregivers through
health decline and
losses

Advocating for
clients for priority
housing status or
transportation
subsidies

Offering free
language
interpretation to
those who do not
speak English



INCREASING ACCESS TO PRIMARY CARE

BENEFITS TO BECOMING A VCHC CLIENT!

- Various options for registration: in person, online, and over the phone
- Free language interpretation in over 100 languages for your registration and appointments
- Team-based approach: our Family Doctors and Nurse Practitioners back up each other's clients to ensure timely access for all clients.
- All ages welcome
- Regular preventative cancer screening
- On call physician availability for after hours
- We use various digital tools for your convenience including: online appointment booking, self-check in kiosks, secure email communication for completion of forms and more
- One-time registration to access all our services and seamless referrals between health care professionals
- Availability of timely appointments for semi-urgent needs
- Comprehensive and continuous primary healthcare all under one roof
- In-person, telephone, or virtual appointments
- Onsite bloodwork and lab specimen collection
- Services available for individuals with or without health insurance or precarious status
- Extended hours of operation – 3 evenings per week.
- We care about your well-being!



Are you or someone you know looking for primary care?
Contact us today by signing up online at www.vaughanchc.com
or calling the VCHC at 905-303-8490.



INCREASING ACCESS TO PRIMARY CARE

What clients have shared about
primary healthcare services at VCHC!

Returning VCHC Client

I'm happy with the Centre. I used to come here many years ago and now returned to the area to stay. I've noticed you have a lot of doctors and nurses, and many services for people. Reception is very friendly and knowledgeable. The services are very good for people living in this community, especially for seniors...I have friends living in other areas who don't have something as good as what this Centre offers. This includes the number of staff you have, services like physiotherapy, chiropody, nutritional counselling...this is really good for patients having everything in one office.



New VCHC client

My doctor explains things very thoroughly and explains things well, which is important to me. She takes time with me, my husband and my children in the few times that we've visited so far. My husband initially was the first one to register and then he put my name on the list- he was very happy with how the clinic was doing things.



New VCHC Client

My provider is a good listener. They listen and take their time with me and follow-up when needed.



New non-insured client

My doctor takes her time to make you feel comfortable and at ease. They are very professional which is so helpful for me. The whole Vaughan Community Health Centre is also very professional and helpful. Early on, there was a time when I went to the Mackenzie Health Hospital and needed more information about health coverage and access to care. I called the Centre and got the information I needed that day.



New VCHC Client

So far, my experience has been very good. I'm new to the clinic and have a lot of issues and specialists. My doctor is following up on everything accordingly including testing...I might hear from her tomorrow to review my test results.



CHRONIC DISEASE PREVENTION AND MANAGEMENT

IMPROVING CONFIDENCE IN DIABETES SELF-MANAGEMENT THROUGH COMMUNITY ENGAGEMENT

The VCHC Diabetes Education Program team aims to raise awareness of type 2 diabetes while focusing on improving individuals' knowledge, skills, and confidence in diabetes self-management and prevention. Through workshops and presentations in the community, we offer group sharing opportunities where participants can share experiences and learn from each other.

In 2025/2026, our team engaged 649 members of the public in 45 group presentations hosted in community settings across York Region. These presentations took place in libraries and community centres across York Region, as the team worked in coordination with community partners such as the Elspeth Heyworth Centre for Women, the Bernard Betel Centre, Vaughan Public Libraries and CHATS.

In addition, 4 multi-week workshops were designed to support individuals to increase their knowledge in diabetes self-management. These included: Insulin Management, Obesity Management, Living a Healthy Life with Diabetes, and Craving Change. Overall, 32 individuals participated in these programs which were provided in-person at the Centre through the fall and winter.

**649 members
engaged in
45 group
presentations**

INSULIN MANAGEMENT

One participant completed the post workshop evaluation and noted being much more knowledgeable regarding carbohydrate counting and improvement in their skills related to insulin injection.

OBESITY MANAGEMENT

- **67%** "strongly agreed" and **33%** "agreed" that their knowledge and/or skills increased because of attending the workshop.
- **79%** "strongly agreed" or "agreed" that they felt more confident in managing their health after attending the workshop.

LIVING A HEALTHY LIFE WITH DIABETES

- **100%** of clients felt more confident in using self-management tools to manage diabetes daily
- **100%** strongly agreed that after attending the program that they could explain the plate method for a healthy eating plan.

CRAVING CHANGE

- **100%** of participants "strongly agreed" or "agreed" that the program helped them learn how to set goals for long term success.
- **83%** reported feeling more confident in controlling cravings to maintain healthy eating behaviours and a healthy relationship with food.

Locally Driven Population Health Model: Chronic Disease Management

2024

In 2024, VCHC was awarded the Locally Driven Population Health Model funding to expand its work with priority populations. The Centre set out to improve health care access, education and awareness of support for management of type 2 diabetes for the African, Caribbean and Black (ACB) community.

Diabetes Canada wants to change the conversation about Diabetes. “Too often conversations about diabetes include blame, judgement, or misinformation - leading to stigma, unfair attitudes and stereotypes that harm people living with diabetes.”

2025

In April and May 2025, we gathered feedback from the community on their lived experience through consultations with local partner organizations, focus groups, and participation in local community events. Our learnings included the following: **1) Lack of engagement with the ACB community and cultural awareness; 2) Lack of access to a primary care provider; 3) Lack of awareness about diabetes complications and preventative tests such as eye screenings; 4) Lack of trust in health care services.** As next steps, we are working on identifying ways to address these gaps.

Our goal is to continue to build trust with our community by engaging with community members, organizations, and places of business on an ongoing basis. With our engagement efforts the Community Ambassadors (CAs) had **11,544 one-to-one conversations with community members, attended 8 community events and connected to 50 places of business.**

Referred 2,321 individuals for blood glucose screening

Referred 251 individuals for retinal eye screening

Referred 167 individuals to primary care provider at our Centre

2026

Along with education sessions and public engagement, outreach focusing on reaching our ACB community, continues to inform pathways for individuals to complete blood glucose and retinal screenings.

Referred 249 individuals to our System Navigator for wraparound support services since Feb 2026.



Celebrating Black History Month

As part of the Locally Driven Population Health Model strategy, the Diabetes Education Program (DEP) team and Community Ambassadors collaborated to provide blood glucose screenings and education to the public over the course of the month February 2026 at three Black History Month Celebration events. We worked with partner organizations including York Region Alliance of African Canadian Communities (YRAACC), ANCHOR Canada, and the City of Vaughan to promote and deliver three screenings along with education to members of the African, Caribbean, and Black community. Our team highlighted VCHC programs and services such as system navigation, diabetes education and management program, and primary care to the community.



Responding to Increased Demand for Exercise Education Programs

Two new Total Body Conditioning exercise classes were added to the Exercise Education Program in 2025/2026. These classes were offered in-person at our Jane St location. Both of these classes filled up quickly due to the need for more exercise program offerings at the intermediate level and due to the popularity of the in-person setting. The exercise classes ranged from beginner to advanced level of fitness. The focus of all classes is to gain confidence and learn how to exercise safely.

317

**individuals
participated
in the Spring
and Fall/
Winter
Session**

264

**exercise
sessions
were held**

98%

**of participants
strongly agreed
or agreed that
the program
content met
their level of
physical
fitness**

88%

**strongly agreed
or agreed that
they could see
themselves using
the exercises
learned outside
of the
program**

Feedback from our clients:



**"Very detailed
in explaining all
exercises. I love
this program."**

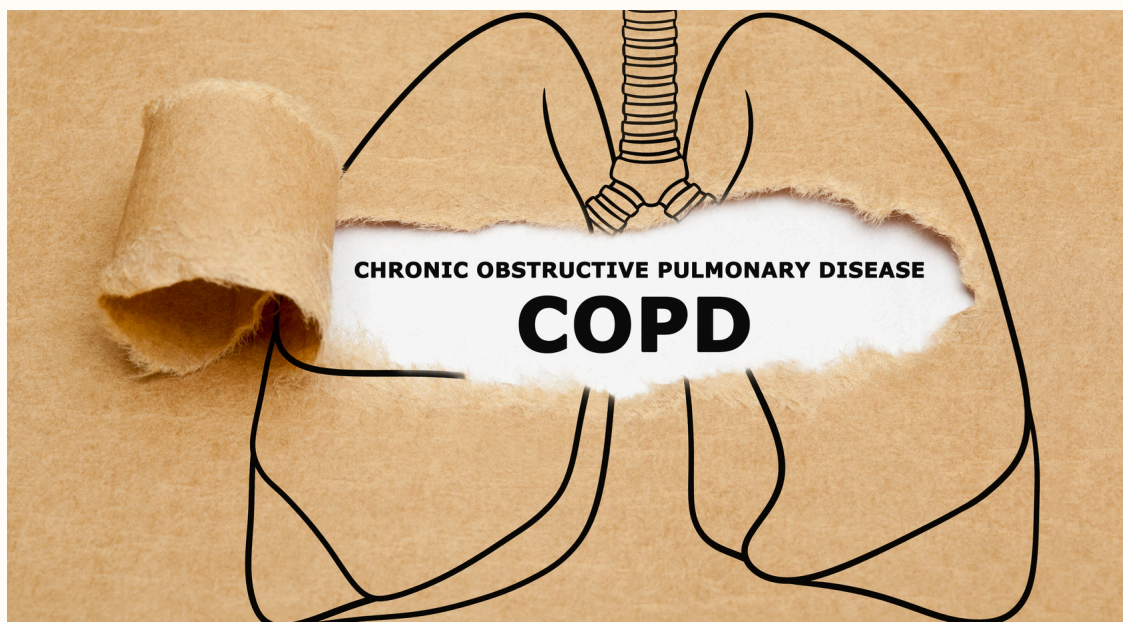


**"This class
surpassed my
expectations. The
instructor does a
fantastic job."**



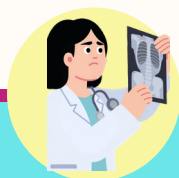
**"The instructor does an
amazing job guiding us
through all the exercises
with explanation of each
step and choice of
higher or lower impact
steps"**





Increasing Lifestyle Confidence through COPD Support Groups

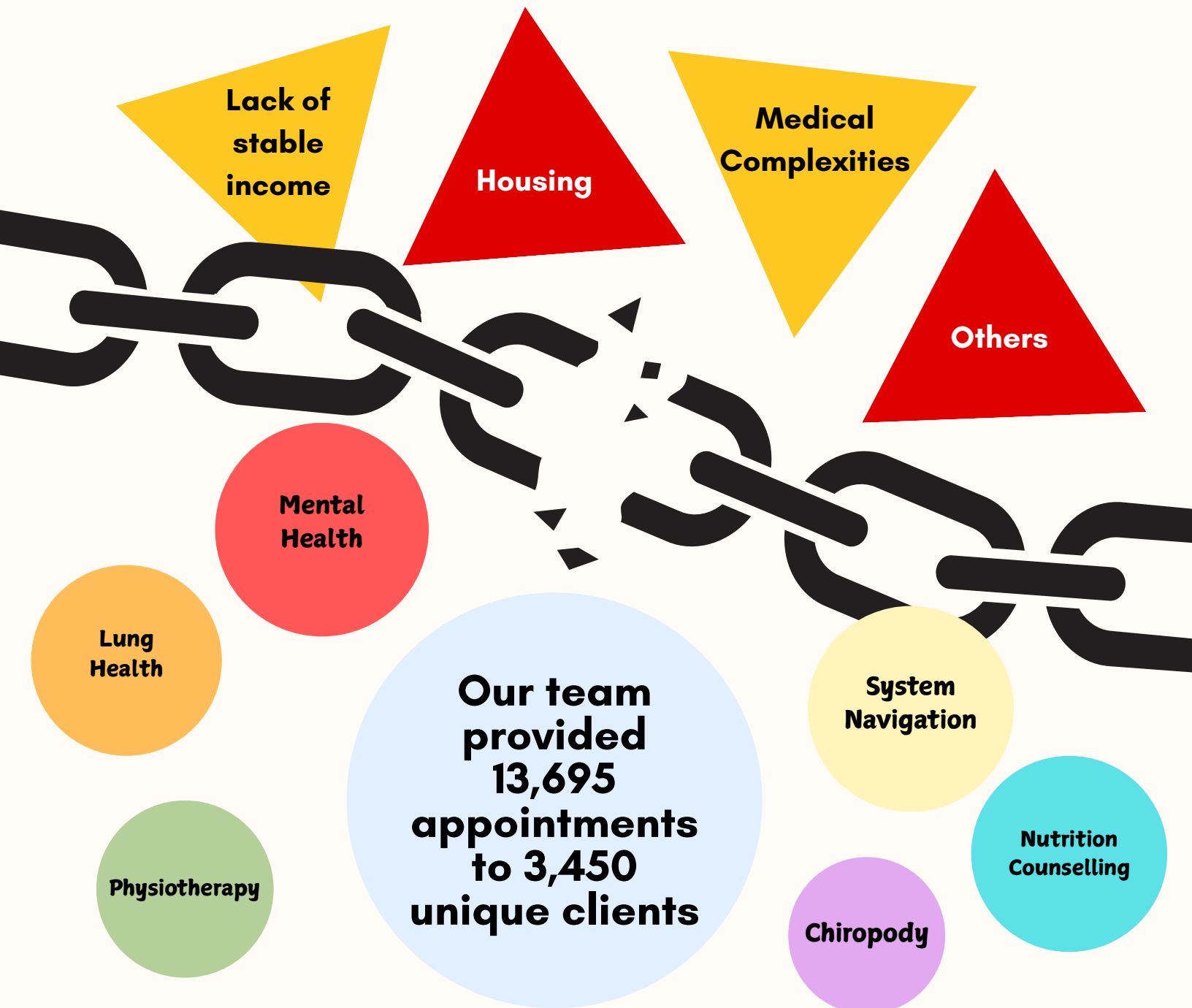
Those living with Chronic Obstructive Pulmonary Disease (COPD) and other lung conditions participated in monthly online support groups along with one-to-one sessions as needed with healthcare professionals either in-person or virtually. The COPD Virtual Care group continues to meet twice a week. Clients attending these group sessions benefit from a holistic, interprofessional approach to care and have access to a Respiratory Therapist, Kinesiologist and Community Dietitian. Each session is tailored to healthcare needs with topics presented by healthcare professionals. The sessions provide participants with knowledge and resources to live well while managing their condition. Those looking for support to stop smoking were provided one-to-one counselling with our Respiratory Therapist. The COPD care team continued to support Keswick clients by offering virtual and in-person support.



“ I am very happy to have the opportunity to participate in your program. I feel more confident in my lifestyle. My capabilities to do many things increased significantly. I feel psychologically stronger in making decisions in my life.

INTERPROFESSIONAL ALLIED HEALTH SERVICES

VCHC's inter-professional allied health services include mental health counselling, system navigation, nutrition counselling, physiotherapy, chiropody and lung health services. Our team of allied health care providers work alongside our family doctors and nurse practitioners at VCHC. In addition, our team provides services to clients of family doctors outside of VCHC, whose clients need community-based allied health services. Most clients referred to us do not have the financial means to pay for private health services and are experiencing with various barriers related to the social determinants of health including lack of stable income, housing, medical complexities and others.



INTERPROFESSIONAL ALLIED HEALTH SERVICES



Mental Health Counselling

~Healing takes time and asking for help is a courageous step~

3,079 client interactions with a mental health service provider in 2025-2026.

* At VCHC, Registered Social Workers and Psychotherapist provide short-term mental health counselling for individuals, couples, and groups. We prioritize services for individuals from equity-deserving communities, those living with complex medical and social needs, chronic medical conditions, and those facing barriers related to social determinants of health.

* We provide individual appointments and group programs for managing stress, anxiety, chronic mental & physical health issues, life stressors, work-life balance, relationships, family issues, isolation, loneliness, and more. Key benefits of sessions: improved emotional wellbeing, enhanced self-awareness, coping strategies, better relationships, personal growth, and increased resilience.

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Highlights of our impact

"As soon as we give ourselves permission to take very small steps toward our goals, we can break out of unhelpful cycles in our lives."

**Message from
the provider**

"In a marital relationship, a client felt like she didn't have a voice to express her concerns or wishes and noticed her spouse's personality was impacting the children too. Through the use of dialectical behavioral therapy, she was able to learn the skills to slowly find her voice and feel confident in expressing herself".

"A client came in to better understand why he behaves in unhealthy ways in his relationships. Through our clinical counselling sessions, he was able to better understand how his past life experiences contribute to his current relationship dynamics. During the sessions he learned how to respond differently and noticed positive changes within himself and his relationships".

INTERPROFESSIONAL ALLIED HEALTH SERVICES

System Navigation

System Navigation at VCHC

* **What is system navigation:** Our System Navigators work alongside the primary health care team to provide wraparound support for our clients facing barriers related to social determinants of health. They link clients to services in the health, social, legal, and government systems to address their social needs.

They can help clients to complete applications and forms for employment, housing, financial assistance, community care, and more.

Our System Navigators provide support to VCHC clients and community residents - **no referral is required from a healthcare provider to access the service.**



SYSTEM NAVIGATION

~Together we can~

1,981 client interactions with a system navigator
in 2025-2026

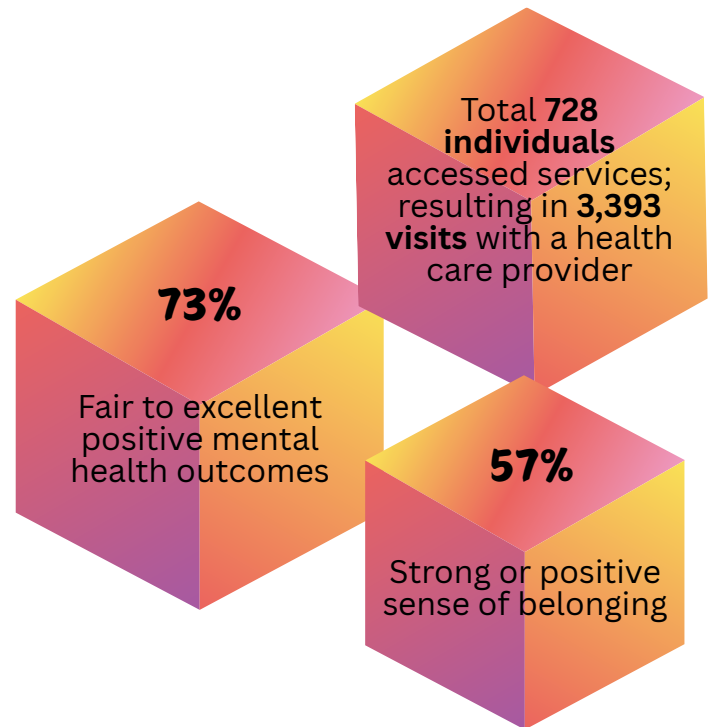


Our strategic priority is to support our local African, Caribbean, and Black (ACB) community. We hired a System Navigator and a Psychotherapist who are representative of the community and have experience serving the ACB community. Our staff are conducting outreach actively to connect with individuals and community leaders.

KESWICK SITE SERVICES

Located in one of the most geographically concentrated areas for health services in Georgina, our Keswick site continues to play a vital role in supporting the health and well-being of residents of Northern York Region. We provide system navigation, mental health counselling, nutrition counselling, physiotherapy, chiropody services and community health promotion programs.

In the 2025-2026 fiscal year, **a total of 728 individuals accessed services, resulting in 3,393 visits with a health care provider**, demonstrating both the reach and depth of care provided within the community.



Last year, we received 860 service requests from **122 referring primary care physicians, located primarily in Newmarket (30%) and Keswick (27%). Most clients referred were from Keswick (41%), followed by Newmarket (10%) and Sutton (9%),** highlighting these communities as key areas where residents rely on us for accessible, integrated health and social services.

These service requests show the growing need for chronic disease management, mobility support, mental health care, and preventative health services within the community. **Almost 59% of our clients reported moderate-to-low household incomes below \$60,000, highlighting the importance of affordable, community-based health services.**

Beyond service delivery, our programs continue to contribute meaningfully to quality of life and community involvement. Among clients accessing mental health services, **73% reported fair-to-excellent positive mental health outcomes. Additionally, 57% reported a strong or positive sense of belonging,** demonstrating the value of supportive, community-centered care in fostering resilience, well-being, and social inclusion. Through collaboration with healthcare providers, community partners, and residents, we continue to support the solo primary care physicians and to strengthen access to essential allied health services and improve outcomes for individuals and families across Keswick, Newmarket, Sutton, and surrounding communities.

Spotlight on Group Programs

Dedicated to Supporting Participants' Nutritional Health

The VCHC Health Promotion team and Community Dietitians worked together to provide relevant and engaging educational programs based on the needs we were hearing about from the community. Thirty-five (35) sessions on nutritional health were delivered over the span of 8 months. Individuals reported increases in knowledge and overall positive experience with the program.

Key Achievement

80% of participants learned something new about different types of digestive health issues.

100% of participants learned some tips to keep your digestive system healthy.

100% of participants can list two tips about digestive health.



"Go with Your Gut: Digestive Health Program" was designed for adults (aged 19+) wanting to learn about the digestive system. Participants in this program learned how to prevent and manage the following issues: Gastro Esophageal Reflux Disease/Heartburn, Irritable Bowel Syndrome/Small Intestinal Bowel Overgrowth, Constipation and Diarrhea, Diverticulosis and Diverticulitis, Gut Microbiome and Probiotics.

The **"Food Safety Program"** provided important information on food handling, preparation, food storage and how to prioritize food safety. Participants in this program learned about the potential risks of foodborne illnesses, the path our food takes from farm to plate, and all the steps needed to keep food safe, from purchasing and preparing, to safe storage. Topics such as personal hygiene, cross contamination, and minimum internal cooking temperatures were also highlighted. The program aimed to increase participants' confidence in their food safety knowledge.



FOOD SAFETY PROGRAM

Key Achievement

100% of participants learned something new about keeping food safe during purchasing, receiving, storing, preparing, cooking, and serving.

100% of participants learned some tips on how to protect themselves from foodborne illnesses.

100% of participants can list two preparation tips.

Spotlight on Group Programs

Dedicated to Supporting Participants' Nutritional Health

A virtual wellness program **"Weight, Diet and Health"** was designed to educate people on the role of healthy weight, proper weight management, and healthy eating in overall health. The weekly topics supported the goal of increasing nutrition knowledge and promoting healthy weight management, healthy eating, and prevention of chronic diseases.

WEIGHT, DIET AND HEALTH

Key Achievement

89% of participants learned about connection between weight and the development of chronic diseases

78% of participants reported they can differentiate between modern diets and proper weight management

100% of participants reported they can identify diet priorities for health and weight management

Key Achievement

90% of participants reported the program provided them skills to help save money at the grocery store

80% of participants reported feeling very confident in preparing a budget-friendly meal

100% of participants reported they had a good understanding of food labels

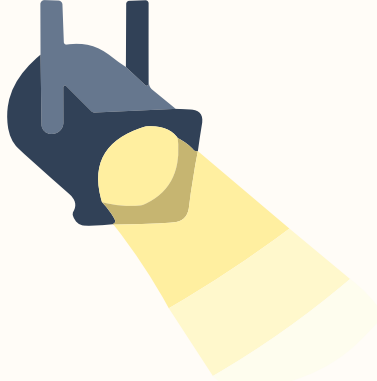
COOKING ON A BUDGET

Cooking on a Budget Series:

Our community health worker and dietitian at the Keswick location provided a cooking on a budget series in partnership with Georgina Food Pantry. The workshops provided an opportunity for individuals to meet in a safe, empowering environment where they can learn and share skills on food budgeting, meal planning, grocery shopping, and learn new healthy recipes.

Spotlight on Group Programs

Dedicated to Supporting Participants' Mental Wellness



The **Refresh Quiet Space Program** provided an opportunity for participants to learn mindful affirmations and teachings to reduce stress and promote mental wellness. The program offered guided meditation to help release stress.



REFRESH QUIET SPACE PROGRAM

Key Achievement

75% of participants reported the program has introduced them to different types of meditation practices

80% of participants reported the program provided a positive meditation practice

70% of participants reported the program has helped reduce stress through meditation

Key Achievement

100% of participants reported gaining a deeper understanding of their personal boundaries and learning various communication skills to strengthen their ability to express their boundaries.

67% of participants reported group activities effectiveness in demonstrating communication skills.

100% of participants reported feeling safe and free of judgement within the program.



SENSE OF SELF

The **Sense of SELF** program series highlighted strategies to navigate conflict through communication skills, to promote the growth of participants' positive relationships with others and themselves. The program provided participants with basic tools and building blocks to build on existing skills, foster healthy relationships, offer time for valuable reflection, and engage in interactive activities, all carefully selected to encourage a deeper understanding of self.

Dedicated to Supporting Children with Financial Literacy Education



The **Money Smart Kids** program was established to teach children how to manage money, build life skills and tools that will help them throughout their lives.

In the program, children come together to engage with others, learn financial literacy through interactive activities, and have fun.



MONEY SMART KIDS

Key Achievement

86% of participants understood that money has value, and it is earned and not just given.

Participants indicated a shift from asking an adult to buy their item to finding ways to earn/collect more money and do research on the items

50% of participants indicated they are involved in comparison shopping.

STUDENTS & VOLUNTEERS

**We couldn't have done it without
your generous support.**

**THANK YOU TO ALL OUR
STUDENTS AND VOLUNTEERS!**

Feedback from our students

Application process was clear and easy to complete

- **Strongly Agree: 86%; Agree: 14%**

Feel their efforts are valued at VCHC

- **Strongly Agree: 86%; Agree: 14%**

Training I received was relevant and useful

- **Strongly Agree: 100%**

Feel their talents and skills are being put to good use in the
program - **Strongly Agree: 100%**

Satisfied with my student experience at VCHC

- **Strongly Agree: 100%**



September 2025 to June 2026 Academic Year:

- 2 Coop students - Maple High School
- 1 Medical Office Administration - Academic of Learning Career College
- 2 Education - York University
- 1 Social Work - York University
- 1 Dietetic Intern - University of Toronto



MAKING IT SIMPLE TO USE OUR SERVICES

**Evening
appointments
and group
programs
available 3
days a week**

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




**Transportation
support**

**Appointment
email
reminders for
all services**



**On call after
hours service
for clients of
family doctors
and nurse
practitioners**

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

**In-person
and virtual
group
programs**


**In-person and
telephone
appointments**



**Secure email
communication
between clients
and providers**



**Language
Interpretation
Services**




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

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



**REPORT OF THE INDEPENDENT AUDITOR ON THE SUMMARY
FINANCIAL STATEMENTS**

To the Members of Vaughan Community Health Centre Corporation,

Opinion

The summary financial statements, which comprise the summary statement of financial position as at March 31, 2026, and the summary statement of operations and changes in fund balance, are derived from the audited financial statements of Vaughan Community Health Centre Corporation (the "Organization") for the year ended March 31, 2026.

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

- The information in the summary financial statements is in agreement with the related information in the complete financial statements; and
- The summary financial statements contain all the information necessary to avoid distorting or obscuring matters disclosed in the complete financial statements, including the notes therein.

Management determined that the statement of cash flows does not provide additional useful information, and as such has not included this as part of the summary financial statements.

Summary Financial Statements

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

The Audited Financial Statements and Our Report Thereon

We expressed an unmodified audit opinion on the audited financial statements in our report dated June 23, 2026.

Management's Responsibility for the Summary Financial Statements

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

Auditor's Responsibility

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

Hogg, Shain & Scheck PC

Toronto, Ontario
June 23, 2026

Authorized to practise public accounting by the
Chartered Professional Accountants of Ontario

VAUGHAN COMMUNITY HEALTH CENTRE CORPORATION**SUMMARY STATEMENT OF FINANCIAL POSITION**

<i>AS AT MARCH 31</i>	<i>2026</i>	<i>2025</i>
ASSETS		
Current Assets:		
Cash and cashequivalents	\$ 3,520,367	\$ 1,077,723
Accounts receivable	102,930	147,823
Prepaid expenses	80,289	59,423
	<u>3,703,586</u>	<u>1,284,969</u>
Capital Assets, net of amortization	<u>133,075</u>	<u>182,181</u>
TOTAL ASSETS	<u>\$ 3,836,661</u>	<u>\$ 1,467,150</u>

LIABILITIES AND FUND BALANCES

Accounts payable and accrued liabilities	\$ 346,600	\$ 223,855
Due to Ontario Health	3,270,294	994,857
Due to other funders	6,568	6,568
	<u>3,623,462</u>	<u>1,225,280</u>
Capital assets fund	<u>133,075</u>	<u>182,181</u>
Growth and development fund	<u>80,124</u>	<u>59,689</u>
	<u>213,199</u>	<u>241,870</u>

**TOTAL LIABILITIES AND FUND
BALANCES**

\$ 3,836,661 **\$ 1,467,150**

**SUMMARY STATEMENT OF OPERATIONS AND CHANGES IN
FUND BALANCE**

<i>FOR THE YEAR ENDED MARCH 31</i>	<i>2026</i>	<i>2025</i>
REVENUES		
Ontario Health	\$8,435,946	\$7,114,188
Miscellaneous	363,438	151,699
	<u>8,799,384</u>	<u>7,265,887</u>
EXPENSES		
Salaries, benefits and relief	6,642,875	5,436,362
General and operating	1,229,449	985,060
Occupancy costs	878,010	803,802
Amortization	49,106	62,247
Medical supplies	28,615	40,487
	<u>8,828,055</u>	<u>7,327,958</u>
DEFICIENCY OF REVENUES OVER EXPENSES	<u>(28,671)</u>	<u>(62,071)</u>
FUND BALANCE -BEGINNING OF YEAR	<u>241,870</u>	<u>303,941</u>
FUND BALANCE -END OF YEAR	<u>\$ 213,199</u>	<u>\$ 241,870</u>

OUR PARTNERS

Many thanks to our partners!

Our partnerships with a diverse range of organizations are vital to the delivery of our programs and services. By working together, we can provide the care and support our clients deserve and address the complex needs of the communities we serve.

- 
- Academy of Learning Career College - Etobicoke Campus
 - ANCHOR Canada
 - Anida Foodbank
 - Bernard Betel Centre
 - CAYR Community Connections
 - Community & Home Assistance to Seniors
 - Circle of Care
 - City of Vaughan
 - COSTI Immigrant Services/Vaughan Welcome Centre
 - Elspeth Heyworth Centre for Women
 - Georgina Food Pantry
 - Grand Genesis Medical Centre
 - Health Commons Solutions Lab
 - Human Endeavour
 - Humanity First Food Bank
 - Ivory Medical
 - Kids Up Front
 - Mackenzie Health Hospital
 - Maple High School
 - Markham Stouffville Hospital/Oak Valley Hospital
 - Miracle Arena for All Nations
 - Mount Sinai Academic Family Health Team
 - Nigerian Canada Association
 - Newmarket African Caribbean Canadian Association (NACCA)
 - Social Enterprise for Canada (SEC) & EarlyON Child & Family Centers
 - The Health Centre of Maple
 - The Regional Municipality of York
 - University of Toronto
 - Vaughan Public Libraries
 - VIP Medical Centre
 - Vitanova Foundation
 - Woodbridge Medical Centre
 - Western York Region Ontario Health Team
 - York Region Alliance of African Canadian Communities (YRAACC)
 - York Region District School Board
 - York University

Snapshots of the year

Primary Health Care Expansion Announcement



Vietnamese Association Canada Day event



Indigenous Day event



Snapshots of the year

Black History Month event



VCHC-Vaughan Open House



VCHC - Keswick Open House



CONTACT US

VAUGHAN SITE

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Vaughan, ON, L6A 4H7**

Phone: 905-303-8490

Admin fax: 905-303-9444

Clinical fax: 905-832-0093

**Chronic Disease Program fax:
905-303-0320**

**Allied Health-PACT fax:
905-303-4922**

KESWICK SITE

**716 The Queensway South,
Keswick, ON, L4P 4C9**

Phone: 905-476-5621

Fax: 905-476-3008

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For more information, visit:**



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**Ontario
Health**



VAUGHAN
COMMUNITY HEALTH CENTRE

A Different Kind of Healthcare

