District of Nipissing Social Services Administration Board

Conseil d'administration des services sociaux du district de Nipissing

COMMUNITY SERVICES COMMITTEE MEETING AGENDA

Healthy, Sustainable Communities

Date: **Wednesday, March 22, 2023**

Time: **12:00 PM**

Location: **In person in DNSSAB Boardroom or virtually via link below:**

Join Zoom Meeting
https://us06web.zoom.us/j/86281331449?pwd=ZEwwUjdDeU9nNGZvWlNxU0Z0QlRDZz09

Meeting ID: 862 8133 1449
Passcode: 63128028
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Councillor Melanie Chenier, Mayor Peter Chirico, Councillor Maggie Horsfield, Councillor Terry Kelly, Councillor Mark King, Councillor Justine Mallah, Councillor Chris Mayne, Councillor Lana Mitchell, Mayor Dan O'Mara.

Item	Topic
1.0	**1.1 CALL TO ORDER - ROLL CALL** **1.2 Declaration of Conflict of Interest**
	1.3 Elect Committee Chair **A) Call for Nominations** **MOTION #CS2023-01** THAT _____ accept the nomination(s) for Chair.

Item	Topic
	B) Call for Vote **MOTION #CS2023-02** THAT _____ be the elected Chair of the Community Services Committee for the term ending December 31, 2026. **1.4 Elect Committee Vice Chair** **A) Call for Nominations of the Vice Chair** **MOTION #CS2023-03** THAT _____ accept the nomination(s) for Vice Chair. **B) Call for Vote** **MOTION #CS2023-04** THAT _____ be the elected Vice Chair of the Community Services Committee for the term ending December 31, 2026.
2.0	**OPENING REMARKS**
3.0	**APPROVAL OF THE AGENDA (March 22, 2023)** **MOTION #CS2023-05** THAT the Community Services Committee accepts the Agenda as presented.
4.0	**DELEGATIONS** 1. **Built For Zero Canada –** by Robyn LeBlanc **HS05-23 Building for Functional Zero - Homelessness System Update** **MOTION #CS2023-06** WHEREAS report HS05-23 provides an update on the Homelessness System and implementation of Built for Zero (BFZ); a data-driven approach to ending Chronic Homelessness, including an update on the current shelter system capacity; and, WHEREAS there remain visible gaps in service for the homeless across the district; BE IT RESOLVED THAT the Board approves attaining the services of an outside consultant to complete a feasibility study and potential business model for an unsheltered hub within the of North Bay and to review and recommend pathways and suppports for homeless individuals throughout the district; and, THAT, the study be funded from the affordable housing reserve up to a maximum of $40,000.

Item	Topic
	2. **CS01-23 CWELLC Space Allocation Plan –** by Lynn Démoré-Pitre and David Plumstead **MOTION #CS2023-07** That the District of Nipissing Social Services Administrative Board (DNSSAB) accepts Briefing Note CS01-23 for information purposes.
5.0	**CONSENT AGENDA -** *All items in the consent agenda are voted on collectively. The Chair will call out each item for consideration of discussion. Any item can be singled out for separate vote; then, only the remaining items will be voted on collectively.* **MOTION #CS2023-08** THAT the Committee receives for information Consent Agenda item 5.1 to 5.3. **5.1 HS06-23 – Response to Bill 23, More Homes Built Faster Act, 2022** – This report provides details on the Association of Municipalities Ontario (AMO) response to Bill 23, More Homes Built Faster Act, 2022, for information purposes. **5.2 SSE01-23 MCCSS Modernization Update** - Information Report SSE01-23 provides an update on the implementation of the Ministry of Children, Community and Social Services (MCCSS) Ontario Works modernization initiatives in Nipissing District. **5.3 B14-23 Strategic Activities of the 2019-2022 Board Term -** an overview of the activities of the 2019-2022 Board term as they relate to the long-term goals of the 2022-2042 Strategic Plan, for information.
6.0	**MANAGERS REPORTS**
	6.2 B10-23 Mobile Nurse Practitioner Pilot Program Evaluation and Final Report **MOTION #CS2023-09** THAT the District of Nipissing Social Services Administration Board (DNSSAB) accepts the Mobile Nurse Practitioner Pilot Program Evaluation and Final Report included in the appendix of Board Report B10-23 and that staff carry out the report's recommendations.
	6.3 PS03-23 Response Time Standards **MOTION #CS2023-10** THAT the District of Nipissing Social Services Administration Board (DNSSAB) accepts the Ontario Ambulance Response Times Standards (RTS) and compliance for 2022.
	OTHER BUSINESS

Item	Topic
	NEXT MEETING DATE Wednesday, April 26, 2023
7.0	**ADJOURNMENT** **MOTION #CS2023-11** *Resolved* THAT the Community Services Committee meeting be adjourned at____ PM.

Nipissing District Board Built for Zero Intro

Mar 2023

Nice to meet you!

Robyn LeBlanc (she/her)

Improvement Advisor

THE CANADIAN ALLIANCE TO END HOMELESSNESS

The CAEH leads a national movement of individuals, organizations and communities working together to end homelessness in Canada.

caeh.ca

Advocacy

The CAEH advocates for the federal and provincial policy changes needed to end homelessness.

Allied Networks

The CAEH supports several allied networks working toward our shared mission of ending homelessness.

Built for Zero Canada

Helping a core group of leading communities end chronic and veteran homelessness.

bfzcanada.ca

Data & Policy

Revolutionizing the way communities and governments use data to end homelessness.

National Conference on Ending Homelessness

Join us for the 2023 National Conference on Ending Homelessness, Nov 8-10 in Halifax.

conference.caeh.ca

Training & Technical Assistance

Helping communities and organizations end homelessness with expert training and technical assistance.

training.caeh.ca

Journey to Zero

REAL-TIME DATA

Homelessness is constantly changing. You'll start by building a comprehensive, real-time, by-name list of all known people experiencing homelessness in your community.

REDUCE TO ZERO

There's no one-size-fits-all solution. You'll learn the science of rapid cycle testing to find out what works to reduce and end homelessness in your community.

ZERO FOR ALL

Sustainability is the real end game. After reaching your first zero, you'll focus on maintaining your progress as you expand your focus to new populations.

LEADERSHIP, LOCAL TEAM, BUILDING THE WILL, DEVELOPING COMPLEX PROBLEM-SOLVING SKILLS

The “shift” is happening

2017

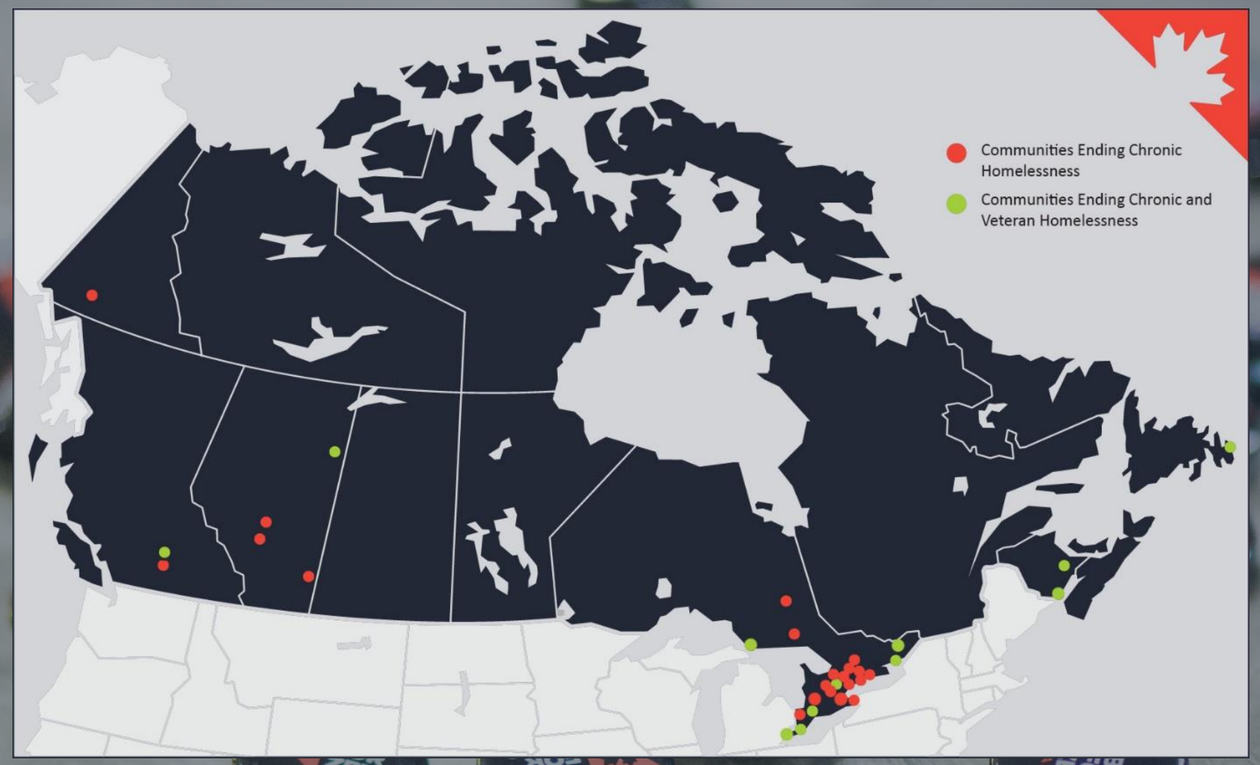
First quality By-Name Lists confirmed in Canada. No one knew what a By-Name List was. Lots of skepticism.

2019

Federal government requires all Designated communities to develop Coordinated Access, implement HIFIS, and report BNL data as outcomes. Sets target to cut chronic homelessness by 50%. In 2020, commits to fully ending chronic homelessness.

2021

Ontario requires all communities to develop BNL by December 2021. Project in federal budget for veteran homelessness



79

61 communities are being supported by Built for Zero Canada (40 BFZ-C + 21 ON BNL)

18 communities are being supported by Training and Technical Assistance

32

communities have achieved **quality real-time data**

26

communities have quality **coordinated access systems**

9

communities have reduced **chronic or veteran homelessness**

3

Communities have **ended veteran** or **chronic homelessness**

Refreshing the Understanding of BFZ-C Reduce

Old Frame

Its only about chronic homelessness

New Frame

Whole systems, sub-populations & next population

Old Frame

BFZ-C is a side project

New Frame

BFZ-C is a movement and methodology intended to support your overall goals and work

Old Frame

We have to constantly create new projects

New Frame

Lean into existing improvement projects aligned with your goals

Old Frame

BFZ-C is just filling in a bunch of boxes and doing PDSAs

New Frame

Lean into those areas for greatest impact in your system and towards a continuous improvement response discipline

Robyn LeBlanc,
Improvement Advisor
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bfzcanada.ca **#bfzcanada**

@endinghomelessness
@CAEHomelessness
@CAEHomelessness
Canadian Alliance to End Homelessness

District of Nipissing Social Services Administration Board | Conseil d'administration des servicessociaux du district de Nipissing

BOARD REPORT HS05-23

☐ For Information or ☒ For Approval

Date: March 22, 2023

Purpose: **Building for Functional Zero - Homelessness System Update**

Prepared by: Stacey Cyopeck, Director, Housing Services

Reviewed by: Justin Avery, Manager of Finance

Approved by: Catherine Matheson, Chief Administrative Officer

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Alignment with Strategic Plan: Healthy, Sustainable Communities

☒ Maximize Impact ☒ Remove Barriers ☒ Seamless Access ☒ Learn & Grow

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RECOMMENDATION

BE IT RESOLVED THAT the Board receives report HS05-23, providing an update on the Homelessness System and implementation of Built for Zero (BFZ); a data-driven approach to ending Chronic Homelessness; and,

WHEREAS there remain visible gaps in service for the homeless across the district; and,

BE IT RESOLVED THAT the Board approves attaining the services of an outside consultant to complete a feasibility study and potential business model for an unsheltered hub within the City of North Bay and to review and recommend pathways and supports for homeless individuals throughout the district; and,

THAT the study be funded from the affordable housing reserve up to a maximum of $40,000.

BACKGROUND

- **2014** - The District of Nipissing Social Services Administration Board (DNSSAB), with input from communities and citizens across the District, created *A Place to Call Home: Nipissing District 10 Year Housing and Homelessness Plan 2014-2024*.

  The plan is reviewed annually, and a fulsome evaluation of progress was conducted in 2019, at the halfway point of the plan. The five-year review noted the following needs in the district:

  - More emergency shelter beds for homeless men;
  - Transitional housing programs for adults;
  - Supportive discharge planning from hospitals and correctional facilities;
  - Supports for at-risk individuals tied to housing

- **2019 -** The Report from the Mayor's Roundtable on Mental Health and Addictions' Action Team noted the need for integration of Social Services and mental health and addiction services for vulnerable populations with the creation of a "Transitional Housing and Stabilization Centre"[1]

- **2020 -** The COVID-19 Pandemic presented significant challenges for both service providers and recipients. Time-limited, pandemic-specific Federal and Provincial funding offered opportunities to meet goals identified in the 10-Year plan and those from the Mayor's Roundtable.

- **2020, 2021**- Homelessness counts were conducted in 2020 and 2021. The 2020 count identified 293 homeless individuals in the District. In 2021, the homelessness count increased by seven, totalling 300.[2]

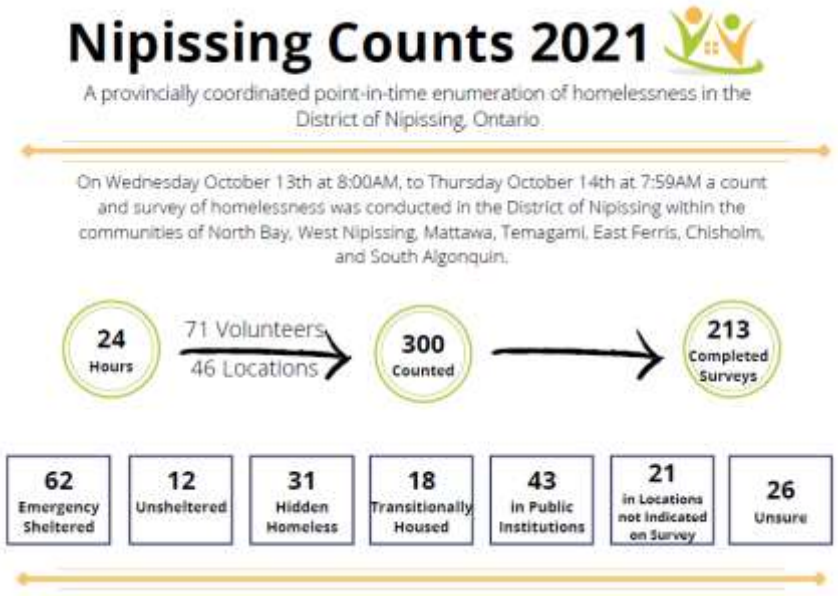


Figure 1 – Nipissing Counts 2021 Results Infographic

The homelessness count in 2021 was also used as a starting point in the creation of the District's By-Name List (BNL); a tool that can be utilized to identify best matches for housing and support resources for homeless individuals and households.

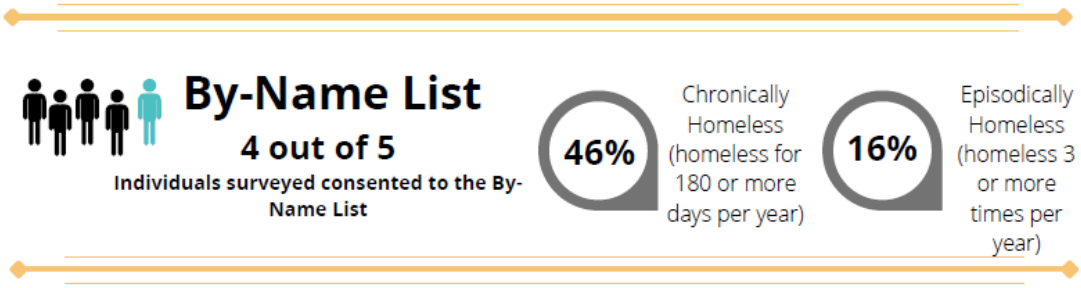


Figure 2– Nipissing Counts 2021 By Name List Infographic

Homeless Migration in the District

During the COVID-19 pandemic, concerns were raised about homeless individuals travelling between communities and adding financial and social pressures on the already challenged capacity of shelter and support services within the District. In an effort to address this concern, additional survey questions were added pertaining to where the respondents lived before moving to the

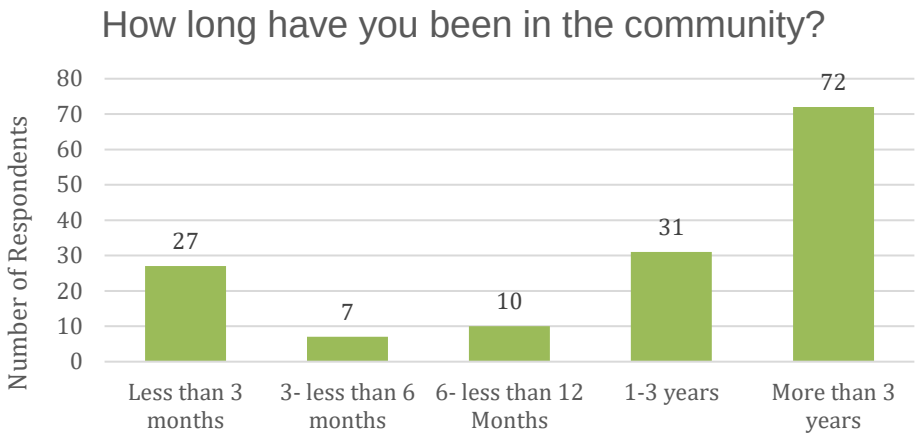
[1] Report from the Mayor's Roundtable on Mental Health and Addictions' Action Team p 9

[2] Everyone Counts 2020, Nipissing Counts 2021

Nipissing District (if applicable), how long ago they moved to the District and the reasons behind their migration.[3]

Reasons for Migration:

Respondents were asked how long they had been in the community. The results from their responses can be found below. Of the 213 survey respondents, 27 (13%) indicated that they had just recently (within the last three months) moved to the District.



To understand why individuals experiencing homelessness travelled to the Nipissing District, the indicated reasons for moving were examined. Respondents were asked, “What is the main reason you came to the community?” The reasons given are listed below in order of response frequency. Of the 27 individuals who indicated that they had moved to the District within the previous three months, 19 (70%) indicated that they had moved to the area for reasons not directly related to homelessness, including incarceration and family.

Indicated Reason	Number of Responses	Percentage of Respondents
Family moved here	35	24%
Reason not on survey	28	19%
Visit friends/family	16	11%
To find housing	13	9%
Access emergency shelters	10	7%
To attend school	8	5%
Incarceration	7	5%
Personal safety reasons	6	4%
Access services and supports	6	4%
Seeking employment	5	3%
Secured employment	4	3%
Attend court	1	1%
Environmental displacement	1	1%
Recreation	1	1%
Decline to answer	6	4%
Total	**147**	**100%**

[3] Nipissing Counts 2021 – Final Report Section 3.4.5 – Migration p 23

CURRENT STATUS/STEPS TAKEN TO DATE

Homelessness Service Capacity

Over the last several years, and particularly during the pandemic, there has been an acknowledged and evident increase in the number of households experiencing homelessness, especially those with additional barriers including mental illness and substance use issues. A corresponding lack of capacity within the housing sector and the homelessness shelter and service system has continued to be identified as barriers and priorities. Pandemic specific funding, both Provincially through SSRF and Federally through Reaching Home, has been used to mitigate the ongoing financial risks of these increases. The same funding has been used to create new transitional housing units and support service pilots.

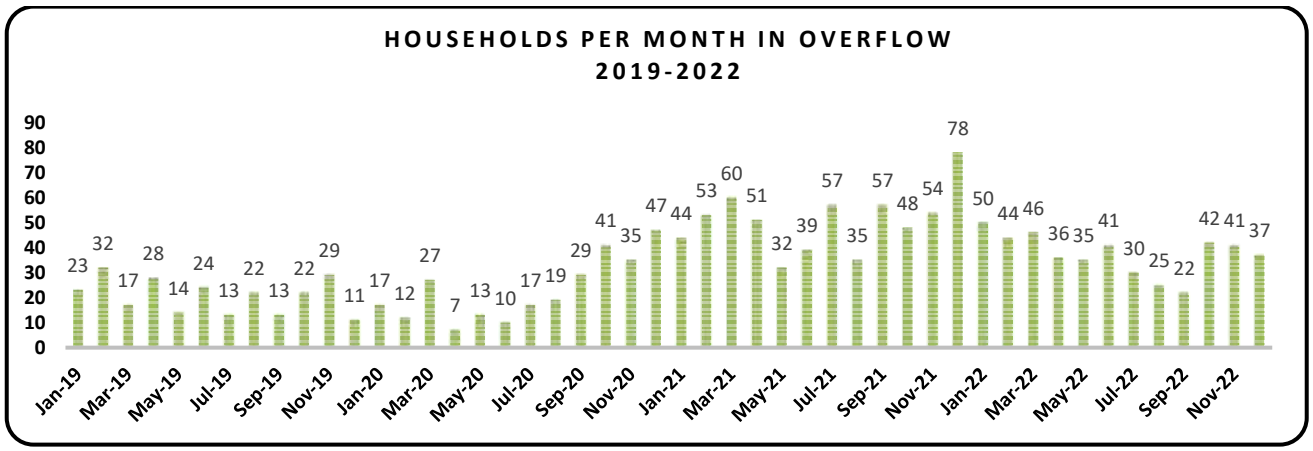


Figure 3 – Overflow Use 2019-2022

An Overflow Policy, introduced and approved in 2022, mitigates use of hotel overflow as new resources are introduced within the system. A flexible implementation plan for the policy has been designed around the introduction of new transitional housing units. With the opening of Northern Pines Phases 1, 2 and 3, Suswin Village and the family overflow units through NDHC, hotel overflow will only be required for families with children and in crisis displacement circumstances.

Homelessness Shelter Use and Capacity - 2022:

Hotel Overflow Use by Household - 2022		
Size of Household	**# of Unique Households**	**# of Bed Days**
1	126	3951
2	34	1269
3	15	887
4	9	421
5	7	461
6	6	262
7	1	23
Total	**198**	**7274**

Figure 4 - Hotel Overflow Use in 2022

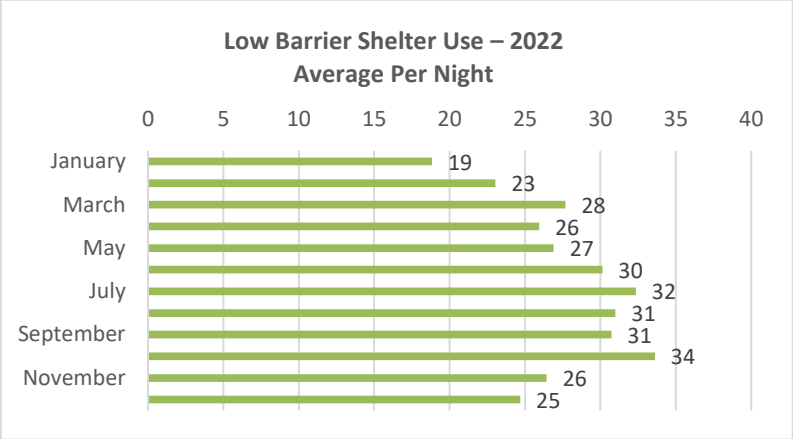


Figure 5 Low Barrier Shelter Use – 2022 - Average Per Month

Current Wait lists for Northern Pines Phase 1 and 2 January 2023	
NP 1	52
NP 2	35
Total*	87

*18 individuals are on both wait lists

Figure 6 – Wait Lists for Northern Pines 1 and 2 - January 2023

The day-time warming centre, temporarily located at 590 Chippewa, averages 30 to 35 individuals per day.

Homelessness Action Plan Results:

With a commitment to advance the overall goal of the 10 Year Housing and Homelessness Plan, the *Homelessness Action Plan* (HAP) was created and approved by the DNSSAB in October of 2021.

The year-long plan, consisting of 42 measurable, time-specific goals to implement the strategies contained in the 10 Year Housing and Homelessness Plan, ended in December of 2022.

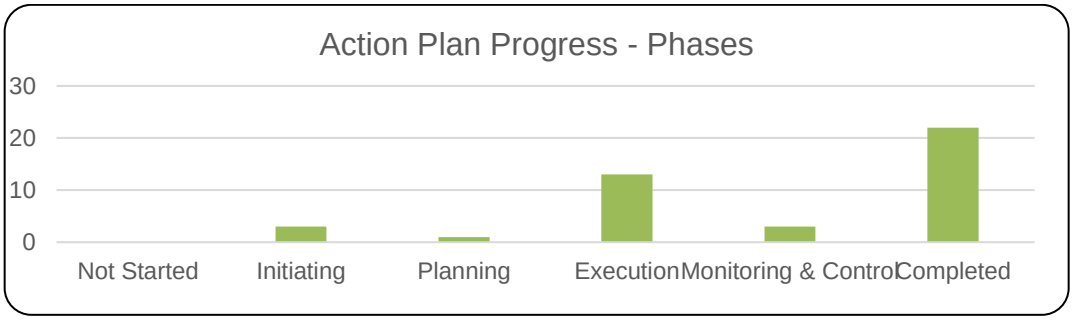


Figure 3– Homelessness Action Plan Results

Twenty-two action items have been completed during the 12-month lifespan of the Action Plan. This is a significant achievement. Major highlights include:

- Nipissing District became a Built for Zero Canada member community with the goal of ending chronic homelessness in the District. A By-Name List of homeless individuals in the Nipissing District was developed and is active.
- A Data Sharing Agreement is in place with all agencies participating in HIFIS 4.0.
- HIFIS 4.0 officially went live with Phase 1 Coordinated Access Nipissing members on July 1st. The Low-Barrier Shelter was stabilized with funding through to the end of the Action Plan.
- The North Bay Mobile Nurse Practitioner pilot and the Housing Unit Stability and Recovery pilot provided health and crisis services in the community.
- The Northern Pines transitional and supportive housing campus was officially announced at a ribbon-cutting ceremony on April 21, 2022.
- Nipissing District Housing Corporation became the new owners and landlords of Mackay Homes; ensuring that these affordable housing units are sustained in the community.
- Northern Pines Supportive Transitional Housing:
  - Phase 1 achieved occupancy - added 16 transitional units offering mid-range level supports.
  - Construction of Phase 2 neared completion. Funded through the Social Services Relief Fund Phase 2 (SSRF P2) and the Ontario Priorities Housing Initiative (OPHI), this phase consists of 20 units offering low-level supports.
  - Construction of Phase 3, funded through SSRF P4 and reserve, is nearing completion and will provide 24 units. Phase 3 also includes space for clinical services and on site health supports.
- The Coordinated Access Nipissing Team, comprised of community front-line workers, meets weekly to conduct action-based, District-wide case conferencing for individuals or households on the BNL.
- The Unsheltered Task Group, a sub-committee of the Community Advisory Board, meets weekly to coordinate responses for individuals living unsheltered and in encampments and helps to coordinate service delivery on a District-wide scale.

Built for Zero (BFZ) Implementation:

In June 2022, the Nipissing District Homelessness and Housing Partnership **(**NDHHP) Community Advisory Board (CAB) recommended becoming a Built for Zero (BFZ) Community. Funding for the membership was approved through Reaching Home, and the application was accepted by the Canadian Alliance to End Homelessness (CAEH) and BFZ. BFZ is a National and International movement that provides resources and guidance to communities as they work toward their goals of ending homelessness. Nipissing's BFZ goal is to reach Functional Zero for Chronic Homelessness by 2025.

The components of becoming a BFZ community align with the requirements of both the Federal Reaching Home (RH) program and Provincial Homelessness Prevention Program (HPP) and include the implementation of a Quality By Name List (QBNL) and Coordinated Access. In the first three months of 2023, the District fulfilled the basic requirements for Coordinated Access and the BNL, including the completion of the Coordinated Access Nipissing Guide and the development of the CAN Team and basic Housing Resource Inventory to be used in the matching process.

BFZ's requirements include more comprehensive structures and detailed processes to be achieved to reach full compliance. The Housing Resource Inventory template created in Nipissing has been shared with other communities as an example, and now requires full completion for the District, since the current resources listed are those of CAN partner agencies only.

BFZ Canada is working with the Nipissing BFZ Change Team to guide the creation of the District's Action Cycle plans to reach functional zero for Chronic Homelessness by 2025.

On March 1st and 2nd, 2023, CAB and BFZ Change Team members attended the BFZ Learning Session in Toronto with other BFZ communities from across Canada. At the end of the learning session a goal plan was created for the next six month Action Cycle that was then taken to the CAB for consultation and approval at the March 8th, 2023 meeting. These Action Cycle goals are outlined below:

Finalization of the Quality By Name List (QBNL):

Required Tasks:

- Development and adoption of a process that ensures 90% of households experiencing homelessness are given the opportunity to be added to the By Name List.
  Actions required:
  - Forums/discussions with all municipalities in District
  - BNL Blitz/Magnet Events to connect with community Members and households experiencing homelessness
- Develop 24/7 District-wide process for calls/contacts concerning homelessness, including triage and assessment (HIFIS), and in-person responses.
  Actions Required:
  - Establish contact methods, Agency responsibilities
  - Implement process
  - Communicate process throughout District
- Complete the Housing Resource Inventory for the District
  Actions Required:
  - Create and distribute a survey to go out to community service and housing providers across the District asking them to detail the numbers and kinds of housing and supports that they offer and the eligibility criteria for each so that it can be added to the Housing Resource Inventory.
  - Transfer information from surveys into Housing Resource Inventory Workbook

Recent Rulings and Recommendations affecting Homelessness Response:

On Friday, January 27, 2023, the Ontario Superior Court of Justice issued a ruling that the City of Waterloo could not evict individuals living in an encampment on city-owned land unless there was capacity in the shelter and housing system for all of those living in the camp.[4] This ruling is one of a number of rulings that have been issued across Canada that correspond with a housing-focused, and human rights-based approach to homelessness.[5]

In January 2023, the Canadian Alliance to End Homelessness issued a White Paper recommending that the Federal Government adopt a Homelessness Prevention and Housing Benefit to "accelerate exits from homelessness and prevent new inflows into homelessness" based on the Right to Housing.[6]

On February 3, 2023, the Ontario Human Rights Commission issued a statement on human rights and access to cold Weather Services.[7] The OHRC announced the "need to protect and uphold the rights for people experiencing homelessness and living in temporary shelters and encampments".

In September 2022, the Community Advisory Board (CAB) recommended that unallocated funds from Reaching Home be prioritized for the creation of an "Unsheltered Hub" that would be open all year

[4] Region of Waterloo v Persons Unknown CV-22-717- Reasons for Judgment - 27Jan2023 Valente J

[5] A National Protocol for Homeless Encampments in Canada: A Human Rights Approach; UN Special Rapporteur on the right to housing – April 30, 2020

[6] https://caeh.ca/wp-content/uploads/Homelessness-Prevention-and-Housing-Benefit-Policy-Whitepaper-CAEH.pdf

[7] https://www.ohrc.on.ca/en/news_centre/ohrc-statement-human-rights-and-access-cold-weather-services

(funding permitting) and mitigate weather related risks for those living rough. The Unsheltered Hub would provide a one stop access point for individuals to be added to the By Name List (BNL) and connected with Coordinated Access Nipissing Services and supports.

The current shelter system continues to be at capacity most nights, especially during extreme weather. Specifically, the low barrier spaces that would best fit individuals coming from encampments, are beyond capacity every night and, as 12 hour overnight spaces requiring individuals to find somewhere else to be during the day, do not fit the required risk mitigation requirements of the Ontario Superior Court ruling. The ruling does not indicate that unsanctioned encampments on public lands cannot be moved or closed at all; it simply states that there must be appropriate 24/7 options available to residents of the encampment that mitigate the risks of them being moved.

RECOMMENDATION

DNSSAB staff recommend issuing an RFP to complete a feasibility study and a potential business model for a 24/7 unsheltered hub for the city of North Bay, and investigate various models that exist in other communities, including other BFZ communities, that could be adopted locally and that would comply with the recent recommendations and rulings. This study will also include a review of homelessness supports and pathways including emergency shelter, warming site and outreach services district-wide.

Some of the models that should be explored include:

The Windsor Homelessness and Housing Help Hub (H4):

Opened in April 2020. The original project vision can be found here: Council Report.

The City of Windsor is exploring the feasibility of re-homing, and re-imagining the H4 facility as a permanent community asset, and is in the process of identifying potential locations for a new Housing Hub. The latest council report and project update can be found here: Project Update.

Medicine Hat's Housing First Approach:

Initiated in 2009 this data-driven, housing-first approach with supports to address other issues they may be facing. Last year, through this model, officials said shelter use dropped by 64% overall since 2009.[8]

Charlottetown's Modular Shelter:

Providing low-barrier, gender-inclusive, pet-friendly units with accessibility support. It is open to adults, with particular emphasis on couples and people with pets."[9]

Chilliwack Community Services:

The Village Transitional Housing[10]

Chilliwack has implemented modular Transitional Housing for youth with onsite supports.

https://www.comserv.bc.ca/youth-housing/

OrgCode's Housing Focussed Low Barrier Shelter Model:

[8] Medicine Hat – Housing First https://nextcity.org/urbanist-news/medicine-hat-alberta-canada-city-chronic-homelessness#:~:text=Putting%20Housing%20First,build%20self%2Dreliance%20once%20housed.

[9] https://www.saltwire.com/atlantic-canada/news/new-shelter-opens-in-charlottetown-offering-gender-inclusive-pet-friendly-units-with-accessibility-support-100804379/

[10] https://www.comserv.bc.ca/youth-housing/

Shelters are a critical part of the crisis response system, and when operated effectively have a strong housing orientation which have the shortest possible lengths of stay and the least number returns to shelter in the future possible.[11]

CONCLUSION

Throughout the past year, Nipissing has continued to move ahead with the goals within the 10 Year Housing and Homelessness Plan and the Homelessness Action Plan (HAP). In one year, the District has reached 50% of the action items in the HAP and added new Transitional and permanent housing to the District's portfolio of Housing Resources.

In June, a further step was initiated when the District joined BFZ. The next step is to begin the implementation of processes and prioritization that will create a seamless continuum of housing and support options for vulnerable individuals living in chronic homelessness across the district.. The District's BFZ plan will use data from the BNL and HIFIS to identify the gaps and barriers that will need to be addressed before the District can move toward its goal of reaching functional zero for chronic homelessness by 2025.

With approval from the Board, DNSSAB staff will issue a RFQ/RFP to complete a feasibility study and potential business model that exists in other communities that could be adopted locally.

[11] Org Code Housing Focused Sheltering – November 21, 2017

Children's Services

Canada-Wide Early Learning and Child Care

Nipissing's Space Allocation Plan

District of Nipissing Social Services Administration Board

Conseil d'administration des services sociaux du district de Nipissing

Background

- On March 28, 2022, the Governments of Ontario and Canada signed the Canada-Wide Early Learning and Child Care (CWELCC) Agreement.

- The objectives of the agreement include:
  - Reducing parent fees for licensed early learning and child care and reaching an average parent fee of $10 a day by 2025-26 for licensed child care spaces;
  - Creating 86,000 new high-quality, affordable licensed child care spaces (relative to 2019 levels), predominantly through not-for-profit licensed child care;
  - Addressing barriers to providing inclusive child care; and
  - Valuing the early childhood workforce and providing them with training and development opportunities.

Children's Services

Background

- On December 19, 2022, the Ministry of Education issued a memo related to the Access and Inclusion Framework and Notional Space Targets.
- Under the framework, the ministry has also developed a model to allocate spaces and funding for the creation of licensed child care spaces for children from infancy up to 5 years of age.
- This model provides notional space allocations for expansion of licensed child care services with a focus on improving access to services to a common provincial access ratio of 37%.
- Service system managers were asked to review their notional space expansion targets, identify priority neighbourhoods for CWELCC funding and submit a plan to the ministry by January 20, 2023.

District of Nipissing Social Services Administration Board
Conseil d'administration des services sociaux du district de Nipissing

Children's Services

Notional Space Allocation

- The ministry provided DNSSAB with a notional space allocation of **109 spaces** for the district from 2022 to 2026.
  - 73 form part of the school-based space allocation
  - 36 represent the community-based allocation

- Some spaces are already operational and planning for others are well underway.
  - In 2022, 13 JK/SK spaces (Redbridge) and 13 JK/SK community-based spaces (North Bay) were created.
  - A school-based project is currently underway for the 73 spaces, creating an additional 53 net new school based spaces (North Bay – Fricker Project)

- 30 community based spaces must be planned for by end of 2026.

District of Nipissing Social Services Administration Board
Conseil d'administration des services sociaux du district de Nipissing

Children's Services

Notional Space Allocation

- The provincial space allocations vary widely across Ontario's 47 service managers, from 109 spaces in Nipissing District to 7,261 spaces in Peel.

- Since DNSSAB received the lowest number of spaces in the province, staff did a review and analysis of the data.

- At the time of the analysis the provincial formula for space allocation was unknown.

District of Nipissing Social Services Administration Board
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- Although 109 licensed child care spaces appears relatively low, it becomes more reasonable when looking at other factors.

- For example, when taking the current provincial share of licensed child care spaces and the children's population (ages 0-5) in to account, the allocation is adequate relative to Ontario's other service managers.

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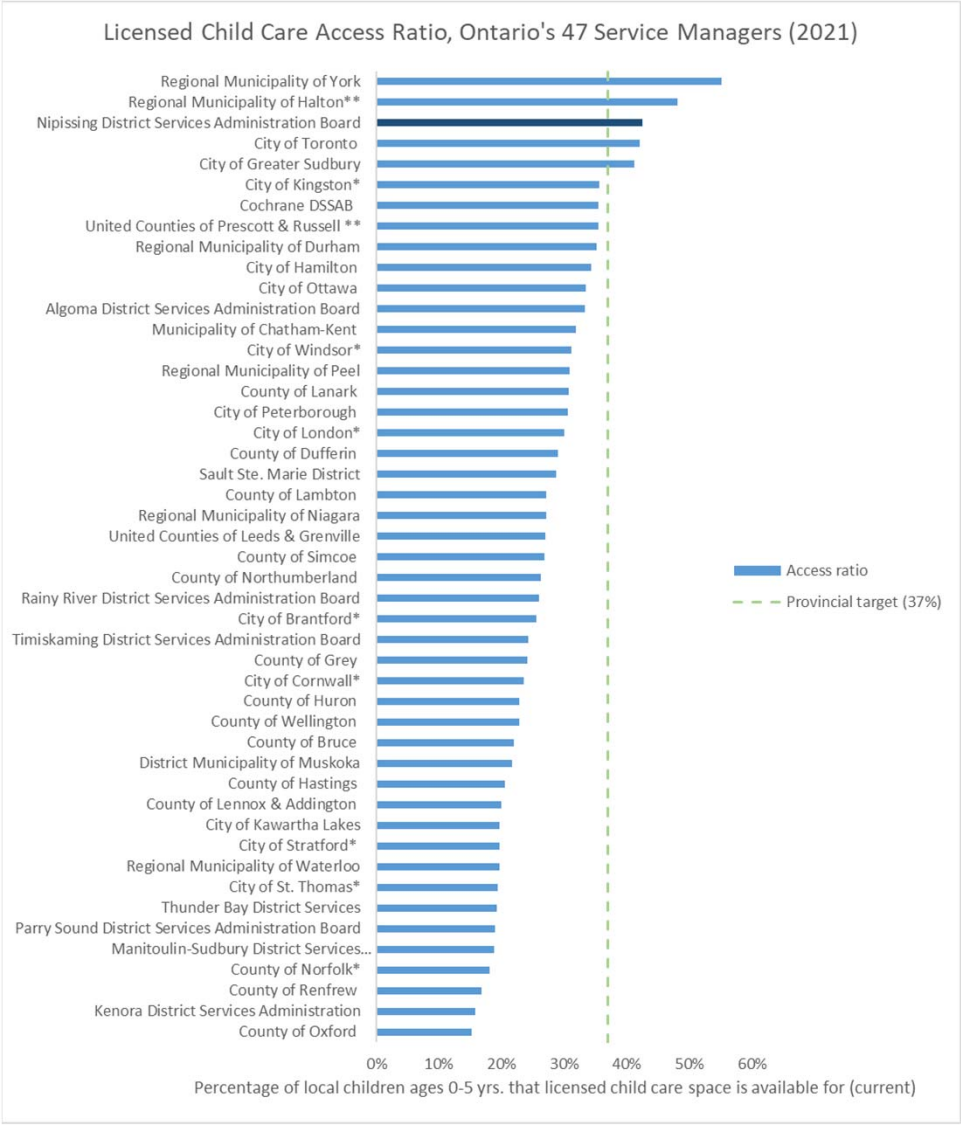
Children's Services



- Additionally, when considering the provincial access ratio target of 37% across the province, Nipissing currently has one of the highest ratios amongst service managers.

- The Nipissing DSSAB has licensed child care spaces available for 42.5% of the children ages 0-5 years in the district. This exceeds the ministry's provincial access target of 37.0%.

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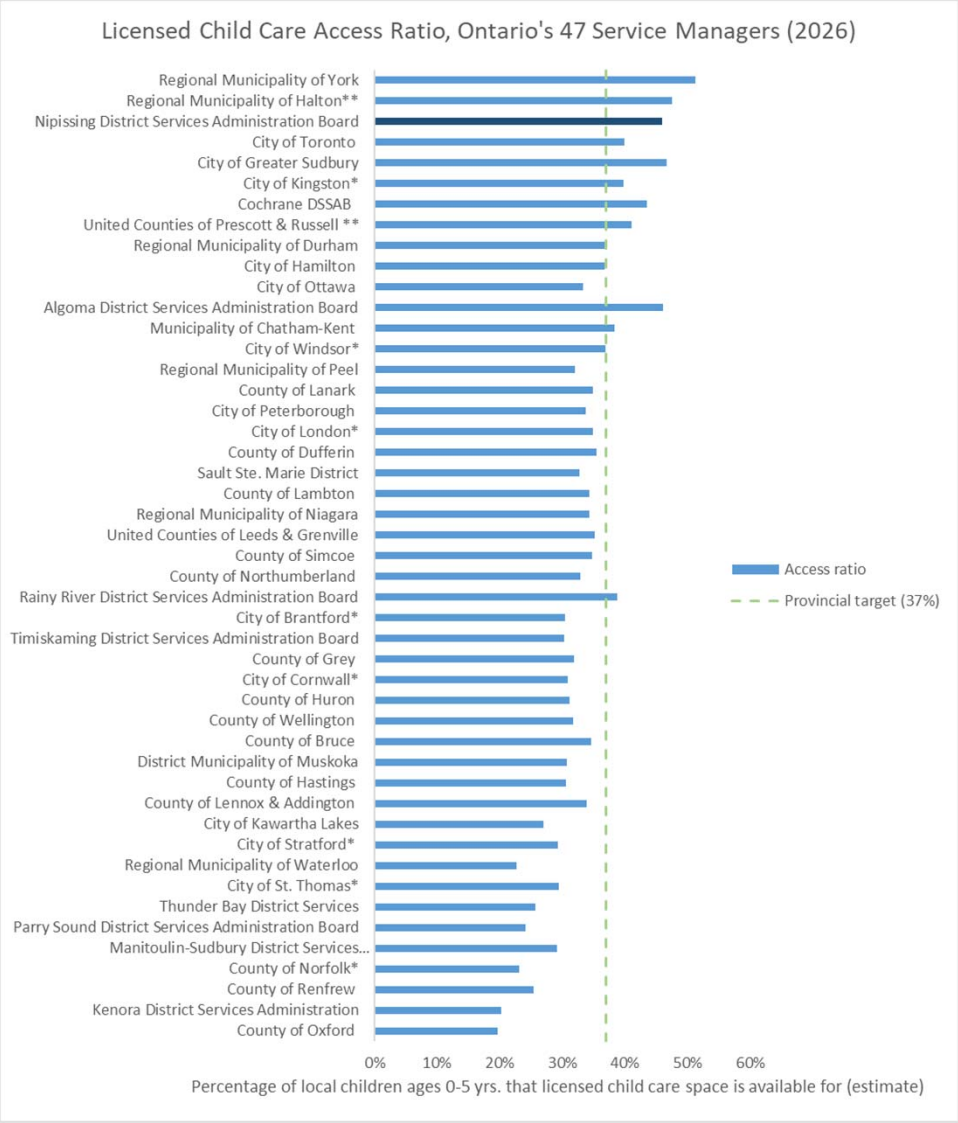

- By the end of the Canada – Ontario CWELCC agreement in 2026 the Nipissing access ratio will still be one of the highest in the province.

- Thus, the Ministry of Education's CWELCC space allocations appear reasonable and equitable
  from a population and capacity-based approach.

- In terms of targeted space creation for vulnerable children in low-income families and other demographic groups, Nipissing has a case for additional spaces based on the relatively high numbers in these areas.

District of Nipissing Social Services Administration Board
Conseil d'administration des services sociaux du district de Nipissing

CWELCC Space Allocation Plan

- DNSSAB indicated a willingness to work with the Ministry of Education in order to expand the licensed child care sector within the Nipissing District beyond the existing space allocation.

- To determine the areas of greatest need the following data sets were considered:
  - access to care,
  - census demographics,
  - population projections,
  - District's waitlist for licensed child care services, etc.

- DNSSAB also took into account the biggest challenge that the sector is facing – staff recruitment and retention.

Children's Services

CWELCC Space Allocation Plan

- Priority1: District of Nipissing (2023 to 2026)
  - This priority is focused on expanding the licensed home child care sector with an attention to underserviced and rural communities throughout the district.
  - The goal is to open 16 new homes within the district providing an additional 96 licensed child care spaces.
- Priority 2: North Bay (2023)
  - This priority aligns with the school-based project currently underway in North Bay (Near North District School Board, Fricker Project).
  - Of the 73 spaces being created, 53 are net new spaces to the district as the YMCA, EW Norman Early Learning and Child Care will be relocating to the new site in 2023 (20 licensed spaces for children up to 5 years of age).

District of Nipissing Social Services Administration Board
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Children's Services

CWELCC Space Allocation Plan

- <u>Priority 3: Municipality of East Ferris (2026)</u>
  - Proposes the creation of 62 new licensed child care spaces.
  - The plan indicates that while DNSSAB supports this program, the viability and reality to create these spaces is dependent on provincial funding that will support with operating and capital requirements.
  - Given the additional investment needed, the plan further indicates that prior to moving forward with this project, DNSSAB board approval would need to be sought.

Nipissing's CWELCC Space Allocation Plan that was submitted to the province indicated a potential expansion of **237 licensed child care spaces** for children from infancy up to 5 years of age by 2026.

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BOARD REPORT CS01-23

☒ For Information or ☐ For Approval

Date:	March 22, 2023
Purpose:	**Canada-Wide Early Learning and Child Care (CWELCC) Space Allocation Plan**
Prepared by:	Lynn Démoré-Pitre, Director Children's Services
Reviewed by:	Justin Avery, Manager of Finance
Approved by:	Catherine Matheson, Chief Administrative Officer

Alignment with Strategic Plan: Healthy, Sustainable Communities

☒ Maximize Impact ☒ Remove Barriers ☐Seamless Access ☐ Learn & Grow

RECOMMENDTATION:
THAT the District of Nipissing Social Services Administrative Board (DNSSAB) accepts Briefing Note CS01-23 for information purposes.

BACKGROUND:
In 2021, the federal budget proposed to invest up to $27.2 billion over five years towards a national early learning and child care plan, starting in 2021-22 as part of initial 5-year agreements.

On March 28, 2022, the Governments of Ontario and Canada signed the Canada-Wide Early Learning and Child Care (CWELCC) Agreement. The Province of Ontario reached a $13.2 billion commitment over six years with the federal government on a national child care plan.

Funding under the Canada-Wide Early Learning and Child Care Agreement (CWELCC) will be used to build and leverage the success of Ontario's existing early learning and child care system by increasing quality, accessibility, affordability and inclusivity in early learning and child care, towards achieving the objectives of:

- Providing a 25% fee reduction retroactive to April 1, 2022, building to a 52.75% reduction in average parent costs (based on 2020 levels) for licensed early learning and child care by December 31, 2022 and reaching an average parent fee of $10 a day by 2025-26 for licensed child care spaces;

- Creating 86,000 new high-quality, affordable licensed child care spaces (relative to 2019 levels), predominantly through not-for-profit licensed child care;
- Addressing barriers to provide inclusive child care; and
- Valuing the early childhood workforce and providing them with training and development opportunities.

On April 27, 2022, the DNSSAB's Community Services Committee received Briefing Note CS04-22 related to Canada-Wide Early Learning and Child Care (CWELCC) Plan, which provided an update regarding the reached agreement. Furthermore, the DNSSAB Board directed staff to develop an expansion plan to address the early years and licensed child care needs in the district to be brought back to the Board in Fall 2022.

CURRENT STATUS/STEPS TAKEN TO DATE:

While much of the focus of the agreement has been to reduce the daily cost of child care for families, under the CWELCC agreement, the province has also been funded to support the creation of 86,000 new licensed child care spaces (relative to 2019) by December 2026.

Since 2019, 33,000 new spaces have become operational within the province, with another 53,000 spaces to be created for children from infancy up to 5 years of age. A key priority for this initiative is to support with the expansion of affordable licensed child care spaces in underserviced communities for populations who require them most.

On December 19, 2022, the Ministry of Education issued a memo related to the Access and Inclusion Framework and Notional Space Targets. The ministry has developed an Access and Inclusion Framework to support service system managers across the province with local space allocation plans and with updating local early years and child care service system plans.

Under this framework, the ministry has also developed a model to allocate spaces and funding for the creation of licensed child care spaces for children from infancy up to 5 years of age. This model provides service system managers across the province with a notional space allocation for expansion of licensed child care services within schools as well as community based services for 2022 through to 2026. The focus is on improving access to licensed services by working towards a common provincial access ratio of 37%.

Service system managers were asked to review their notional space expansion targets, identify priority neighbourhoods for CWELCC funding and submit a plan to the ministry by January 20, 2023.

The ministry has also advised that capital start-up grants would be made available to service system managers to support with the creation of these new spaces. All service providers regardless of auspice (for-profit and not-profit) who are enrolled in the CWELCC System will be eligible to receive a grant covering up to $90 per square foot of a new or expanded space with a cap of up to $350,000 for every 50 child care spaces created.

Nipissing's Notional Space Allocation

The ministry provided DNSSAB with a notional space allocation of 109 spaces for the district from 2022 to 2026. Of these spaces, 73 form part of the school-based space allocation while the remaining 36 represent the community-based allocation.

It is important to note that while DNSSAB received 109 spaces, some spaces are already operational and planning for others are well underway. For example, there were 13 JK/SK spaces (Redbridge) and 13 JK/SK community-based spaces (North Bay) created in 2022. A school-based project is currently underway for 73 spaces in September 2023 (North Bay – Fricker project), creating an additional 53 net new school based spaces (20 spaces are transferring from another site). That leaves DNSSAB with 30 community-based spaces to plan for by end of 2026.

Since DNSSAB received the lowest provincial allocation, David Plumstead, Manager Planning, Outcomes and Analytics completed a review and analysis of the data. The process examined the overall provincial and local data and confirmed that although DNSSAB is receiving a relatively small number of new spaces, Nipissing District' access to care is among the top five in the province based on child population and current licensed capacity. Please see Appendix A for additional details.

Nipissing's Space Allocation Plan

Service system managers across the province were asked to complete a CWELCC Five Year Space Allocation plan based on the notional allocation and to identify the potential for creating additional spaces for 2022 through to 2026.

In identifying priority neighbourhoods, service system managers were asked to consider underserviced areas that will support access to licensed child care spaces for:

- Low-income families
- Vulnerable communities
- Diverse communities
- Children with special needs
- Francophone families
- Indigenous families
- Families needing more flexible models of care, including evening, weekend, and overnight care.

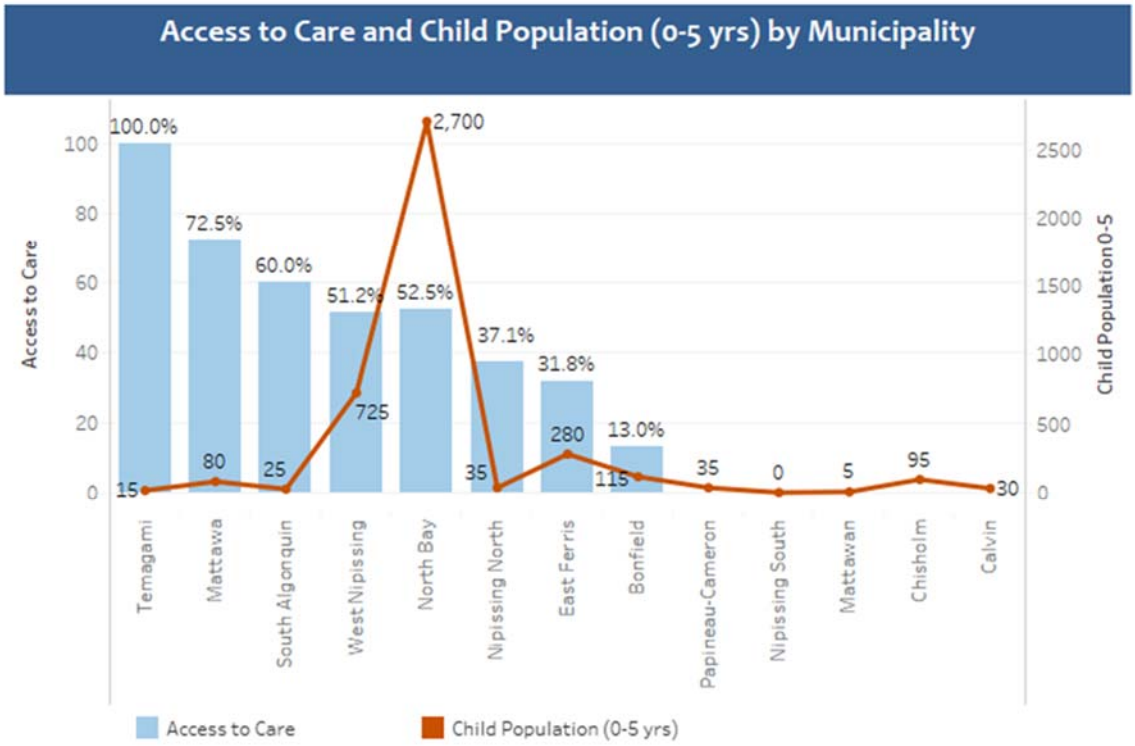
In order to determine the areas of greatest need for the District of Nipissing, various data sets were considered (i.e. access to care, census demographic, population projections, district's waitlist for licensed child care services, etc.). In addition, DNSSAB also took into account the biggest challenge that the sector is facing – staff recruitment and retention. This was a significant issue prior to COVID-19 and has only worsened since the pandemic began.

As noted in the graph below (Figure 1), access to licensed child care varies in each municipality demonstrating a need for licensed child care options in several municipalities

across the district. The access to care was calculated by dividing the child care licensed capacity by the child population (0-5 years of age) for each municipality within the district.

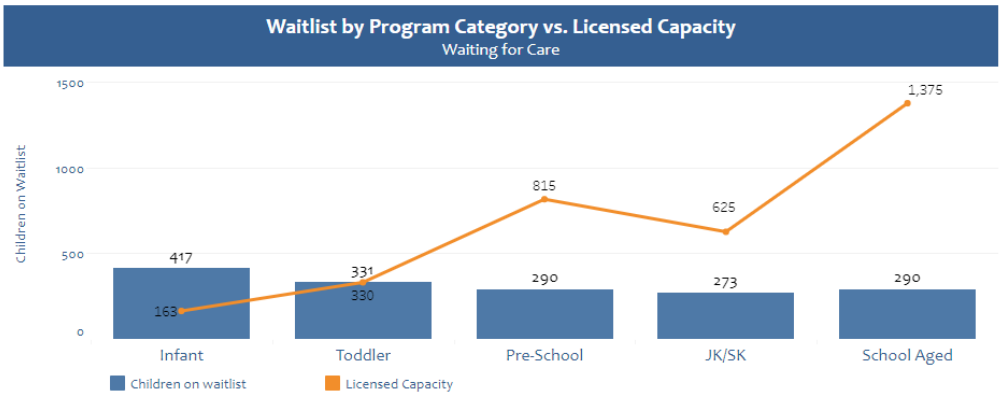
Further to the review of recent population demographics, it was noted that the overall child population within the district has declined from previous years. With that said, the child population has increased in some areas of the district (i.e. East Ferris) while others remain relatively steady since 2011 (i.e. North Bay).

Figure 1



As indicated in the graph below (Figure 2), while a number of spaces remain vacant due to staffing shortages, there is still a need to create additional spaces within the district as the need for licensed child care services exceeds the availability of services in many communities throughout the district. As of January 2023, 1311 children up to five years of age are waiting for care. Considering the available placements if providers were operating at 100% capacity, 570 children would remain on the waitlist for infant and toddler care.

Figure 2



Placement opportunities as detailed in the table below is calculated by subtracting the current operating capacity from the licensed capacity. This represents the number of spaces that are currently 'vacant' due to staffing pressures.

If all placement opportunities are filled with children currently on the waitlist, the table below represents the number of children who would remain on the waitlist.

Licensed vs. Operating Capacity:

	Licensed	Operating	Opportunities for Placement
Infant	163	89	74
Toddler	330	226	104
Pre-School	815	490	325
JK/SK	625	277	348
School Aged	1,375	749	626
Family	60	11	49

Children on Waitlist After Full Licensed Capacity is Achieved

Infant	343
Toddler	227
Pre-School	0
JK/SK	0
School Aged	0

Over the next few years, DNSSAB's expansion plan focuses on increasing capacity within the existing home child care system and is intended to further meet the needs of the vulnerable populations and enhance opportunities for quality child care services that are accessible, affordable, flexible and inclusive for all families. Targeted communities for recruitment of home child care providers will focus on the rural and underserved areas within the Nipissing District. This will also allow DNSSAB to continue working in collaboration with the current sector to strengthen and stabilize the existing licensed centre-based programs without adding further burden to the sector's staffing pressures.

In its submission to the province, DNSSAB indicated a willingness to work with the ministry in order to expand the capacity and the footprint of the licensed child care sector within the Nipissing District beyond the existing space allocation. The submission included three priority areas:

- Priority1: District of Nipissing (2023 to 2026)
  - This priority is focused on expanding the licensed home child care sector with an attention to underserviced and rural communities throughout the district.
  - The goal is to open 16 new homes within the district providing an additional 96 licensed child care spaces.
- Priority 2: North Bay (2023)
  - This priority aligns with the school-based project currently underway in North Bay (Near North District School Board, Fricker Project).

- Of the 73 spaces being created, 53 are net new spaces to the district as the YMCA, EW Norman Early Learning and Child Care will be relocating to the new site in 2023 (20 licensed spaces for children up to five years of age).

- Priority 3: Municipality of East Ferris (2026)
  - This priority proposes the creation of 62 new licensed child care spaces within the rural municipality due to the current and future demand for licensed child care spaces.
  - The plan indicates that while DNSSAB supports this program, the viability and reality to create these spaces is dependent on provincial funding that will support with operating and capital requirements.
  - With the current provincial investment of $90 per square foot of a new or expanded space with a cap of up to $350,000 for every 50 child care spaces, the project would require additional investments to support with the remaining costs (i.e. indoor renovations, outdoor play space, professional fees as well as start up costs of program materials and equipment).
  - Given the additional investment needed, the plan further indicates that prior to moving forward with this project, DNSSAB board approval would need to be sought.

DNSSAB's CWELCC Space Allocation Plan submitted to the province for consideration indicated a potential expansion of 237 licensed child care spaces for children from infancy up to 5 years of age by 2026.

The ministry has indicated that the submissions will be reviewed and where necessary, they will meet to discuss submissions with service system managers. In Spring 2023, the ministry will confirm space allocations and funding allocations for expansions.

RESOURCES REQUIRED:

Funding provided for the implementation of the CWELCC System related to fee reductions and workforce compensation continues to be 100% and does not require any municipal contributions.

Funding to support licensed home child care with the expansion of services was previously planned for in the Children's Services budget for 2023.

While the data demonstrates a need to expand licensed child care services in the district, significant investments will be needed to expand the system as capital and operational funding for program expansions is not readily available in the current budget. The CWELCC Start-Up Grant offers $90/square foot for renovations; however, DNSSAB has been advised that the current cost of renovations in the District of Nipissing ranges from $200/square foot for a simple renovation, up to $225/square foot for an extensive renovation.

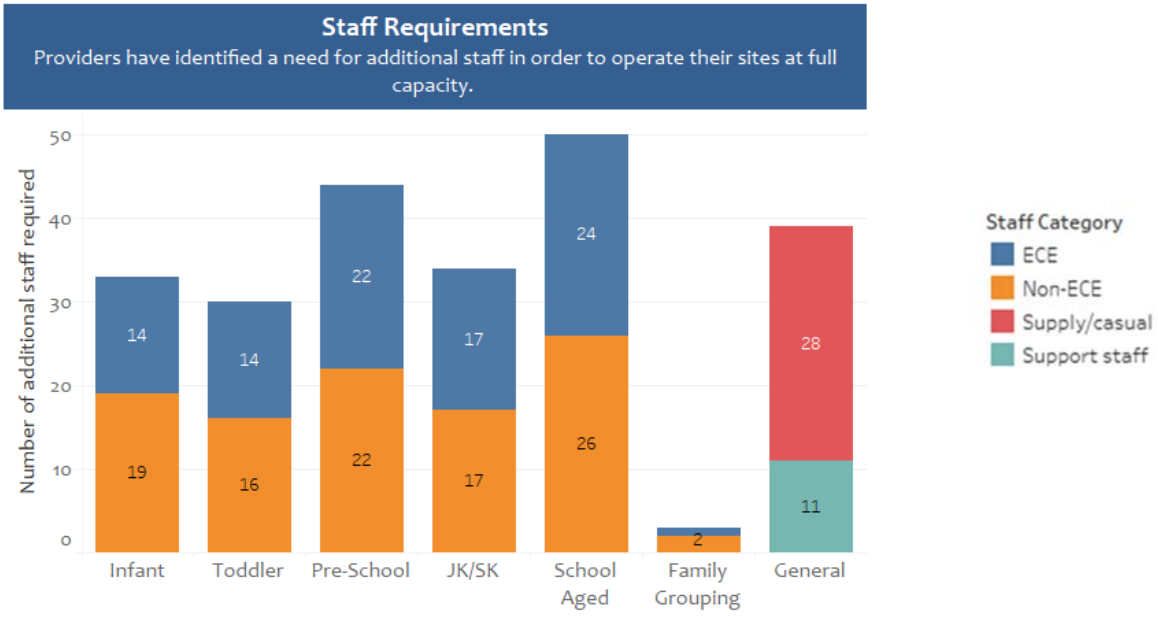
When planning for centre-based community-based space expansions, DNSSAB will need to consider and plan for financial contributions within its annual budget process.

In the space allocation plan submitted to the ministry, DNSSAB did request that the ministry reconsider the $90 per square foot and/or remove the maximum allocation of $350,000 per 50 spaces to better align funding with anticipated costs within the district. DNSSAB also indicated that viability and reality to create these spaces is dependent on provincial funding to support with operating and capital requirements.

RISK IDENTIFICATION AND MITIGATION:

As previously mentioned, the biggest challenge that the sector is currently facing is staff recruitment and retention. At this time, Nipissing's licensed child care agencies are operating at between 48% and 100% of their licensed capacity (55% overall).

While the need for additional staff varies from one child care agency to another, the service providers in the sector have indicated a need for well over 200 individuals (i.e. RECEs, non-qualified staff, support staff) in order to operate at the current licensed capacity.



In order to stabilize and strengthen the current sector, recruitment and retention strategies are being implemented to complement and support the sector's efforts in achieving sufficient staffing levels to operate at full licensed capacity. These efforts include marketing strategies (i.e. recruitment, recognition, etc.), professional development opportunities, and more.

CONCLUSION:

In order to ensure stability and sustainability of the licensed child care sector, the province is planning a phased approached to the implementation of the CWELCC System. DNSSAB will continue to work closely with the early years and child care service providers to ensure that the sector is well supported as the CWELCC System is implemented across the province. DNSSAB will continue to explore new and creative solutions in order to enhance and complement the recruitment, retention and recognition strategies for the district.

Ongoing collaboration between the Ministry of Education, licensed child care service providers, school boards, municipalities, community partners and stakeholders will be required to meet local needs and meet desired outcomes.

The Board will continue to receive updates as additional information becomes available.

CWELCC Licensed Child Care Space Allocation (Ontario Ministry of Education, Early Years and Child Care Division)

The following analysis is based on the MOE's *CWELCC Five Year Space Allocation (Annex 2*) recently sent out in a memo to Ontario's service managers. Additional child care capacity, and census demographic data and population projections are included in the analysis to create access ratios and other indicators.

Under the Canada – Ontario CWELCC agreement over the next few years (to 2026), the ministry is allocating new licensed child care spaces for children ages 0-5 years across the province. The space allocation varies widely, from 109 spaces in Nipissing District, to 7,621 spaces in Peel.

In absolute terms, the Nipissing DSSAB is receiving the smallest allocation of licensed child care spaces in the province which may be concerning. However, when taking the current provincial share of licensed child care spaces and the children's population (ages 0-5) in to account as shown in the figure below, the allocation appears reasonable relative to Ontario's other service managers:

Figure 1

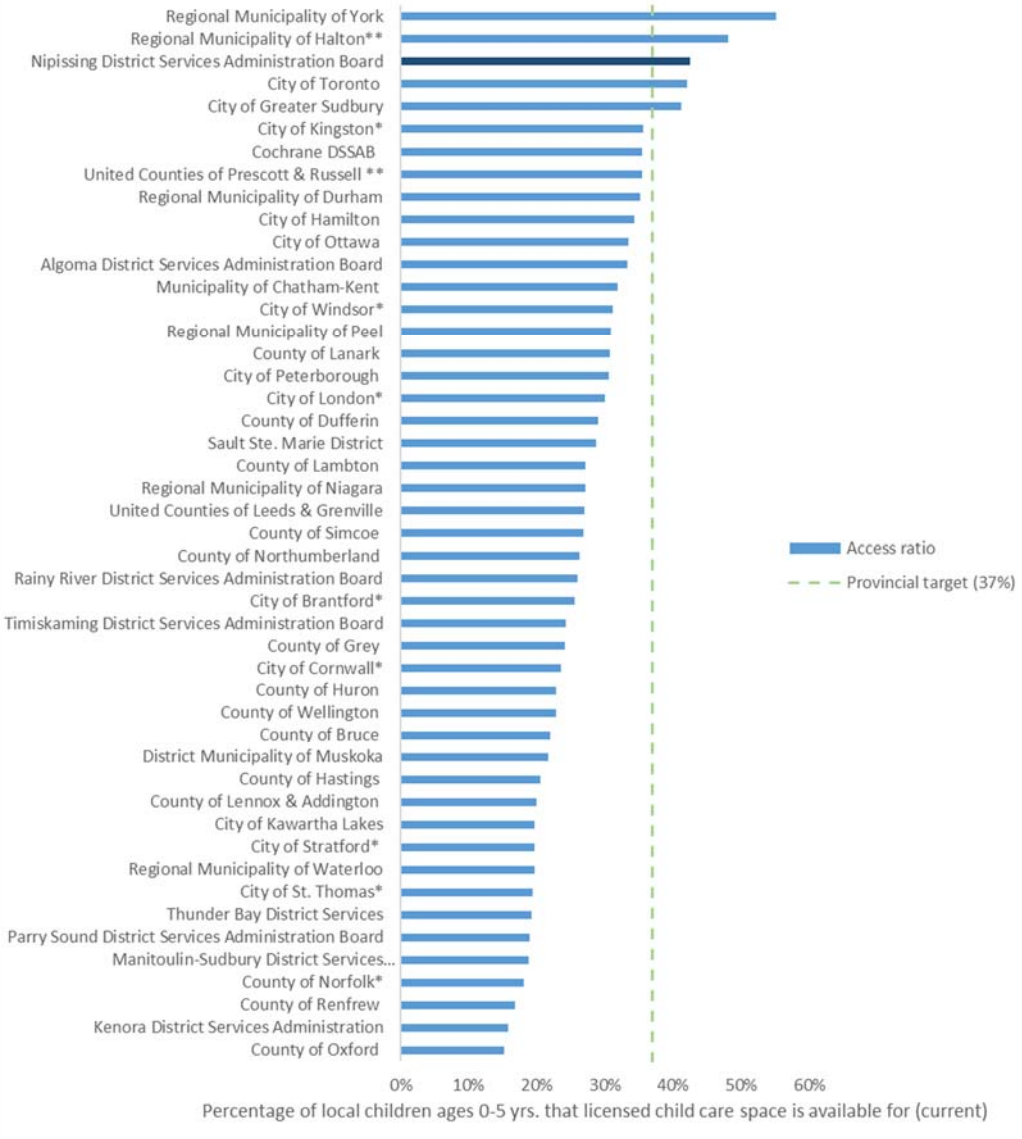
Currently, nine (19%) service managers have proportionately more licensed child care spaces for children ages 0-5 relative to their children population. This includes the Nipissing DSSAB, which has 0.7% of the provincial childcare capacity and 0.5% of the children's population, providing proportionately more spaces.

On the flip side, over two-thirds (68%) of Ontario's service managers have proportionately less child care spaces relative to their children population. In the remaining (13%) cases, service managers have the same proportion of child care spaces as their children population.

While the ministry's formula for space allocation is unknown, there is a strong statistical correlation between the CWELCC allocations, and current child care capacity and population share, indicating these are main factors in the provincial allocation model.

From a Nipissing perspective, the CWELCC allocations also look equitable when considering the current access ratio (licensed spaces /population ages 0-5 yrs.) and the provincial target as shown below:

Figure 2 Licensed Child Care Access Ratio, Ontario's 47 Service Managers (2021)

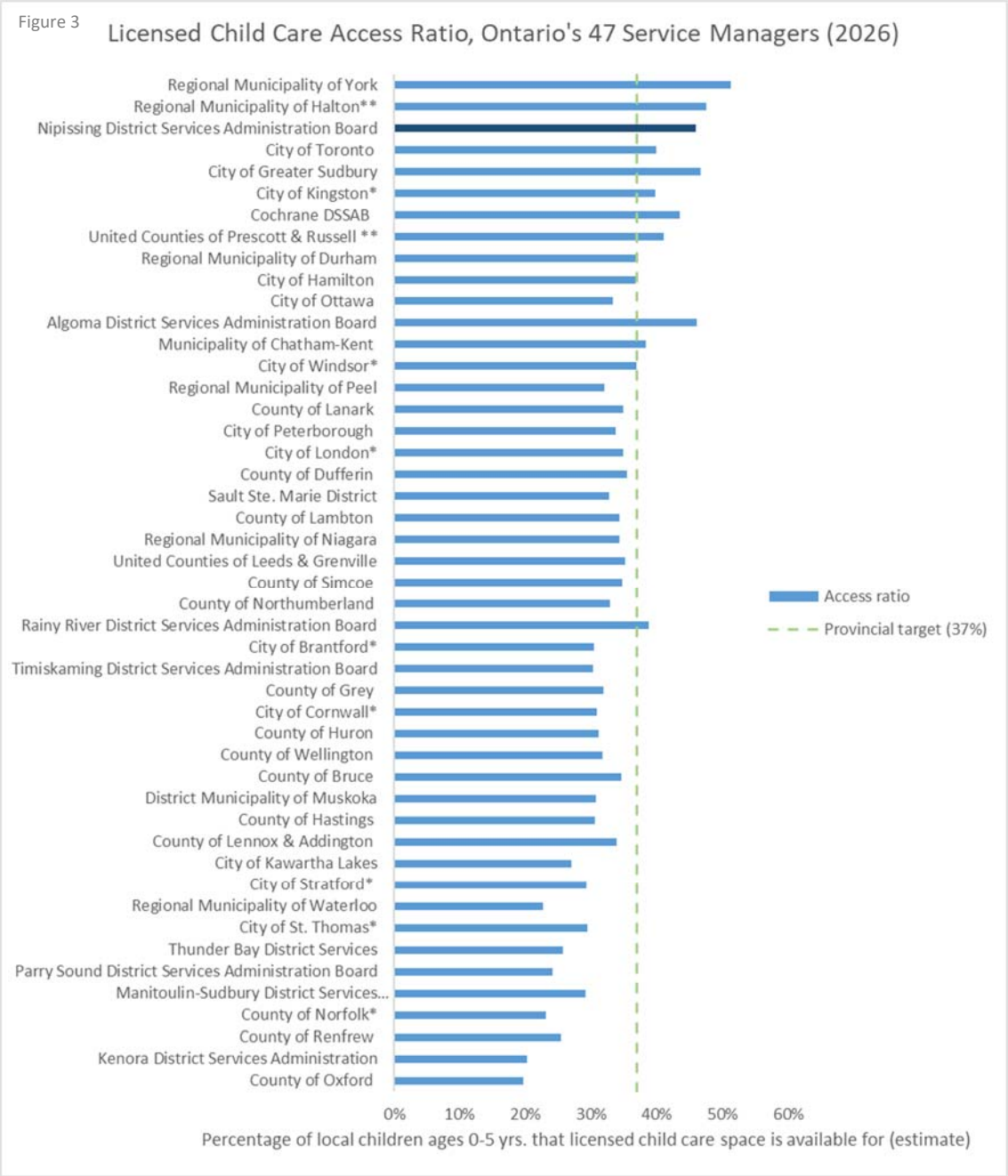


The Nipissing DSSAB currently has the third highest access ratio in the province, with licensed child care spaces available for 42.5% of the children ages 0 -5 years in the district. This exceeds the ministry's provincial access target of 37.0%.

In addition to Nipissing, just four other service managers exceed the provincial access target for licensed child care. The remaining (90%) service managers fall below the target threshold, ranging from a low of 15.0% in Oxford to closer to the target (35.5%) in Kingston (Frontenac).

The figure below (in the same order as above) shows the estimated access ratios at the end of the Canada – Ontario CWELCC agreement in 2026, based on the ministry's space allocations and population projections for the 0-5 years age group:

Figure 3



The large gap in child care access will be significantly reduced as more service managers meet the provincial target of 37.0%, or are closer to meeting it.

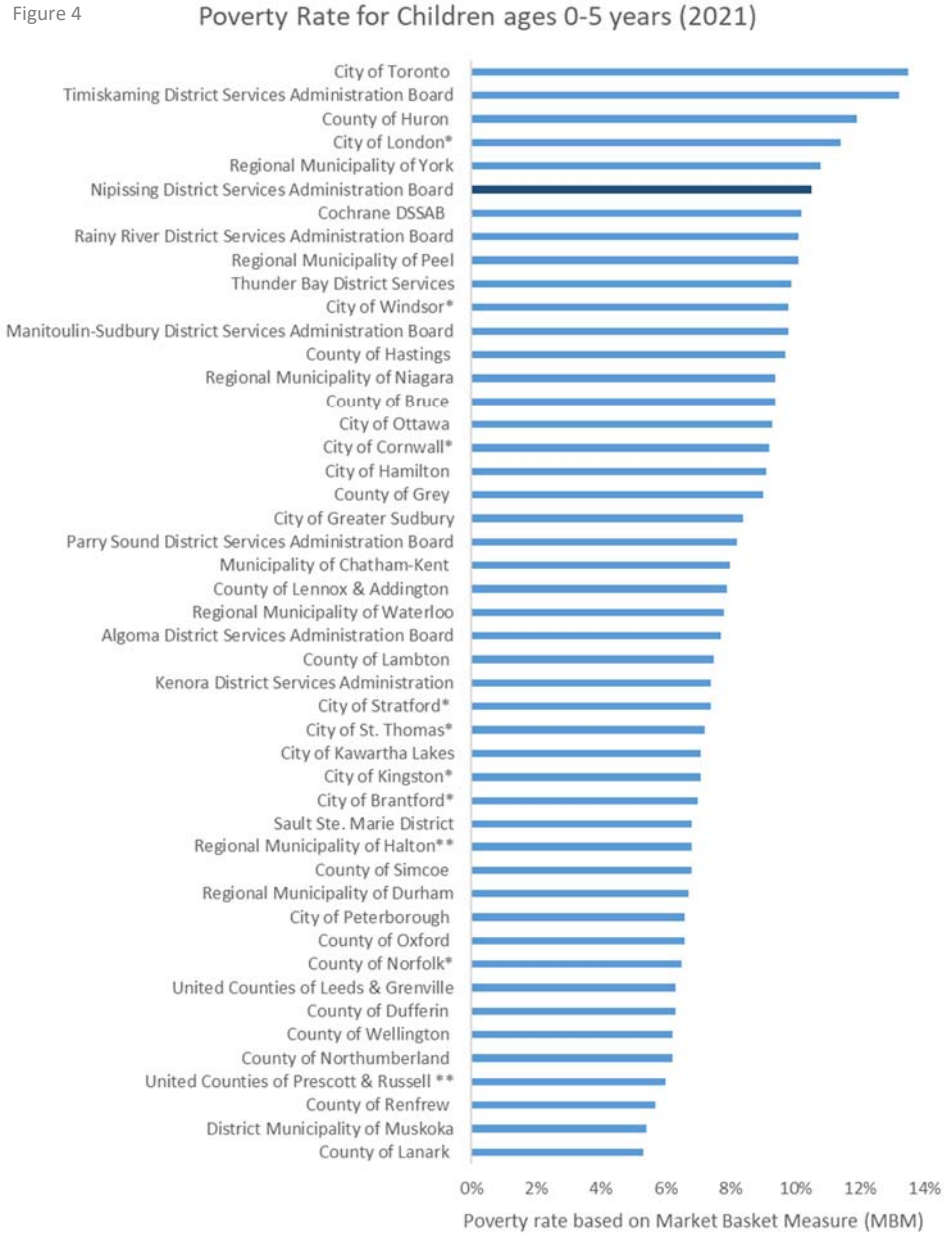
Although the Nipissing DSSAB is receiving a relatively small number of new spaces, the children's population is declining so the child care access ratio will increase to about 46.0%. [1]

The access ratio is derived from the number of licensed child care spaces and children ages 0-5 years, which are highly correlated with the ministry's CWELCC space allocations. It appears the access ratio is also a main factor in the allocation of new spaces and is consistent with the ministry's intention to allocate the spaces in communities with lower rates of space availability.

While the above analysis takes a straight population and capacity-based approach, the Ministry of Education is committed to supporting improved access to child care for vulnerable children in low income families. Adding this factor in to the allocation model and formula may result in additional new spaces being allocated to the Nipissing DSSAB.

For example, Nipissing District has one of the higher children poverty rates in the province:

Figure 4



About one out of every 10 children (10.5%) ages 0-5 years in the district, is living in poverty as measured by the Market Basket Measure- Canada's official poverty line. This poverty rate is higher than the provincial rate (9.5%) for the 0-5 years age group, and is one of the highest amongst Ontario's service managers.

Under the access and inclusion framework for the new CWELCC child care spaces, the ministry is also committed to improving access for indigenous and francophone children and those from diverse communities. The charts that follow show the distribution of these respective children populations across the service managers.[2]

Figure 5

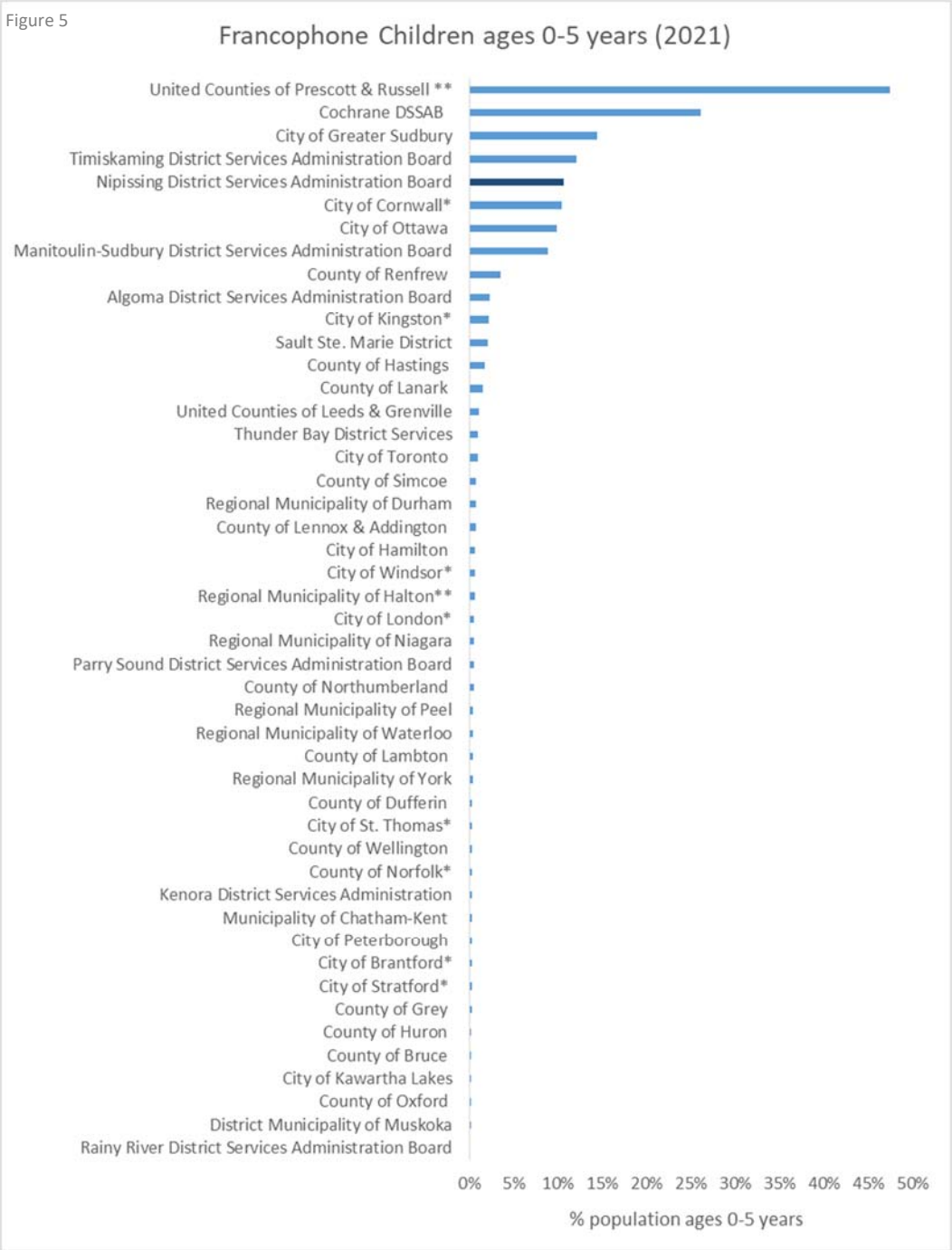
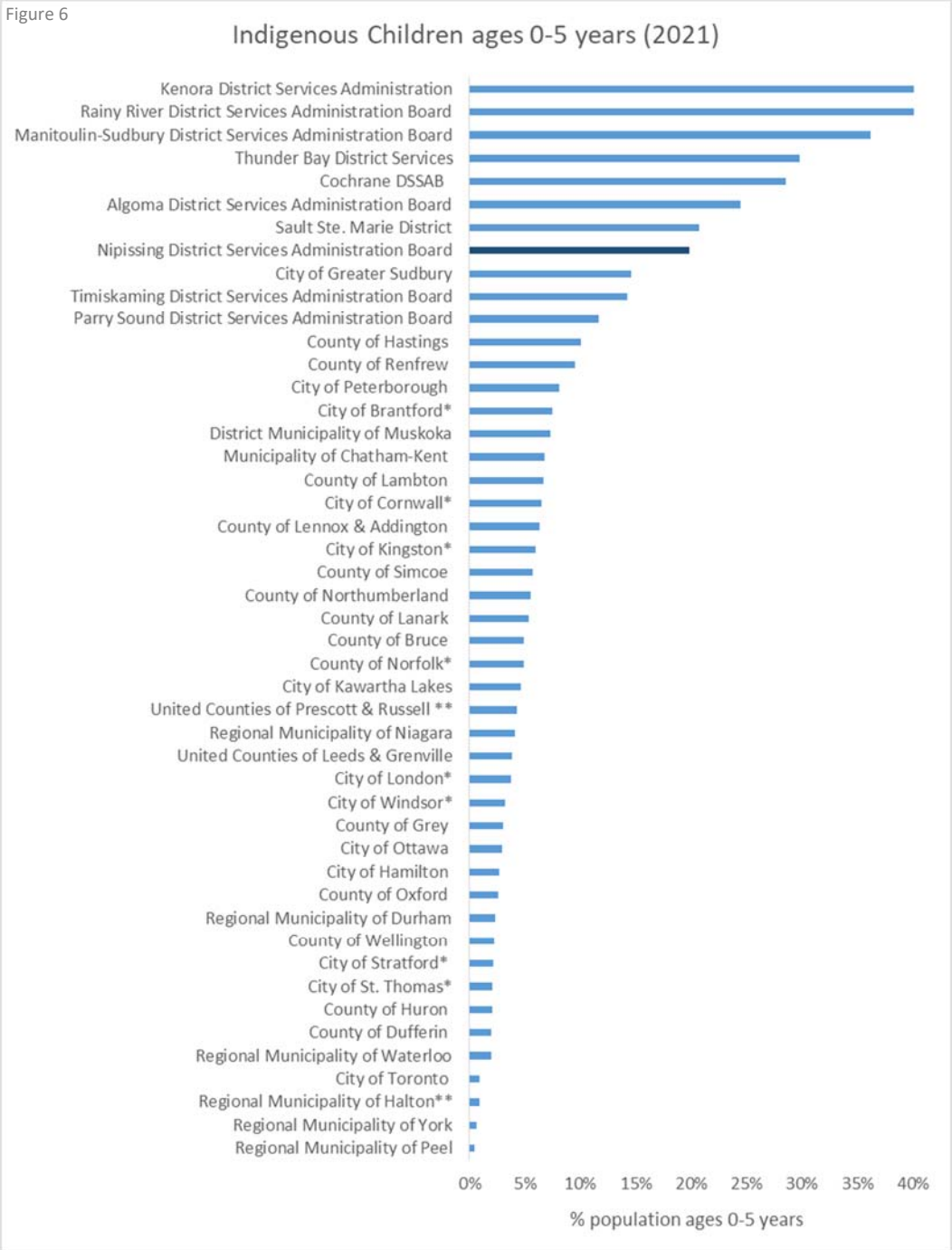


Figure 6

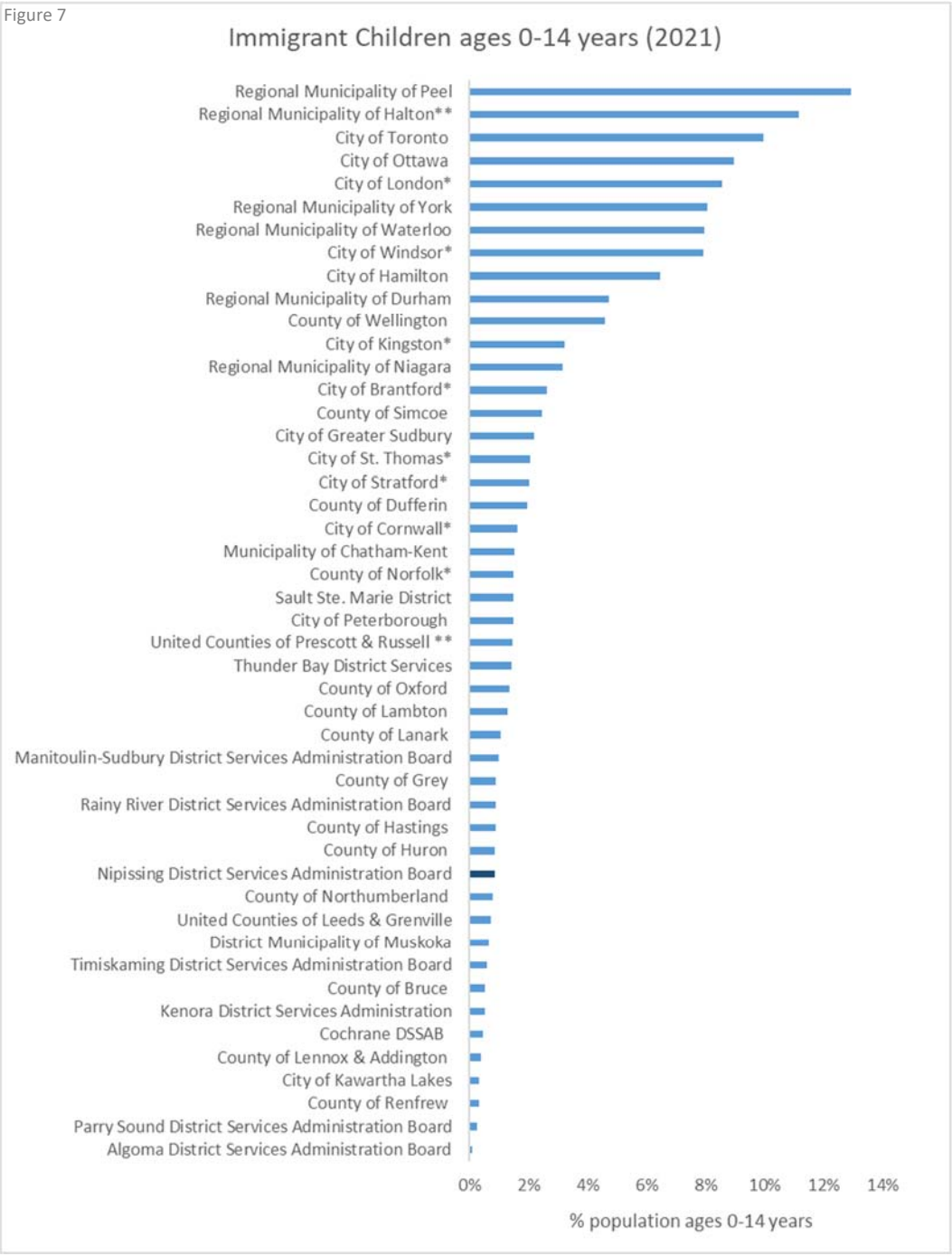


As noted in Figures 5 and 6 above, the Nipissing DSSAB has a relatively large number of francophone (10.5%) and indigenous (20.0%) children ages 0-5 years. Combined, three out of every ten children in the district ages five or under are indigenous or francophone. Nipissing's relative francophone and indigenous children's population are also about five-times that of the province (2.0% and 4.0% respectively). It can also be noted that the Northern Ontario service managers have the largest respective shares of indigenous children, in the province.

Similar to the poverty indicator mentioned earlier, a CWELCC allocation model that takes the distribution of the francophone and indigenous populations in to account, would likely result in additional spaces being allocated to the Nipissing DSSAB for targeted space creation.

The final chart below shows the share of the children's population ages 0 - 14 years that are immigrants, as a proxy for child care need in diverse communities:[3]

Figure 7



In contrast to the francophone and indigenous populations described earlier, the Nipissing service area has a relatively small share (0.9%) of children under the age of 15 that are immigrants. Nipissing sits around the lower quartile point in the above distribution and is well below the provincial share (7.0%) of immigrant children in this age group. It can also be noted that the southern service managers tend to have the largest respective shares of immigrant children, in the province.

Again, an allocation model that also factors in the immigrant population will offer additional capacity and targeted space creation for service managers with relatively large immigrant populations and diverse communities.

In conclusion, and from a Nipissing perspective, the Ministry of Education's CWELCC space allocations appear reasonable and equitable when taking into account the children's population ages 0-5, licensed child care capacity, and access ratios (current and future). The Nipissing DSSAB has one of the highest

child care access ratios in the province, which will continue to the end of the Canada-Ontario CWELCC agreement. The strong statistical correlation between the population and capacity variables, and the CWELCC space allocations, suggest they are the main factors in the ministry's allocation model and formula.

In terms of targeted space creation for vulnerable children in low-income families and indigenous and francophone children, the Nipissing DSSAB could receive additional spaces if the ministry's allocation model factored these in (the weak correlation between these variables and the CWELCC space allocations suggest that they are not principal factors in the allocation model). For example, Nipissing District has one of the highest children poverty rates in the province and relatively large numbers of francophone and indigenous children ages 0-5 years (about five-times that of the province).

End Notes

[1] Over the next few years, the 0-5 age group is projected to decline in a little over one-third of the service manager areas, including most of Northern Ontario.

[2] The 0-5 age group for the francophone and indigenous children population is extrapolated from the 2021 census general age groups (0-4 + 5-9) as single-year age data is not available for these populations. Additionally, the francophone population is based on the 2021 census *mother tongue* data while the indigenous population is based on *indigenous identity.*

[3] The census immigration age data is limited and only available in broad age groups (unless accessing custom data tables). For the purpose of this analysis and report, the percentage of immigrant children ages 14 years or less, is considered a reasonable approximation for the younger 0-5 years sub-group.

Data Sources

CWELL space allocations: Ministry of Education, Annex: CWELCC Five Year Space Allocation.

Licensed childcare spaces/ capacity by service manager: DNSSAB Children's Services.

Population ages 0- 5 years, 2021: Statistics Canada. Table 98-10-0022-01 Age (in single years), average age and median age and gender: Canada, provinces and territories, census divisions and census subdivisions.

Population ages 0-5 years, 2025: Population Projections for Ontario's 49 Census Divisions by Age and Sex, 2021-2046; Statistics Canada for 2021 and Ontario Ministry of Finance projections (Summer 2022).

Poverty rates, 2021: Statistics Canada. Table 98-10-0113-01 Individual Market Basket Measure poverty status by economic family characteristics of persons: Canada, provinces and territories, census divisions and census subdivisions.

Francophone population, 2021: Statistics Canada. Table 98-10-0220-01 Mother tongue by age: Canada, provinces and territories and census divisions.

Indigenous population, 2021: Statistics Canada. Table 98-10-0266-01 Indigenous identity by Registered or Treaty Indian status: Canada, provinces and territories, census divisions and census subdivisions.

Immigrant population, 2021: Statistics Canada. Table 98-10-0307-01 Immigrant status and period of immigration by place of birth: Canada, provinces and territories, census divisions and census subdivisions.

District of Nipissing Social Services Administration Board

Conseil d'administration des services sociaux du district de Nipissing

BOARD REPORT HS06-23

☒ For Information or ☐ For Approval

Date:	March 22, 2023
Purpose:	**Response to Bill 23, More Homes Built Faster Act, 2022**
Prepared by:	Stacey Cyopeck, Director, Housing Services
Reviewed by:	Justin Avery, Manager of Finance
Approved by:	Catherine Matheson, Chief Administrative Officer

Alignment with Strategic Plan: Healthy, Sustainable Communities

☒ Maximize Impact ☒ Remove Barriers ☒Seamless Access ☐ Learn & Grow

Report HS07-23 provides details on the Association of Municipalities Ontario (AMO) response to Bill 23, More Homes Built Faster Act, 2022, for information purposes.

BACKGROUND:

On November 28, 2022, the *More Homes Built Faster Act, 2022* (Bill 23) received Royal Assent from the Government of Ontario. The primary purpose of Bill 23 is to help build more homes and increase affordability for Ontarians by targeting development approval delays and development fees. Key components of Bill 23 include:

- Building More Homes
  - Gentle Density – increasing the number of units in urban areas with minimal impact on the existing neighbourhoods (i.e. basement apartments, garden houses, etc.)
  - Density Near Transit Hubs
  - Revitalizing New Housing Supply – not limiting what can be built to replace demolished housing units.
  - Municipal Housing Targets – the creation of housing targets to meet the population growth in 29 of Ontario's largest and fastest-growing municipalities.
  - Identifying More Land for Housing

    - Building More Schools
    - More Affordable Housing Options
- Helping Homebuyers
    - Incenting More Efficient Use of Vacant Homes
    - Protecting Consumers – strengthening existing protections for purchasers of new homes, including pre-construction homes and condos, from unethical builders and vendors who contravene the *New Home Construction Licensing Act*.
    - Streamlining Land Lease Approvals
- Reducing Construction Costs and Fees
    - Reducing Development Charges
    - Reducing Parkland Requirements and Fees
    - Reducing the Property Tax Burdens on Apartment Buildings
    - Tax Measures to Support Affordable Housing
- Streamlining Development Approvals
    - Accelerating Municipal Processes – optional public meetings for draft plans of subdivision.
    - Streamlining Aggregate Applications – removing the two-year freeze on amendments to new official plans, secondary plans, and zoning by-laws for aggregate applications.
    - Ontario Land Tribunal – speeding up the decision-making at the Ontario Land Tribunal level.
    - Heritage and the Environment – managing natural heritage while supporting growth and development.
    - Natural Hazards – streamlining development regulations across all 36 conservation authorities.
    - Protecting Heritage While Meeting Housing Needs – updating Ontario's heritage policies to promote sustainable development that conserves and commemorates key places with heritage significance.

CURRENT STATUS/STEPS TAKEN TO DATE:

AMO Response:

Before Bill 23's Royal Assent, on November 16, the Association of Municipalities of Ontario (AMO) submitted a response regarding the proposed Bill. AMO's response included the following key areas of concern:

Shifting the Cost Burden of Growth

Development Charges: Bill 23 proposed a suite of changes to the Development Charges Act that would effectively shift the cost of development growth onto municipalities and property taxpayers. Bill 23 proposes the following changes:

- The removal of housing services from the list of eligible development charge services.
- Excluding the cost of studies and the cost to acquire land for specific services from eligible costs that can be recouped by development charges.
- Reducing development charges on rental housing, based on the number of bedrooms.
- Requiring a mandatory 5-year phase-in of development charge rates for by-laws approved after June 1, 2022.
- Exempting development charges for affordable housing, attainable residential units, non-profit housing developments, and inclusionary zoning residential units.

AMO estimates that development charges in Ontario's 29 largest municipalities will drop by at least $569 million per year or $5.1 billion (through 2031). AMO does not support the changes that shift the burden of cost from developers to taxpayers, including low-income taxpayers. Rather, AMO looks to the province to provide major infrastructure funding to support the government's lofty housing supply goals.

Parkland Dedication: Bill 23 proposed municipal planning changes that will reduce a municipality's ability to provide for local parks.

- Capping the amount of land or equivalent value at 10% or 15% for sites under or over 5 ha, respectively.
- Reducing the maximum alternative dedication rate (high-density development) to 1 ha/600 units for land and 1 ha/1000 units for cash in lieu.
- Allowing encumbered land and privately owned publicly accessible spaces to be eligible for parkland credits.

These changes would reduce the amount of parkland available and will increase costs to municipalities. AMO indicates that these provisions should be removed from the Bill.

<u>Undermining Planning and Community Livability</u>

Bill 23 proposes multiple changes to the *Municipal Act*, *Planning Act*, *Heritage Act*, *Ontario Land Tribunal Act*, and *Conservation Authorities Act*. These changes will limit a municipality's ability to manage growth.

Development Approvals Process: Bill 23 includes the elimination of public meetings for the approval of a draft plan of subdivision and the exemption of site plan control requirements for projects with fewer than 10 residential units. This will affect how municipalities conduct land use planning and will particularly impact rural and remote municipalities which will have limited abilities to manage developments with fewer than 10 residential units given the scale of developments in those municipalities.

Other changes that AMO seeks reconsideration include:

- Limiting local powers regarding the demolition and conversion of residential rental properties.

- Proposing new rules around heritage properties.
- Limiting third-party appeals to the OLT of official plans and amendments, zoning by-laws and amendments, consents, and minor variances.
- Changing existing zoning by-laws to allow up to three residential units per lot “as of right,” with no local ability to regulate minimum dwelling size or parking requirements beyond one space/unit.

Exacerbating Risks to the Environment and Human Health

Bill 23 also proposed several changes to the *Conservation Authorities Act*, which will impact the ability of Conservation Authorities to work with municipalities to mitigate environmental, human health, and natural heritage risks that could be caused by developments. AMO recommends that Schedule 2 of Bill 23 be removed and that the Ministry-led Conservation Authority Working Group be re-established to consider appropriate changes to support the Housing Supply Action Plan without sacrificing the environment.

CONCLUSION:

In summary, Municipalities should be aware of the potential impacts of Bill 23. Municipalities with development charges will be limited in their ability to collect development charges to support growth. Furthermore, municipal land use processes will be impacted, especially surrounding parkland dedication and public meetings for draft plan approvals of subdivision. Ultimately, AMO appreciates the provincial government’s recognition of its role in addressing the housing crisis, however, proposed changes contained in Bill 23 could prove problematic.

District of Nipissing Social Services Administration Board
Conseil d'administration des services sociaux du district de Nipissing

BOARD REPORT SSE01-23

☒ For Information or ☐ For Approval

Date:	March 22, 2023
Purpose:	**Ministry of Children, Community and Social Services Modernization Update**
Prepared by:	Michelle Glabb, Director of Social Services
Reviewed by:	Justin Avery, Manager of Finance
Approved by:	Catherine Matheson, Chief Administrative Officer

Alignment with Strategic Plan: Healthy, Sustainable Communities

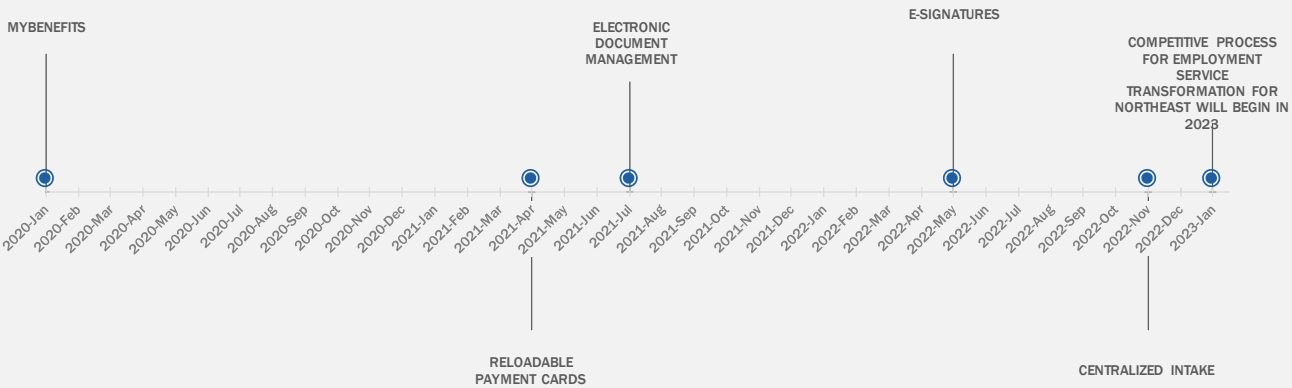
☒ Maximize Impact ☒ Remove Barriers ☒Seamless Access ☐ Learn & Grow

Information Report SSE01-23 provides an update on the implementation of the Ministry of Children, Community and Social Services (MCCSS) Ontario Works modernization initiatives in Nipissing District.

BACKGROUND:
As indicated in Reports SSE01-20, SSE09-20, SSE03-21, SSE04-21, SSE11-21 and SSE05-22, in an effort to transform social assistance in Ontario, MCCSS has introduced a number of modernization initiatives that are intended to create program efficiencies, improve service delivery mechanisms and increase employment outcomes.

Nipissing has promoted and implemented a number of modernization initiatives including MyBenefits, Reloadable Payment Cards, Electronic Document Management, eSignatures, and Centralized Intake. In the coming months the competitive process to select a Service System Manager (SSM) as part of the MCCSS Employment Services Transformation is expected to begin. Figure 1 on the following page provides a modernization initiative timeline. For a brief description of each initiative please refer to the overview attached as Appendix 1.

Figure 1

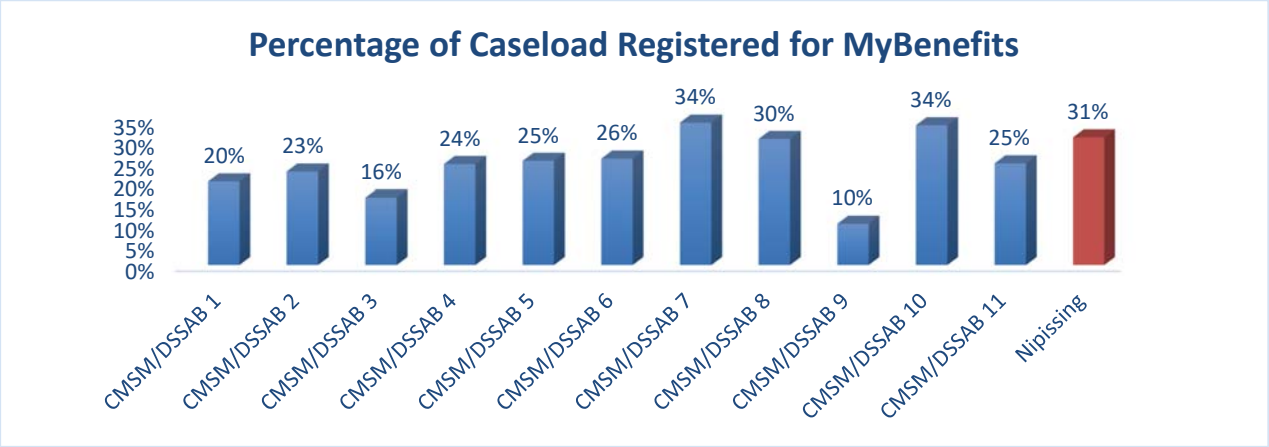


CURRENT STATUS/STEPS TAKEN TO DATE:

MyBenefits

As of November 2022, MyBenefits was enhanced to allow for the registration of trustees appointed to an Ontario Works (OW) or Ontario Disability Support Program (ODSP) case file. User registration for MyBenefits continues to be promoted as a service delivery pathway. Figure 2 below illustrates the percentage of caseload registered for MyBenefits with Nipissing OW being among the top three offices in the North as of January 6, 2023. Among northern DSSAB's and CMSM's, the average percentage of uptake by caseload is 25%.

Figure 2

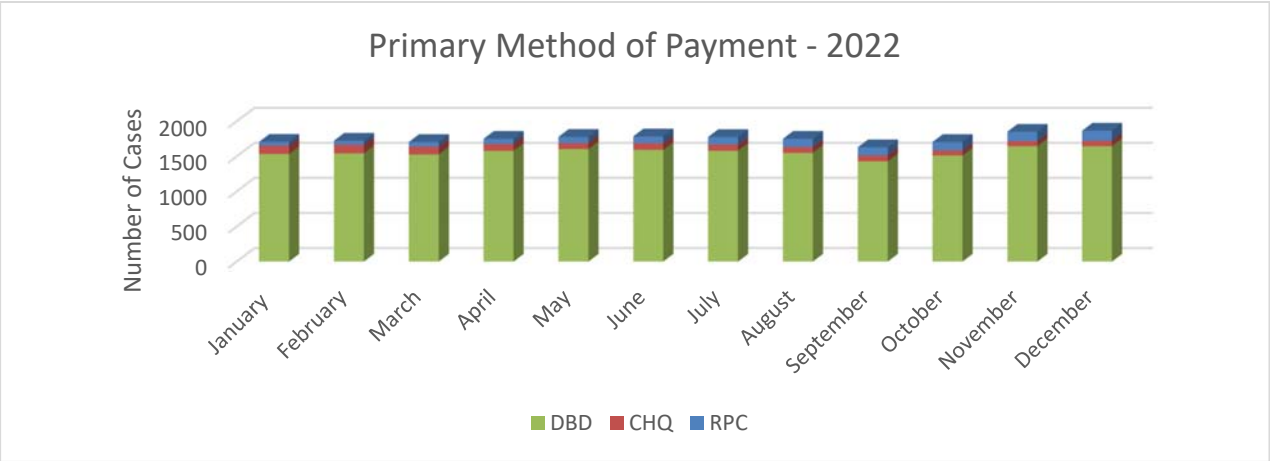


Source: MyBenefits Registration by Office (Ontario Works), January 6, 2023

Reloadable Payment Cards

Nipissing continues to promote Direct Bank Deposit (DBD) as the primary method of payment. When DBD is not a viable option, payments may be made via Reloadable Payment Card (RPC) or by paper cheque. As illustrated in Figure 3 below, the majority of cases in Nipissing have DBD as the primary method of payment and the percentage of cases with RPC has slowly increased between January and December 2022.

Figure 3



Source: Integrated Case Summary Reports for Nipissing District for the period of January to December, 2022

As the number of cases with RPC as the primary method of payment has increased, so has the number of replacement cards being issued month over month. The number of replacement cards issued month over month in 2022 ranged from a low of 12 in January to a high of 47 in December. Based on the number of active cases with RPC, the percentage of replacement cards was 23% and 33% respectively. Due to the cost associated with replacement cards, a number of mitigation strategies were implemented such as mandatory referrals to the ID clinic to obtain documentation required to open a bank account or a determination if a trusteeship is required to assist the recipient with managing their monthly entitlement.

Electronic Document Management

As of January 2023, 304,174 documents have been digitized through the Electronic Document Management initiative in Nipissing. This number includes the pages from active historical master files as well as ongoing daily scanning of documents required to be retained on file since the onset of the initiative in July 2021. In an effort to ensure we are able to process paper work quickly as well as to minimize ongoing costs, Nipissing continues to only scan documents that are required to be retained on file once the document has been processed.

Electronic Signatures

Electronic Signature or eSignature as referred to by MCCSS is a digital tool that allows documents to be signed electronically without an in-person appointment. Upon the implementation of eSignature not all documents were available. In recognition of this limitation, the Ministry continues to expand the forms available to maximize the potential of this service pathway.

ESignatures have proven to be a useful tool especially in relation to cases granted through Centralized Intake (highlighted below) as it reduces the paperwork that has to be signed with a wet signature as part of the post-grant activities once the case is transferred to the local office. It is important to note however that eSignature is not a viable option for all social assistance applicants and recipients for a number of reasons which may include:

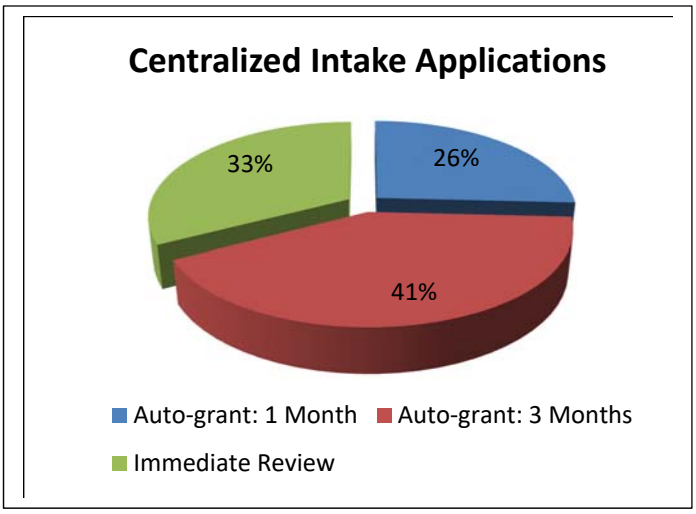
- Limited or no access to internet or technology

- No personal email address
- Barriers related to computer literacy
- Language barriers
- Family composition when there is more than one dependent adult

From a local perspective, eSignatures provides frontline staff with an additional service pathway based on individual need. This is especially useful in the context of serving remote communities where in-person appointments cannot always be accommodated quickly or during a public health crisis such as the COVID-19 pandemic.

Centralized Intake

Figure 4



Centralized Intake was launched in Nipissing effective November 28, 2022. Based on reports for November 2022, December 2022 and January 2023, 190 cases had flowed through the centralized intake process. Of those 190 cases, 33% required immediate review before eligibility could be determined, 26% were granted with verification items due within one month, 41% were granted with verification items due within three months.

Source: RBED Tracking Report (Monthly) for Nipissing District for the period of November 2022 to January 2023

Employment Service Transformation

In February 2019, the province announced its plan to transform employment services in Ontario through the integration of employment services delivered through Ontario Works (OW), Ontario Disability Support Program (ODSP) and Employment Ontario (EO). Employment Services Transformation (EST) is intended to create efficiencies allowing staff more time to focus on life stabilization in order to prepare clients to actively participate in employment supports and services which will be delivered by EO.

This new service delivery model is overseen by a Service System Manager (SSM) designated for each of the 15 catchment areas as illustrated in Appendix 2. The selection of a SSM involves a multi-stage competitive process which has been implemented in phases, with the most complex areas transitioning in the final phase. To date, SSM's have been identified for the Prototype, Phase One and Phase Two catchment areas with SSM's for phase two being selected on February 9, 2023.

It should be noted that a number of the SSM's selected are consortiums with one lead agency. Additionally, there is representation from the private, public, and non-profit sectors, including municipalities. Please refer to Appendix 3 for a list of SSM's by catchment area and implementation timelines. SSM's will have a planning and transition period before taking full responsibility for the local service delivery network and prior to Ontario Works employment being integrated into the service delivery

system.[1] Based on communications to date, it appears that there will be no funding impacts until full integration occurs however, it is important to note that the specifics for phase three catchment areas have not yet been released.

In the meantime, local planning and groundwork continues in an effort to prepare for the transition from a service delivery model that focuses on the achievement of employment outcomes to life stabilization. Figure 5 below provides an overview of the supports and services available to assist a client on their pathway towards employment. As illustrated, OW already delivers life stabilization supports as part of our current model as clients are more likely to engage in activities to assist them to secure and maintain employment when they have stable housing and appropriate supports in place.

Figure 5

In order to determine what supports and services are required to support a client on their path to sustainable employment, the Ministry has developed a Common Assessment Tool that is similar to the locally developed employability assessment Nipissing OW currently uses. Both tools provide a framework to facilitate conversations with clients around needs and barriers to help inform what referrals, activities and supports are required based on individual needs. The common assessment tool is currently only being used in EST sites although it is anticipated that the tool will be rolled out to non-EST sites at some point in the foreseeable future.

CONCLUSION:

The long term vision for social assistance in Ontario is in part driven by the recognition that social assistance recipients generally need more than financial assistance alone to effectively move from social assistance dependency to self-sufficiency through sustainable employment. It is widely known that people are more likely to achieve employment success and financial independence when the rest of their life is stable, including having a safe place to live, their health needs met and feeling connected and supported within the community. Modernization initiatives seek to create program

[1] Ministry of Labour, Training and Skills Development, *Employment Services Transformation Update to Consolidated Municipal Services Managers and District Social Services Administration Boards,* March 17, 2022

efficiencies to improve outcomes. While Nipissing has not yet experienced any significant time savings, OW is optimistic that through a commitment to continuous improvement of local practices and continued engagement with the Ministry, OW will begin to see efficiencies that will allow our front line staff to spend more time to better support clients.

Modernization Initiative Overview

MyBenefits is an online service that social assistance recipients can register to use to view payments and letters, communicate with staff and report changes to the office. The MyBenefits initiative includes a paperless by default strategy to reduce the printing and mailing of hard copy documents including the statement of assistance and letters generated through the Social Assistance Management System (SAMS). MyBenefits was enabled in Nipissing in January 2020.

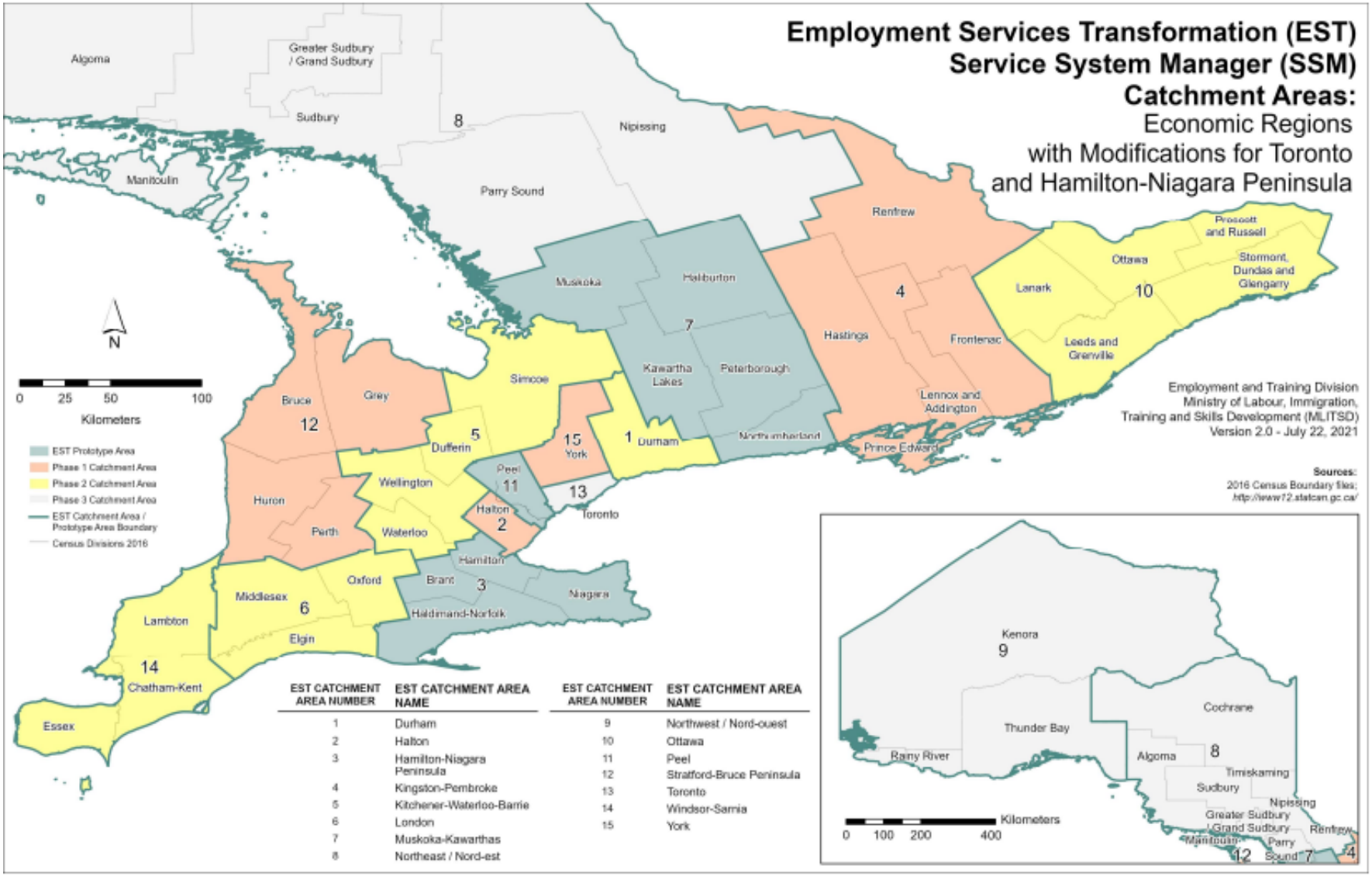
Reloadable Payment Cards (RPC) are an alternative method of payment for social assistance recipients who do not have a bank account. RPC work similar to a debit card except they are not linked to a bank account. RPC were made available in Nipissing in April 2021.

Electronic Document Management (EDM) initiative involves the digitization of historical master files on active cases and the ongoing digitization of incoming documents that need to be retained on file. Paper documents are digitized and made accessible through the Social Assistance Management System (SAMS) eliminating the need to store hard copy files. EDM was implemented in Nipissing in July 2021.

E-Signatures initiative allows for a limited number of documents, designated by MCCSS, to be signed electronically through a web service called Core Share. At present the documents available for eSignature are limited to the Rights and Responsibilities, General Consent and Consent to Disclose and Verify Information (CRA). There is some potential for the Ministry to expand the documents available for eSignature in the future; however there are no additional details available at this time.

Centralized Intake streams the majority of social assistance applications through a provincial intake system that allows for both telephone and online applications. Local offices continue to manage some applications locally including but not limited to emergency assistance and when an in-person application is required.

Employment Service Transformation is a provincial initiative that will integrate social assistance employment services into Employment Ontario in an effort to make them more efficient, streamlined and outcome focused. EST is being rolled out in phases across the province through a multi-stage competitive process which is anticipated to begin in Nipissing (Northeast catchment area) in 2023.



EST CATCHMENT AREA NUMBER	EST CATCHMENT AREA NAME
1	Durham
2	Halton
3	Hamilton-Niagara Peninsula
4	Kingston-Pembroke
5	Kitchener-Waterloo-Barrie
6	London
7	Muskoka-Kawarthas
8	Northeast / Nord-est

EST CATCHMENT AREA NUMBER	EST CATCHMENT AREA NAME
9	Northwest / Nord-ouest
10	Ottawa
11	Peel
12	Stratford-Bruce Peninsula
13	Toronto
14	Windsor-Sarnia
15	York

Source: Ministry of Colleges and Universities, *Phase 3 Market Sounding Document*, October 5, 2022, Phase 3 Market Sounding Document

Appendix 3

Rollout Phase	Catchment Area	Service System Manager Selected	Consortium Member	Planning and Transition Phase		Integrated Employment Services Delivery
Prototype	Hamilton-Niagara Peninsula	Consortium led by Fedcap Inc.	Fedcap	January to March 2020	January to December 2020	January 1, 2021
			Canadian Council on Rehabilitation and Work			
			Operation Springboard			
			Corbrook			
			Community Living Toronto			
	Muskoka-Kawarthas	Fleming College	Not Applicable			
	Peel	WCG	Not Applicable			
Phase 1	Halton	Consortium led by Fedcap Inc.	Fedcap	April to June 2022	July 2022 to March 2023	April 1, 2023
			Canadian Council on Rehabilitation and Work			
			Operation Springboard			
			Corbrook			
			Community Living Toronto			
	York	WCG	Not Applicable			
	Stratford-Bruce Peninsula	Consortium led by the Corporation of the County of Bruce	Corporation of the County of Bruce			
			Corporation of the County of Grey			
			Corporation of the County of Huron			
			Corporation of the City of Stratford			
	Kingston-Pembroke	Consortium led by Serco Canada	Serco Canada	September to December 2022	January 1, 2023 to September 2023	October 1, 2023
			Deloitte Canada			
			Thrive Career Wellness			
Phase 2	Durham	Consortium led by the Regional Municipality of Durham	Regional Municipality of Durham	Planning Phase February 2023 to April 2023	Transition Phase May 2023 to December 2023	January 1, 2024
			Durham Workforce Authority			
			Durham College			
	Kitchener-Waterloo-Barrie	Serco Canada	Serco Canada			
			Deloitte Canada			
			Thrive Career Wellness			
	London	Corporation of the City of London	Not Applicable			
	Ottawa	WCG	Not Applicable			
	Windsor-Sarnia	Consortium led by the Corporation of the City of Windsor	Corporation of the City of Windsor			
			Workforce Development Board Windsor Essex			
Phase 3	Northeast	Competitive Process to select a SSM is anticipated to begin in 2023		No timeline available		No timeline available
	Northwest					
	Toronto					

Sources:

- DNSSAB Internal Communication from the Ministry of Labour, Training, and Skills Development, Announcement of Service System Managers General Questions and Answers, February 14, 2020.
- Ministry of Colleges and Universities, *ADM Memo: Selection of Phase 1 Service System Managers*, April 25, 2022, ADM Memo: Selection of Phase 1 Service System Managers and Questions and Answers: Employment Services Transformation Update Phase 1 and Phase
- Ministry of Colleges and Universities, *ADM Memo: Employment Services Transformation Update*, September 22, 2022, ADM Memo: Employment Services Transformation Update and Questions and Answers: Fall 2022 Update
- DNSSAB Internal Communication from the Ministry of Labour Immigration, Training and Skills Development, *Memorandum: Selection of Phase 2 Service System Managers*, February 9, 2023

District of Nipissing Social Services Administration Board

Conseil d'administration des services sociaux du district de Nipissing

BOARD REPORT B14-22

☐ **For Information or** ☒ **For Approval**

Date: March 22, 2023

Purpose: **Strategic Activities of the 2019-2022 Board Term**

Prepared by: Marianne Zadra, Executive Coordinator and Communications

Reviewed by: Catherine Matheson, Chief Administrative Officer

Alignment with Strategic Plan: Healthy, Sustainable Communities

☒ **Maximize Impact** ☒ **Remove Barriers** ☒**Seamless Access** ☒ **Learn & Grow**

The attached infographic provides an overview of the activities of the 2019-2022 Board term as they relate to the long-term goals of the 2022-2042 Strategic Plan, for information.

BACKGROUND

At the orientation meeting of the new Board in January, it was suggested that recent accomplishments of the organization be provided. The attached infographic provides a high level view of accomplishments and projects undertaken during the previous term. These activities are in relation to the long-term goals of the 2022-2024 Strategic Plan:

Report on the DNSSAB Term 2019-2022

A new strategic plan (2022-2042) provides long-term vision and focus for staff and future Boards. The long-term corporate goals as listed below present areas of focus.

Maximize Human Service Impact

- Improved system coordination through implementation of Coordinated Access Nipissing, including homelessness By-Name List and HIFIS 4.0
- Became a Built For Zero community in 2022, with a goal to reduce chronic homelessness by 50% by April 2025
- Planned increase of capital reserves by $5.8M through the sale of NDHC properties to leverage future affordable housing development
- Engaged with the private, public, and non-profit sectors to leverage collective resources and increase the supply of affordable housing, i.e. Northern Pines
- Acquired Mackay Homes retaining 65 units as affordable housing
- Contracted with the City of North Bay, developed the Community Safety and Well Being Plan
- Community engagement, consultation, collaboration on various transformative projects, including: 5-Year Review of the Housing and Homelessness Plan, Homelessness Action Plan, Mayor's Roundtable Report, Point in Time Homeless Counts (3), Ontario Works Service Plan, Early Learning and Child Care Service Plan, and a Business Case for Direct Delivery of Paramedic Services. Supported a successful anti-stigma campaign led by the North Bay Parry Sound District Health Unit and Community Advisory Board (CAB)
- Prepared 1040 Brookes Street site for housing development
- Lead Ontario Health Team Health and Housing Committee

Remove Systemic Barriers

- Operate the Nipissing Poverty Reduction through Education Program (N-PREP), enabling OW clients to leave social assistance for post-secondary education and employment
- Administered $23M in homelessness funding – including additional emergency pandemic SSRF and Reaching Home funds
- Northern Pines capital project — developed 21 low barrier shelter beds as part of 60 new transitional housing units
- EarlyON Child and Family Centre capital projects with the development of 87 new childcare spaces at the Indigenous Hub and 30 new childcare spaces at the South Algonquin Hub
- In collaboration with NOSDA partners, implementation of Pre-ECE Certificate Program (2022)
- Continued to support local initiatives to stream OW clients into PSW programs funded through the Province to meet local labour market needs
- Implemented a Social Justice Pilot through existing resources to better support individuals released from incarceration
- Expanded the Community Paramedicine program district-wide
- Mobile Nurse Practitioner Pilot Project to connect vulnerable and under-served populations to primary health care and other services, and reduce hospital use
- Emergency response to the global pandemic— provided emergency child care services (2020-2022); administered COVID-19 vaccinations to the general population; and provided additional emergency shelter beds for vulnerable people experiencing homelessness
- Lobby provincial government for funding of Northern Pines integrated model of housing and health interventions

Continuous Improvement & Adaptation Learning & Growth

- Streamlined Board governance and committee/ reporting structure including revision to the DNSSAB & NDHC by-laws
- Implemented new Provincial centralized intake approach to streamline the OW application process
- Implemented a number of OW modernization and paperless services, including electronic document management, reloadable client payment cards, MyBenefits
- Professional development / community of practice web-portal for Early Learning Child Care service providers
- Upgraded the Get Trained Workers Employment database to improve employment service delivery and provide analytics and insights into the Nipissing OW caseload, while continuing to promote the program through local partnerships to improve employment outcomes
- All staff trained in areas of diversity and inclusion, Indigenous cultural safety and reconciliation, gender sensitivity, support for mental health and addiction supports, deeper understanding of community social supports through monthly training
- New financial-reserves policy
- New Psychological Safety and Workplace Diversity and Inclusion policies
- Adapted quickly to the COVID-19 pandemic with focus on employee safety and adoption of hybrid model
- Reduced the Corporate footprint through sale of 129-133 Main St. North Bay
- Change to direct delivery of paramedic services rather than contracted services

Provide Seamless Access

- Launched an on line application form for fee subsidy applications (2019)
- Developed and implemented the EarlyON mobile and outreach unit (2020)
- Integrated the Nipissing District Housing Registry to deliver coordinated centralized housing waiting list services in-house
- Created new DNSSAB website that includes NDHC
- Designed functional plan for Northern Pines integrating Health Quality Standards with supportive housing best practices
- Increased internal capacity through existing resources to better serve more OW clients with significant mental health and addiction issues by increasing our Transitional Support Case Management team

www.dnssab.ca

District of Nipissing Social Services Administration Board

Conseil d'administration des services sociaux du district de Nipissing

Nipissing District Housing Corporation
Société de logement du district de Nipissing

BOARD REPORT B10-23

☐ For Information or ☒ For Approval

Date: March 22, 2023

Purpose: **Mobile Nurse Practitioner Pilot Program Evaluation and Final Report**

Prepared by: David Plumstead; Manager of Planning, Outcomes & Analytics

Reviewed by: Justin Avery; Manager of Finance

Approved by: Catherine Matheson; Chief Administrative Officer

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Alignment with Strategic Plan: Healthy, Sustainable Communities

☐ Maximize Impact ☒ Remove Barriers ☐Seamless Access ☐ Learn & Grow

RECOMMENDATION

THAT the District of Nipissing Social Services Administration Board (DNSSAB) accepts the Mobile Nurse Practitioner Pilot Program Evaluation and Final Report included in the appendix of Board Report B10-23 and that staff carry out the report's recommendations.

BACKGROUND

The Mobile Nurse Practitioner Pilot Program is a partnership between the DNSSAB and the North Bay Nurse Practitioner-Led Clinic (NBNPLC), and funded through provincial Social Services Relief Funding. The innovative program is designed to connect the district's vulnerable and unattached populations to primary care and other services through the provision of mobile health clinics. A large body of evidence points to a strong relationship between vulnerable populations and poor health care access and outcomes, and the program is intended to improve this situation.

The program evaluation and final report is carried out as a condition in the Service Agreement between the District of Nipissing Social Services Administration Board (DNSSAB) and the North Bay Nurse Practitioner-Led Clinic (NBNPLC).

MOBILE NURSE PRACTITIONER PILOT PROGRAM EVALUATION AND FINAL REPORT SUMMARY

The full report for the mobile nurse practitioner pilot program can be located and referenced in the appendix. The following provides a summary of the report's key points and findings:

The Mobile Nurse Practitioner Pilot Program is being evaluated to measure program performance and develop recommendations and lessons learned for the Board and other program stakeholders. To achieve this goal, the evaluation focuses on program performance in two key areas: *whether the program was implemented as intended* and *whether the program achieved the intended outcomes.*

The evaluation is based on an observational study design that takes a mixed-methods approach. Qualitative survey data from the program committee and quantitative patient data from the nurse practitioner electronic medical record system are the primary sources of information and data to inform the evaluation and assess the outcomes.

In terms of program implementation, the start-up generally went as planned although there were some challenges and issues. For example, while the program partners intended to implement the program in April 2021 for a period of one year, timing constraints and start-up delays resulted in late implementation and the program was not operational until July 2021. In addition to delaying - and shortening - the period for providing health services to patients, the late start up had other consequences that included a change to the program scope, and problems with funding and staff retention at the nurse practitioner clinic.

Additionally, upon implementing the program, it became evident that some of the target locations for the mobile clinics did not require the program's outreach on a regular basis as the expected patient need was not there. Closely related, at times the nurse practitioner's scope of practice was under-utilized as many of the patient's health issues and reasons for visiting the clinics are within a registered nurse's scope of practice and a nurse practitioner may not be necessary on a full time basis.

Turning to program outcomes - and despite the late program start up and implementation issues noted above - the program evidence indicates that the program achieved two of the intended outcomes, which are to *enable primary care to vulnerable and unattached residents*, and *connect clients that have other service needs, with community service providers for the continuity of care*.

The mobile health clinics provided direct access without barriers to vulnerable and marginalized patients, including those who were unattached to primary care and likely would not have received care, otherwise. Over the nine-month operating period, the nurse practitioner provided 153 mobile outreach clinics located in emergency shelters and social housing. The clinics were attended by 123 patients, ranging in age from

youth (17 years) to senior citizens (65 +). Some of the patients had multiple health issues and concerns, and visited the mobile clinics multiple times, while receiving multiple health services. By the end of the pilot period, 68 unattached patients were rostered in to a Primary Health Team through the program and nurse practitioner clinic.

Additionally, through patient consultations and referrals, the nurse practitioner connected patients with other health-related needs, to community service providers and health specialists for the continuity of care. This included collaborating with community paramedics on mutual referrals for people needing care. The clinic's system navigator also helped patients access community resources and programs.

In view of the program's outcome success it is recommended that the mobile health clinic program be established on a permanent basis. This is contingent on making the program changes outlined in the report, to address the implementation issues and improve the program.

NEXT STEPS

Based on approval of the report's recommendations, the next step is to form a steering committee /working group to oversee the process of establishing the program permanently. The committee's initial work will include reviewing the final report and data, conducting further research to confirm the target population and service locations, and reviewing the program model to include registered nurses. Establishing the program funding and resources required will also be part of the process.

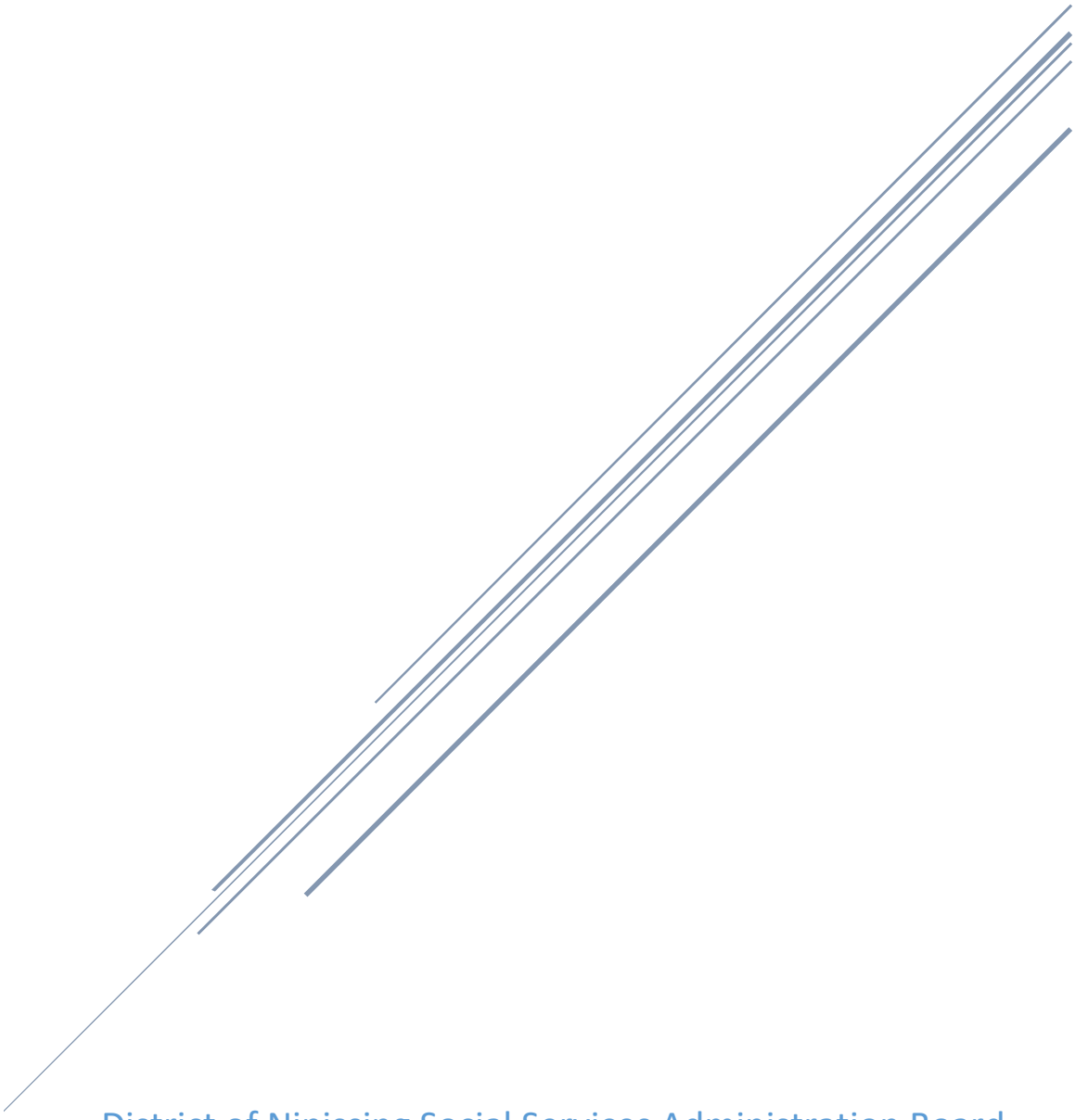
RESOURCES REQUIRED

Implementing the report recommendations will require the staff and time of partner organizations and other program stakeholders. As noted above, a working group will need to carry out some program work before implementing the program on an annual basis.

The funding source and cost to operate the program annually will need to be determined. Staff will bring back another report to the Board with the program costing and recommended funding source for final approval before program implementation. As an estimate, the pilot program was funded with $150,000 provided by the provincial Social Services Relief Fund (SSRF). Other resources were also necessary to operate the program including the staff and time of participating community partners and other stakeholders, community paramedics, and in-kind resources provided by the NBNPLC and other service providers.

MOBILE NURSE PRACTITIONER PILOT PROGRAM

Program Evaluation and Final Report



District of Nipissing Social Services Administration Board
March 22, 2023

Contents

Introduction

1.0 Background and Purpose

The Mobile Nurse Practitioner Pilot Program is an innovative program designed to connect vulnerable and unattached (orphan) populations to primary care and other services through the provision of mobile health clinics.[1] The program is funded through provincial emergency pandemic funding and was implemented in April 2021 for a period of one year.

The following is an evaluation and final report on the program, which is being carried out as a condition in the Service Agreement between the District of Nipissing Social Services Administration Board (DNSSAB) and the North Bay Nurse Practitioner-Led Clinic (NBNPLC). Specifically, the program evaluation measures the program's performance and establishes the lessons learned and recommendations for the Board of Directors and other program stakeholders.

2.0 Program Need

The need for the pilot program stems from evidence showing a strong relationship between vulnerable groups in the target population (above) and poor health care access and outcomes. Local plans and reports have also called for increased mobile health and support teams to perform outreach to the vulnerable and homeless populations. These are briefly described below.

There is a large body of evidence and literature demonstrating that those experiencing low income, homelessness and poverty experience poor health outcomes as measured by mortality, morbidity, and other various health indicators. For example, at the higher level, the social determinants of health (SDH) literature shows income – and other determinants such as housing, education, and employment – as a strong predictor of health and a source of health inequality in the Canadian population. The SDH literature and reports often cite health care access as one of the health inequalities, with those in the low income and socioeconomic groups at a disadvantage (Raphael, 2004). In another example, a study on homeless individuals in Toronto concluded that the odds of having a family doctor decreased significantly with each additional year spent homeless (Khandor et al, 2011). Drawing from that same study and body of knowledge, homelessness researchers Hwang and Liu (2021) stated in a more recent report that "many homeless people lack a source of primary care, and their care pathways often rely on acute services".

At the local level, administrative data also reflects the above relationship and inequality in health care access in Nipissing District. There are currently about 1,800 clients receiving Ontario Works (OW) social assistance in Nipissing District and 38% (680) of the clients state that they do not have a family doctor. This is four times the rate (9.5%) of unattached patients found in Ontario's general population (Statistics Canada, 2019). Furthermore, and based on an OW needs assessment at intake, the majority (90%) of those without a doctor indicate that either their physical or mental health, or addictions issues, are

[1] For the purpose of this report, *primary health care* follows the provincial definition and *is the patient's first point of contact with the health care system*. This includes illness prevention, health promotion, diagnosis, treatment, rehabilitation, and counselling. Those that are *unattached* do not have a primary care provider.

affecting their ability to get or keep a job (the main objective of Ontario Works). Some of these clients also experience various combinations of these poor health outcomes.

The research and evidence has also made its way into local studies and plans with a number of recommendations and strategies aimed at increasing mobile health and support outreach to service vulnerable and homeless populations. For example, the need for a mobile support team to assist individuals and families who are homeless or at risk of becoming homeless has been identified in the Nipissing District 10-year housing and homelessness Plan (2018). More recently, the Nipissing District Homelessness and Housing Partnership identified homelessness /housing outreach services as a priority in their homelessness prevention framework (2021). This was also echoed in the DNSSAB Homelessness Action Plan (2021), which includes an action item to provide mobile health and crisis response service - such as street nursing - that provides care in the community setting and is linked to coordinated housing access and case management.

3.0 Resources

3.1 Provincial Funding

The pilot program is funded through the Social Services Relief Fund (SSRF), which was created by the provincial government to protect the health and safety of the most vulnerable population during the pandemic. The program received $150,000 through Phase 2 of the SSRF as set out in the Investment Plan submitted by the Board to the Ministry of Municipal Affairs and Housing.

3.2 Other Resources

While the provincial SSRF funding above represents the largest share of program resources, other inputs and resources are also necessary to operate the program (see also, Logic Model Appendix 1). These include the various staff of community organizations involved with the project, community paramedics and various in-kind resources provided by the NBNPLC.[2] A transport vehicle and on-site space to conduct the health clinics are additional resources required.

4.0 Program Description

The following sub sections provide summary details of the Mobile Nurse Practitioner Pilot Program:

4.1 Program Outcomes

As mentioned above, the North Bay Nurse Practitioner-Led Clinic is designed to connect vulnerable and under-served populations to primary care and other services. Specifically, the program is intended to achieve the following outcomes:

- Enable primary care to vulnerable and unattached residents in Nipissing District.
- Connect those (above) that have other, related service needs, with community service providers for the continuity of care.
- Reduce hospital and ER admissions/ readmissions.

[2] These include general office supplies, COVID PPE, clinical supplies, testing/lab costs, and documentation/ /administrative costs for patient intake and processing.

4.2 Target Population

The pilot program aims to service vulnerable residents of Nipissing District who have limited, or no access to primary care. This population includes those experiencing low income, poverty, homelessness, and/or housing insecurity (whether through provisional accommodations or the risk of losing housing). In keeping with the project scope and reasonable service expectations during the pilot period, the initial target population was limited to those experiencing homelessness and living in shelters or on the streets, and social housing tenants living in NDHC housing (see Geography and Location, below).

4.3 Scope

4.3.1 Timeline

The pilot program was intended to start operating on April 1, 2021 for a period of one year. However, implementation was delayed by three months and the program became operational in July 2021 (see also, Program Implementation, 6.1).

4.3.2 Geography and Location

As mentioned above, the pilot program is targeting people experiencing homelessness and living in shelters or on the streets, and social housing tenants living in NDHC housing. The table below shows the intended service locations by municipality:

Table 1

Municipality	**Emergency Shelters**	**Unsheltered (Encampments)**	**Social Housing (NDHC)**
North Bay	Crisis Centre North Bay Low Barrier Shelter	Waterfront, bus station, downtown	Edgewater Apartments Golden Age Towers
Mattawa	/	/	Rockhaven Apartments
West Nipissing (Sturgeon Falls)	/	/	Holditch Street William Street
West Nipissing (Verner)	/	/	70 Principal Street East

Due to the delay in starting the program and other factors however, some of the locations in the outlying communities were not serviced as program resources became focused on the areas with the most demonstrated need.

4.4 Operating Schedule

The pilot program draft operating schedule is included in Appendix 2 for reference. In summary, the program was intended to operate during set business hours and days, within an established system that provides administrative support and meets safety protocols for the outreach and street work. Expanded or altered hours of operation could be considered in the future based on need and program experience.

The program schedule includes two days/week for outreach and one day/week for direct patient care and clinic time in office. Additionally, up to one day/ week is set aside for indirect patient care to carry out activities such as reviewing diagnostic testing and patient charts with other care providers. The remaining program time is for general administrative activities, meetings, partner communications and engagement, and patient care planning.

A team that includes the nurse practitioner, a community paramedic, and a member from the Healthy Community Ambassador Program (HCAP) will carry out the street outreach to encampments. The original concept had this team deploying weekly in North Bay and monthly in Sturgeon Falls.

4.5 Mobile Nurse Practitioner Pilot Program Working Group and Steering Committee

The table below lists the members of the steering and working group committee responsible for implementing and managing the program during the pilot period:

North Bay Nurse Practitioner-Led Clinic Program Committee/ Working Group Table 2
Neve Belanger; Tenant Retention Officer, Nipissing District Housing Corporation
Tracy Ann Bethune; Director, Nipissing District Housing Corporation
Jaymie-Lynn Blanchard; Nurse Practitioner, Clinic Director, North Bay Nurse Practitioner-Led Clinic
Stacey Cyopeck; Director of Housing Services, District of Nipissing Social Services Administration Board
Doug Davidson; Supervisor, Crisis Centre North Bay
Andrea Demers; Interim Supervisor Housing Programs, DNSSAB
Rheanon Funnell; Homelessness Program Coordinator, DNSSAB
Bryce Gartner; Community Paramedic, North Bay Regional Health Centre
Rob Smith; Chief of EMS (acting), District of Nipissing Social Services Administration Board
Kali Sohm; Case Manager/System Navigator, North Bay Nurse Practitioner-Led Clinic
Christine Sutherland; Nurse Practitioner, North Bay Nurse Practitioner-Led Clinic

* The table includes members who participated on the committee for the duration of the program.

4.6 Program Evaluation and Final Report:

The following committee members and DNSSAB staff carried out the program evaluation and compiled the final report, with review and input from the program committee:

Table 3. Program Evaluation and Final Report Table 3
Jaymie-Lynn Blanchard; Nurse Practitioner, Clinic Director, North Bay Nurse Practitioner-Led Clinic
David Plumstead; Manager of Planning, Outcomes & Analytics, DNSSAB
Christine Sutherland; Nurse Practitioner, North Bay Nurse Practitioner-Led Clinic

5.0 Program Evaluation, Purpose and Methodology

As set out in the Service Agreement between the DNSSAB and NBNPLC, the Mobile Nurse Practitioner Pilot Program is being evaluated in order to develop recommendations and lessons learned for the Board and other program stakeholders. To achieve this goal, the evaluation focuses on program performance in two key areas: *whether the program was implemented as intended* (process evaluation) and *whether the program achieved the intended outcomes* (outcome evaluation).

The evaluation methodology is described in more detail in the following sections:

5.1 Program Setting and Design

As mentioned earlier, the Mobile Nurse Practitioner Pilot Program is funded through the Social Services Relief Fund (SSRF) emergency pandemic funding. By the nature of this funding, the time between receiving and starting to expend the funds was relatively short which resulted in a short planning

window. Subsequently, there was no formal program evaluation plan or research design in place prior to the program being implemented.

In view of the above, an informal, retrospective observational design is employed to review the evidence collected and evaluate the program. This approach fits the setting and the evaluation objectives and scope, resources, and timeframe. A program logic model (see Appendix 1) shows the association between the program resources, activities, and intended outcomes and provides a conceptual framework to guide the evaluation work. Although developed and applied retrospectively, the model is still useful for describing, communicating, and evaluating the program components and results.

The design takes a mixed-methods approach, relying on qualitative survey data and quantitative patient data collected through the Nurse Practitioner electronic medical record system (see Data Collection below).

5.2 Data Collection

The two primary datasets used to inform the evaluation are sourced from a survey and administrative database - these are described below:

Survey Data

A survey was sent out to the pilot program Working Group and Steering Committee members listed in Table 2. The electronic survey was distributed via Survey Monkey and completed by all members of the committee. The survey consisted of 18 questions with skip logic applied (the number of questions answered by the committee members depended on how they answered). The questions were a combination of dichotomous (yes/no) and open-ended questions that focused on program implementation and outcomes (see survey questions, Appendix 3).

The survey data was exported from Survey Monkey into Excel for organization, formatting, and analysis. The results provide a qualitative assessment and evidence around program implementation and outcomes from those directly involved with developing, administering, and operating the program. To increase the robustness of the qualitative data, the survey results have been reviewed and confirmed by the survey participants and the data is triangulated with patient data (below).

Patient Data

The Nurse Practitioner responsible for operating the program collected patient information and data and entered this in to the provincial emergency medical records (EMR) database. The anonymized patient data was exported from the EMR database to Excel in various tables and analyzed for the purpose of the program evaluation. The patient dataset covers a nine-month period from July 2021-March 2022 and includes the outreach clinic location and date, the patient's age, reason for clinic visits, health issues, and services provided. The patient data complements the survey data above and provides a measurement of the program's outputs and the extent to which the intended outcomes were achieved.

5.3 Data Analysis

The type of survey and patient data collected above largely lends itself to descriptive statistics with various summary measures and frequency distributions. Although the analysis included exploratory

inferential statistics, in most cases the data does not meet the assumptions and/or conditions necessary for statistical tests such as chi square or analysis of variance (ANOVA) common to this type of study. [3]

The software used in the data analysis includes Excel, Tableau, and SPSS.

5.4 Ethics Statement

Free and informed consent was obtained from the clients and patients who participated in the pilot program and received services; patient information and data is collected within the consent arrangements made with the program's patients.

The program evaluation results are tabulated at an aggregate, summary level with non-identifying information and data reported. The patient data analyzed for the evaluation was also anonymous and non-identifying to ensure patient confidentiality.

5.5 Limitations

In this cross-sectional study it is not possible to show statistical causality or answer the attribution question (i.e., *did the program cause the observed outcomes*?). Rather, the intent is to establish whether the program's performance, observations, and evidence are consistent with the intended outcomes of the program.

Due to the nature and timing of the government pandemic funding the pilot program was implemented without a formal research and evaluation design, or implementation plan. This has resulted in significant implementation variation and challenges and delays in conducting the program evaluation.

Closely related to the above, a three-month delay in the program start-up shortened the program's operating period considerably. Subsequently, the patient data and this report covers the nine-month period from July 2021 - March 2022.[4]

The data collected for the program evaluation and measurement is somewhat limited, resulting from the lack of a research design and the implementation process.

Patient feedback on the program's effectiveness is not included in the program evaluation.

[3] For example, in the patient dataset more than 20% of the expected counts are < 5 and some cell values fall below 1, which prevent using statistical tests such as chi square to measure association or goodness of fit. While ANOVA may be useful for testing statistical differences between groups of interest (for example, with patient age as the independent factor) the model is constrained by the data which gives uneven sample sizes and often does not meet ANOVA assumptions such as normality and equal variance.

[4] The original contract term for the program was April 2021 – March 2022 and the project delay resulted in a funding underspend. At the time of this report, while the pilot program with the Nurse Practitioner Clinic has ended, the program continues to operate under the AIDS Committee of North Bay.

Results and Key Findings

6.0 Survey Results, Program Committee

The following are the results from the survey sent out to the program Steering Committee and Working Group members. The results are presented under the main question and topic area and provide feedback around the program's implementation and intended outcomes.

6.1 Program Implementation

6.1.1 Implemented According to Plan

The committee members were asked *whether the program was implemented according to plan or the Steering Committee's direction*. Close to two-thirds of the members felt that the program was implemented as planned while the remainder felt that it was not, or were unsure. It can be noted that most of those who responded favorably are DNSSAB staff.

For the members who felt that the program was not implemented as planned, program delays, timing constraints, and a changing program scope were the main reasons given. For example, as noted earlier, the program was implemented later than expected resulting in a three-month delay in providing services to clients. The delayed start also had other consequences, such as funding and staffing retention issues at the NP Clinic due to the change in project timelines, and insufficient time for the Nurse Practitioner to fully participate in the program evaluation at the end of the pilot period. Additionally, while the original program scope included unsheltered and mobile street outreach with additional community support workers, this was unattainable due to timing constraints, pandemic capacity pressures, and protocols /risk management.

In view of the above however, these committee members recognize that as a pilot project, the program was able to serve high risk and vulnerable populations once it was up and running, and offered learning opportunities along the way.

6.1.2 Changes to Program Implementation

In terms of general program implementation the committee members were also asked if they *would have done anything differently to implement the program.* While a few members would not have done anything differently or were unsure, the majority of the group stated that they would have implemented the program differently in the following ways:

Similar to the previous question, the start-up delay and timing issue surfaced with some of the committee members who feel that the program agreement and funding arrangement could have taken this potential delay into account. Additionally, some of the committee members would have carried out more detailed program and evaluation planning prior to implementation (although they acknowledge that the time constraints of the SSSRF emergency funding made this difficult). This would have included more engagement with community partners and stakeholders, and setting specific goals, milestones and timelines with clearer expectations around roles and responsibilities. On the evaluation front, determining the program metrics and data collection and analysis details prior to implementation would also have been part of the pre-planning work.

Closely related, some of the committee members also feel that more research should have been carried out upfront to reduce program assumptions and confirm the need for primary health care across the intended service population and locations. This research would include collecting more input and feedback from the target population and locations to assess the actual need. The research results would help to optimize the Nurse Practitioner's time and concentrate on the service locations most in need. [5]

More meetings between the Nurse Practitioner and Community Paramedics to review patient files and follow-ups was another area for improvement noted by some of the committee members.

6.1.3 Program Extension or Continuation

When asked about the continuation of the Mobile Nurse Practitioner Pilot Program, the majority of the committee members feet that *the pilot program should be extended or made permanent* while a small number are not sure.

For those in favour of extending the program, they feel that it is a helpful service for those who are vulnerable or marginalized and without primary care. For example, many of the residents at the Four Elms emergency shelter who do not have a primary care provider utilized the program's services. The program also serviced many social housing tenants. It can be noted that some committee members are supportive of continuing the program at select locations only, where there is demonstrated need. As noted earlier and in the footnote below, the expected patient need at some locations did not materialize.

The program provided the marginalized population with access and connections to primary care and offered various health options without significant barriers. Barriers such as transportation, accessibility, and lengthy appointment bookings were eliminated through the nurse practitioner mobile unit that provided onsite appointments and care. The nurse practitioner and community paramedics also conducted patient follow-up appointments, which eliminated another common barrier for this population (i.e., the difficulty in keeping appointments).

As shown in the patient data, the program was able to roster orphan patients (who normally rely on walk-in-clinics or the emergency department) in to a Primary Health Team. The nurse practitioner also collaborated with community paramedics and onsite social services staff to expand service delivery and help connect patients to other community services.

Some of the committee members also feel that providing permanent outreach through the program will improve patient care and other community outcomes, while likely reducing ER use as well. In the event the program is continued, other locations to research for program suitability are the low barrier shelter and Northern Pines day program.

A small number of the committee members are not sure whether the pilot program should continue as is, but recognize the program's strong potential. One of the concerns has to do with patient need as

[5] Upon starting to operate the program, the nurse practitioner discovered that some of the target population and social housing tenants already had a primary care provider. This was also reflected in an NDHC tenant survey to the target population around the same time, with a little over three-quarters of the survey respondents (145) stating that they have a primary care provider. This undermines the general program assumption about the target population's need for primary care.

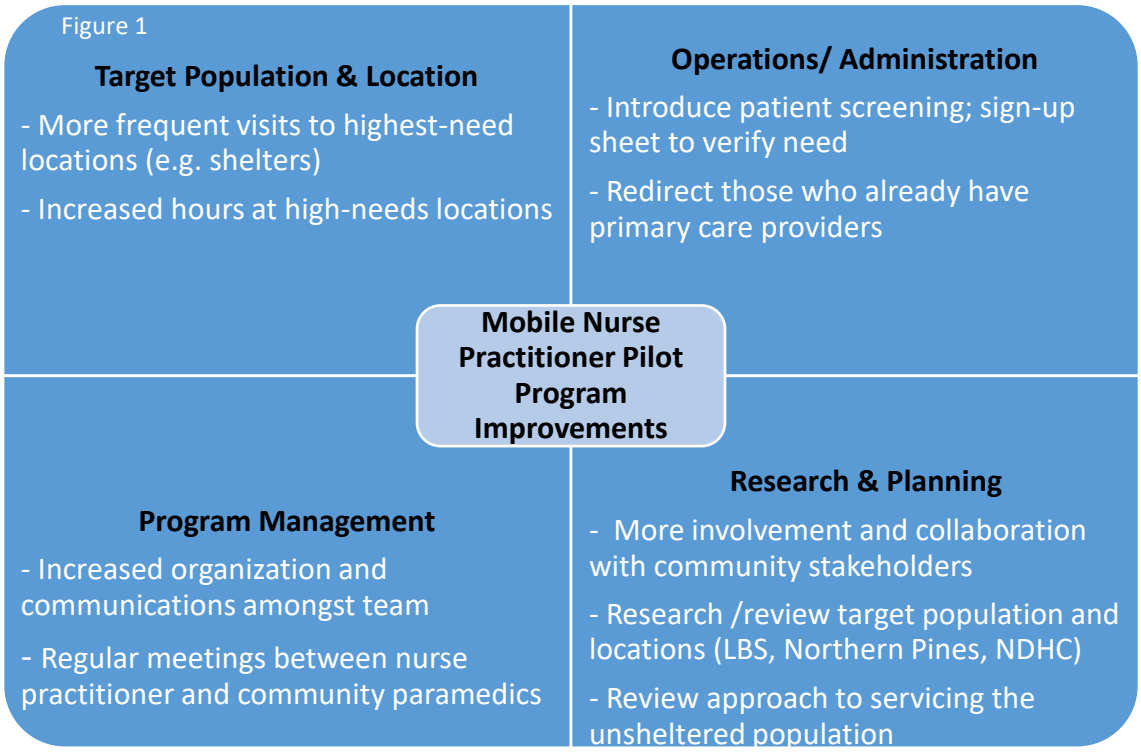
mentioned earlier in the report. During the pilot, it was discovered that many of the initial target locations did not require the program's outreach on a regular basis. Additionally, the nurse practitioners were seeing patients who already had a primary care provider but were opting not to go to the provider or were having difficulty accessing the provider. Program resources and more frequent support should be directed to the locations with the highest need.

Another concern with continuing to operate the program centres around the scope of practice. Many of the reasons for seeing the patients were within a registered nurse's scope of practice so the nurse practitioner may not be necessary on a full time basis. Rather, the nurse practitioner could be brought in where there are situations requiring an expanded scope of service and/or for high-need populations and locations.

6.1.4 Program Improvements

Given the program's intended outcomes and target population, the committee members were also asked if they would *make any changes to improve the program going forward.* About half the committee indicated they would not make any changes to the program or were unsure, while the other half stated that they would make changes to improve the program. The changes they would make are summarized in Figure 1 below:

Figure 1



The improvement changes are summarized by themes that emerged during the survey analysis, which are *target population and location; operations/ administration; program management; and research & planning.* Some of these themes overlap with other survey questions and responses.

In terms of the target population and location, spending more time at the high-need locations would improve the program through increased patient care and health outcomes. This also relates to program research and planning improvements to review the current target population and locations, and the

approach for servicing the unsheltered, homeless population (including encampments and the Northern Pines day program when it becomes operational). Increasing community stakeholder involvement and participation in the program is another planning improvement that would improve patient access to other programs and services they require and help mitigate the risk of homelessness.

On the program administration side, developing a screening mechanism to confirm patient need and redirecting those with a primary care provider will keep the program resources directed to where they are needed most.

Where managing the program is concerned, some of the members feel that the steering committee could be more organized and that more frequent meetings between the nurse practitioner and community paramedics would be helpful.

6.2 Program Intended Outcomes

The second part of the committee survey switched from program implementation details described above to program outcomes. Based on the committee member's experience and observations implementing and/or operating the program, they were asked whether the intended outcomes were achieved and if so, why they think the outcomes were achieved. This provides a qualitative assessment of the program's performance and supplements the patient indicator data.

The following subsections summarize the committee member's survey input regarding the three main program outcomes.

6.2.1 Enabling Primary Health Care

The majority of the committee members feel that the outcome to *enable primary care to vulnerable and unattached residents in Nipissing District* was achieved. A small number feel that the outcome was partially achieved or are unsure if it was achieved. The following table summarizes the input for those who feel the outcome was achieved:

Table 4

Program Outcome	Reasons for Achieving Outcome
Enable primary care to vulnerable and unattached residents in Nipissing District	• The mobile nurse practitioner served patients who were unattached to primary care and the health system. • The program reached patients in North Bay, Sturgeon Falls and Mattawa, and the patients received primary care services such as prescriptions, diagnostic imaging, testing, and referrals without going to walk-in clinics or the emergency room. • The program removed common barriers to primary care experienced by the vulnerable population which include no transportation, no phone, limited knowledge of existing services, and low literacy (for completing applications for care, etc.). • Primary care was provided in an environment that was familiar to the patient and where they felt comfortable and supported. • Some patients became directly linked to the North Bay Nurse Practitioner Led clinic and were officially registered /rostered as patients, thus securing a primary care provider (see also, Rostered Patients section 8.0).

It can be noted that many of the above reasons speak to direct program access for those that are unattached to the healthcare system and who otherwise, would not have likely received primary care. Also of significance are the unattached patients who became rostered and now have a primary care provider (see section 8.0).

For the committee members who feel the outcome was partially met, they note that while it was met for certain people in certain locations (e.g. the homeless staying in shelters) it was less effective for those who already had primary care (e.g. tenants in NDHC housing).

6.2.2 Connecting Patients to Other Service Providers

Close to two-thirds of the committee members feel that the program achieved the intended outcome of *connecting clients that have other, related service needs, with community service providers for the continuity of care*. The remaining one-third was unsure if this outcome had been achieved. It should be noted that most of the committee members who felt the outcome was achieved were those directly involved in operating the program and delivering services to the patients. Their observations speak directly to patient referrals to other community programs and resources, and between the nurse practitioner and community paramedics.

The following table summarizes the reasons why the members feel the program outcome was achieved:

Table 5

Program Outcome	Reasons for Achieving Outcome
Connect clients that have other related service needs, with community service providers for the continuity of care.	• The nurse practitioner made patient referrals to various specialists and other community programs as required. These included the Ontario Health Network, Community Paramedic Services, and mental health services. • The system navigator (nurse practitioner clinic) also connected patients with available community resources and programs. • The nurse practitioner and community paramedics collaborated on mutual referrals for people needing care.

6.2.3 Reducing Hospital Visits

Most of the committee members were not sure if the remaining program outcome to *reduce hospital and ER admissions/ readmission*, was achieved. A small number felt it was achieved and similar to above, these committee members were directly involved in operations or providing patient care. The reasons they feel the program outcome was achieved are summarized in the table below:

Table 6

Program Outcome	Reasons for Achieving Outcome
Reduce hospital and ER admissions/ readmission	• Patients who are seen in the community and feel supported to manage their health concerns and chronic diseases are less likely to present at the ER for these issues, unless it is truly urgent.

	• Many of the patients who accessed care and services through the program would have otherwise had to seek this elsewhere such as the walk-in clinics and/or ER. • The program's low-barrier form of care where patients receive care in their own living space, can improve health outcomes prior to the point of deterioration that requires an ER visit. • Some of the shelter patients were observed at appointments with the mobile nurse practitioner rather than going to the ER for non-emergency care.

7.0 Patient Data

During the program period July 2021 to April 2022, the nurse practitioner served 123 patients who visited the health clinics at various outreach locations.[6] Many of these patients attended multiple clinics at various times during the program and for a variety of reasons and health issues, and they received various health services. Of particular significance, a little over half (68) of the patients became rostered as patients with the North Bay Nurse Practitioner Led clinic and linked to primary care.

The following sections describe the patient data and counts across a number of variables. Following the program logic model, the data represents the outputs of the program's main activities and serves as indicators of progress in achieving the desired outcomes. The data set includes the patient's mobile health clinic location and date, age, the health issues and concerns for visiting the clinic, and the primary care services they received.

7.1 Patient Outreach Location

The table below shows the number of patients by the outreach location of the mobile health clinics:

Table 7. Outreach Location

	# patients	% total
NDHC Housing	71	57.7%
Crisis Center North Bay	47	38.2%
Other location	5	4.1%
Total	123	100.0%

The majority (58.0%) of the patients attended the health clinics at NDHC housing and were likely social housing tenants. While the locations have been rolled-up for reporting purposes, most of these clinics were held at the Edgewater and Golden Age Towers buildings.

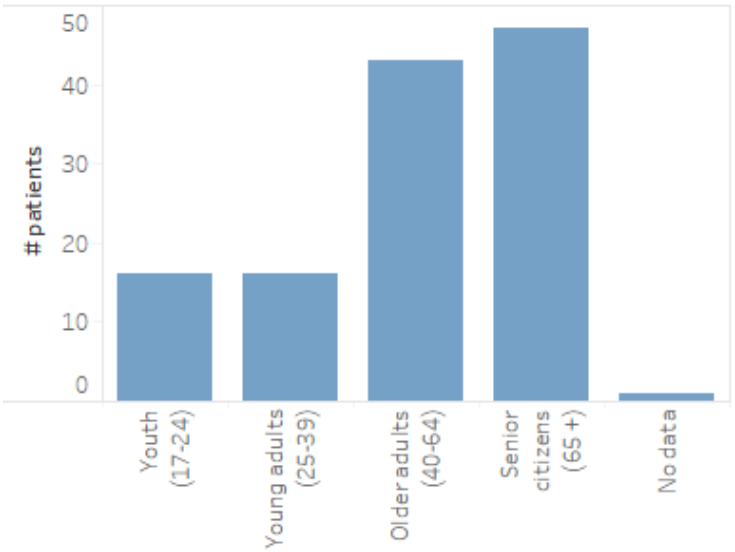
A little over one-third (38.0%) of the patients attended the clinics at the Crisis Centre North Bay emergency shelter and were likely staying there at the time. The small number (4.0%) of remaining clinic patients attended clinics at other various locations including Community Living North Bay and Nipissing Mental Health Housing & Support Services.

[6] Additionally, five patients initially presented with issues but did not become involved with the program or receive primary care or services.

7.2 Patient Age Groups

The median age of the patients visiting the mobile clinics is 58 years, although there is significant variation from the center point with age ranging between 17 and 91 years of age. Figure 2 below shows the age distribution of the patients by general age groups (data is unavailable for one patient).

Figure 2. Patient Age Groups



Older adults and seniors account for nearly three-quarters (73.0%) of the patients that visited the health clinics during the pilot period. Within this group, older adults ages 40-64 years account for 35.0% (43) of the patients followed by seniors at about 38.0% (47). The remaining 27% of clinic patients were young adults and youth under the age of 40 years. Within this group, young adults ages 25-39 account for 13.0% (16) of the clinic patients followed by the same number of youth ages 17 – 24 years (13.0%).

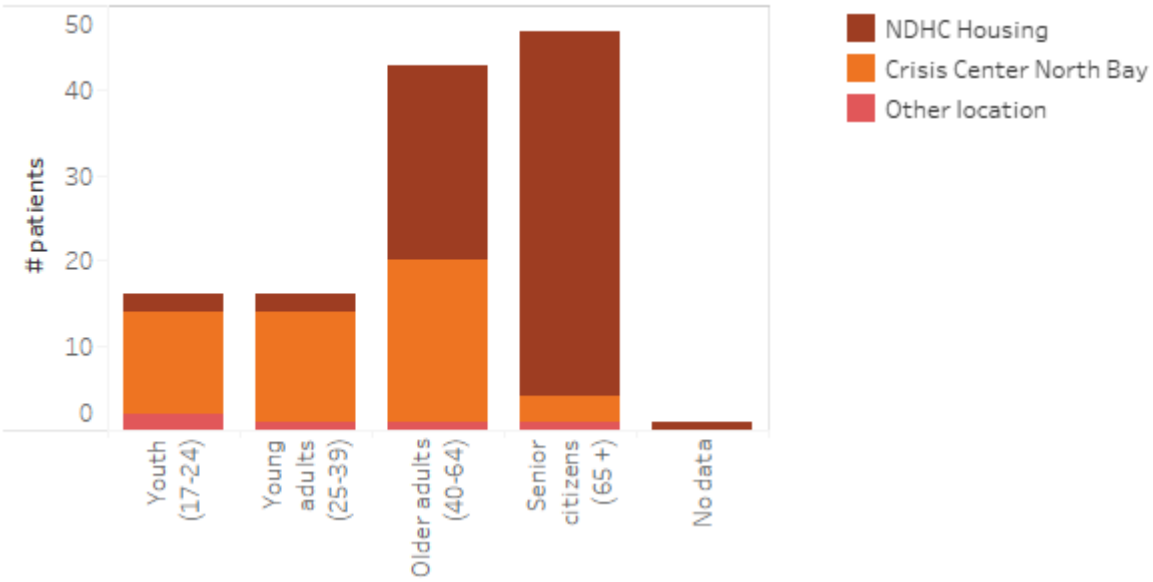
7.2.1 Patient Age Groups by Outreach Location

The figure on the following page shows the age group data stratified by clinic location to see if there is an association between age and clinic location.

For this particular program and group of patients there is a strong association between age and clinic location in most cases. The younger patients were more likely to attend the shelter clinics while seniors were more likely to attend the NDHC clinics (likely influenced by Golden Age Towers, a seniors only building). For example, the majority (78.0%) of the younger patients- youth and young adults – attended the health clinics at the emergency shelter while most (91.5%) seniors visited the clinics at the NDHC location. This differs significantly from what would be expected if there were no association between the two variables. Interestingly, the association between clinic location and older adults is not as significant and is closer to the expected distribution if there were no association between the two.[7]

[7] The stratified chart is the same as a two-way contingency table when presented in tabular form. The expected counts - apart from random variation - when there is no association between age groups and location are when the proportion of all patients in each location by age group, is the same as the proportion of patients in each age group (or joint probabilities equal the product of marginal probabilities). The smaller the difference between the observed and expected counts, the more likely it is that the two are not associated.

Figure 3. Patient Age Groups by Outreach Location



7.3 Number of Mobile Health Clinics and Patient Visits

While 123 patients participated in the program and health clinics as described above, some had more than one health issue and made multiple visits to the clinics at various times throughout the period. The number of health clinics and patient visits is described in the following sections.

7.3.1 Number of Mobile Health Clinics by Location

As shown in the table below, the nurse practitioner held 153 health clinics across the outreach locations described earlier. (Note: the number of health clinics is derived from the number of days the clinics were held. On some days, clinics were held at more than one outreach location).

Table 8. Number of Health Clinics by Location

	# clinics	% total
Crisis Center North Bay	42	27.5%
NDHC Housing	99	64.7%
Other location	12	7.8%
Total	153	100.0%

Close to two-thirds of the clinics were held at the NDHC housing locations while a little over one-quarter were held at the emergency shelter. The remaining health clinics were at other various locations. While the majority (83.7%) of the clinics were held at a single outreach location on a given day, some (16.3%) of the clinics were held at multiple locations on the same day.

The above table is expanded to include the number of health clinics and location by date for the 10-month pilot period from July 2021 to April 2022. The heatmap helps to identify the patterns and variation in the number of clinics across the locations:

Table 9. Number of Health Clinics by Location and Date

	2021						2022				Total
	July	August	September	October	November	December	January	February	March	April	
Crisis Center North Bay	1	4	3	5	4	5	3	7	10		42
NDHC Housing	5	13	8	13	13	15	10	7	9	6	99
Other location		3	5					3		1	12
Total	6	20	16	18	17	20	13	17	19	7	153

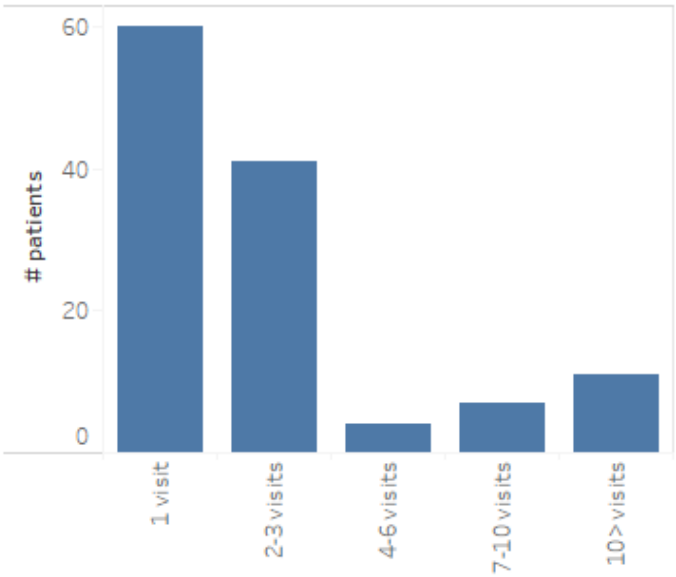
Apart from the program start-up and wind-down in July and April respectively, a monthly average of 18 clinics were held during the program period. This averages out to about one weekly clinic at the emergency shelter and three weekly clinics at NDHC housing during the period.

As noted by the table shading, the majority (62.5%) of clinics held at NDHC were in the earlier stages of the program between August and December. Following a dip in January, the number of NDHC clinics decreased significantly while increasing at the emergency shelter. Approximately 40.0% of the shelter clinics were held in February and March towards the end of the program.

7.3.2 Number of Patient Visits

During the program period, the patients made 324 visits to the mobile health clinics. As shown in the figure below, while many of the patients made one visit to the health clinic over the period, others made multiple visits:

Figure 4. Number of Patient Visits to Health Clinics



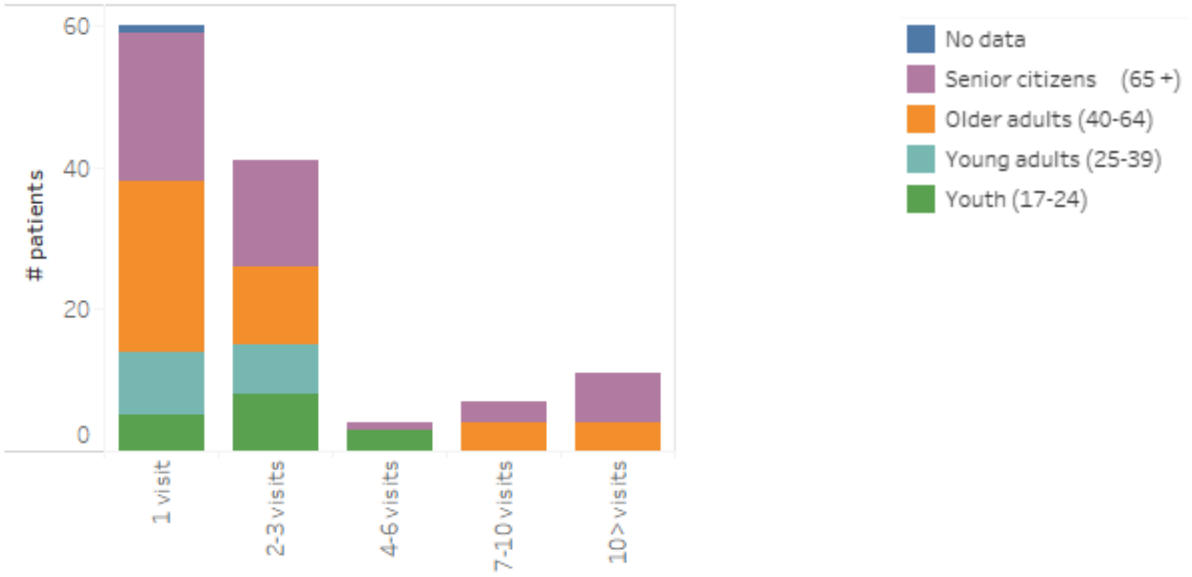
Close to half (48.5%) the program patients made one visit to a health clinic while another one-third of the patients made two or three visits. A further 9.0% of the patients made between four – ten clinic visits while the same number attended clinics 11 time or more.

About half the patients who attended the clinics 11 times or more have a relatively large number of health issues and represent some of the more complex patient needs (see also, patient heath issues and visits, p. 24).

7.3.3 Number of Patient Visits by Age

Figure 5 below shows the number of patient visits stratified by age, to observe any associations between the two variables and whether the number of clinic visits is influenced by age:

Figure 5. Number of Patient Visits by Age Group



As noted by the chart, the overall association between age and the number of clinic visits is a mixed result: there is no association of significance with less than four clinic visits. However, around the midpoint and beyond four-six visits, the number of visits is strongly associated with age.

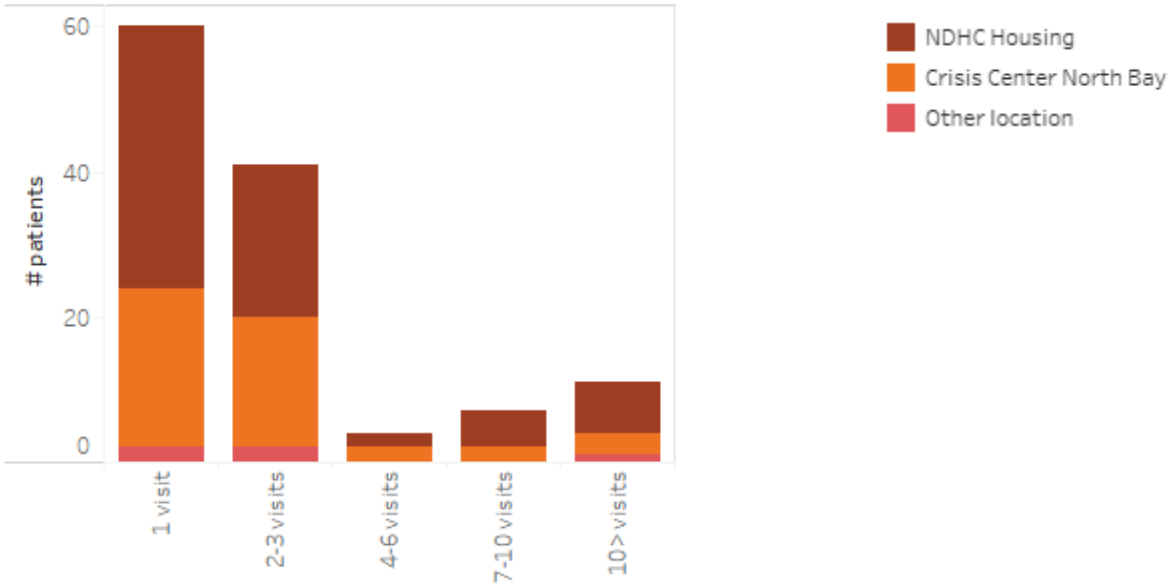
Generally, the age of the patients who made three or fewer clinic visits are spread out more evenly across the groups and follow a distribution that would be expected if there were no association between the variables. Therefore, for this particular program, age is not an influencing factor when there are a relatively small number of clinic visits.

However, after four or more visits the relationship between age and the number of visits changes with a strong association between the two. For example, patients making between 4-6 clinic visits were mainly youth, which is surprising given the expected age-group distribution across visits. Additionally, there were no younger patients making seven or more visits to the health clinics, only older adults and seniors.

7.3.4 Number of Patient Visits by Location

It is also interesting to look at the association between patient visits and clinic location to see if there are further patterns or associations - the figure below shows the number of patient visits stratified by clinic location:

Figure 6. Number of Patient Visits by Location



There does not appear to be an association of significance between the number of patient visits and the location of the clinic. As noted in the chart, the clinic locations are spread out across the groups of visits and follow a distribution that would be expected if there were no association between the variables. However, there is some effect depending on the number of visits. For example, patients visiting the clinics more than six times were more likely to visit the NDHC location than the Crisis Center location. Given that this group of patients are older adults and seniors as noted earlier, this location effect is at least partly attributable to the Golden Age Towers seniors building which was one of the main NDHC clinic locations. Where fewer patient visits are concerned, proportionately more patients made between two-six clinic visits at the Crisis Centre location and fewer at the NDHC.

7.4 Reasons for Attending Clinics and Patient Health Issues

The program patients gave a number of reasons for wanting to visit the mobile health clinic. For example, collectively, the patients provided about 145 different reasons for wanting to attend a clinic. Many patients provided more than one reason and the same reasons as other patients. Additionally, a number of the reasons for attending the clinics are similar and have common, underlying themes.

Upon conducting the health clinics with patients, the nurse practitioner recorded details of the respective visits and their clinical assessment of the patient's health issues and concerns. While the recorded health issues generally align with the patient's initial reason for attending the clinic, the nurse practitioner provided more detail around the patient's current health status based on the visit and clinical assessment. Additionally, a little over half the patients went on to have multiple clinic visits during the pilot period and in some cases, their health issues expanded beyond the initial reasons provided by the patients. For example, over the course of the program the nurse practitioner recorded about 200 unique health issues and concerns. As some of the patients have multiple issues and some issues are common amongst patients, this translates into about 400 issues or concerns for all program

patients during the period [8] (this count falls to 313 when the data is aggregated into groups – see below).[9]

The following sections describe the health issues of the program patients as assessed and recorded by the nurse practitioner. To accommodate the data analysis and frequency distributions, an inductive approach was taken to roll-up the health issues into broad categories based on common, underlying themes that emerged from the data. The thematic analysis is subjective and based on the analyst's judgment and general interpretation of the health issues.

7.4.1 Patient Health Issues

The patient health issues or concerns were rolled-up and combined into about 20 categories based on similarities in the type of illness or disease, and general area of health. One of the categories – patient support – reflects the support provided by the nurse practitioner in conducting client intake, providing patient referrals, and offering general healthcare and other advice. There are also categories for general problems and concerns, and various illnesses that do not fit in to the other health categories. The health 'categories' can also be viewed as 'health issues' for the purpose of this report and reference going forward.

The table on the following page shows the aggregated health issues by the number of unique patients, in descending order. Again, some patients have multiple health issues so the total number shown in the table includes duplicate patients and is greater than the program's actual number of patients (in this case, the number of patients is also the same as the number of health issues. Alternatively, another way of thinking of this is, the program's 128 patients have 313 health issues (the distribution of issues at the patient level of detail is covered in the next section).

About one-third of the total program patients (123) who attended the mobile clinics during the period required general *patient support*. For many of the patients who were unattached to primary care this included being rostered through the client intake process. Many of these patients needed general advice from the nurse practitioner on matters of health care and other areas, and required test results and referrals to other health specialists through the nurse practitioner.

Following the general supports above, *blood pressure* is the most common assessed health issue with a little over one-quarter of the patients attending the clinics for this reason. In most cases, the patients required blood pressure examinations although some of the patients also exhibited hypertension or hypotension.

Similarly, a little over one-quarter of the patients were assessed for general *pain* in various parts of the body. In about one-third of the cases this was considered to be chronic pain.

[8] Additionally, some of the patients attended the health clinics at different times for the same health issue or concern. Taking this into account, there were 514 health issues or concerns addressed at the mobile health clinics during the program period.

[9] When rolling-up the 200 health issues into groups, some patients have more than one health issue that falls in to the same group. Thus, the number of unique patients in each group becomes smaller (313) when the data is aggregated at a higher level of detail.

Table 10. Patient Health Issues and Concerns

Health Issue (group)	# patients
Patient support	42
Blood Pressure	32
Pain	32
General problems/ concerns	29
Mental health	21
Skin problems	20
Medication /Prescription	19
Various conditions/ illnesses	18
Diabetes	15
Ear, nose, throat, sinus	14
Stomach/ urinary infection/ bowel disorder	13
Diet, food insecurity	11
Substance abuse / Addiction	8
Wounds	7
Respiratory illness	6
Sexual health	6
Bone/ Osteoporosis	5
Heart	5
Arthritis & Osteoarthritis	4
Digestion	3
Edema	3
Total	**313**

General problems/concerns capture patient issues that do not necessarily fit any of the other health issue groups and can be viewed more as an individual fear or concern. Many of the patients (29, or 23.5%) expressed fear or concern over matters such as sleep, sexually transmitted disease, money, homelessness, dental care, mobility issues, access to health care, and the social environment in general.

Mental health is the next most common health issue for the program patients, with 21 (17.0%) of the patients at the clinics assessed with mental health issues and concerns. Many of the patients in this group have anxiety and depression, and a small number were assessed with bipolar or other disorders.

Skin problems of various types were another common health issue for 20 (16.0%) of the patients attending the clinics. This category covers a wide range of skin issues including rashes, lesions, and skin infections.

A relatively large number (19 or 15.5%) of the patients also attended the mobile health clinics for *medication and prescription* purposes. Most of these cases involved a prescription renewal or a medication review and counselling with the nurse practitioner. A small number of the patients received a local injection or shots for immunization purposes.

Similar to the general problems and concerns above, a number of the patients (18, or 14.5%) had *various conditions/ illnesses* that do not necessarily fit into one of the above categories based on the

classification method used. These conditions tend to be specific to the respective patient and include examples such as dizziness, headaches, bed bug bites, burns, and cold sores.

Between 11 and 15 (9.0 - 12.0%) of the program patients attended the clinics for the next group of main health issues which includes *diabetes* (Type 2) and various issues related to *ear, nose, throat and sinus*. Patients were also assessed with various *stomach issues, urinary infections and bowel disorders, and diet concerns and food insecurity.*

Fewer than 10 patients (8.0% or less) attending the clinics experienced the remaining health issues which, as noted in the table, cover a wide range of areas. These issues include *substance abuse/addictions* (alcohol, nicotine, and drugs), various types of *wounds*, *respiratory illness* (COPD, pneumonia, asthma, infection) and various issues related to the patient's *sexual health*. A relatively small number (five or less) of the patients in this group experienced *osteoporosis*, *heart conditions, arthritis*, *digestion problems* and *edema*.

7.4.2 Patient Health Issues by Age Groups and Location

Examining possible factors that are associated with health can provide further insights into program planning and delivery to service vulnerable populations. The following sub-sections look at the association between the health issues, age groups and clinic location:

7.4.2.1 Health Issues and Age

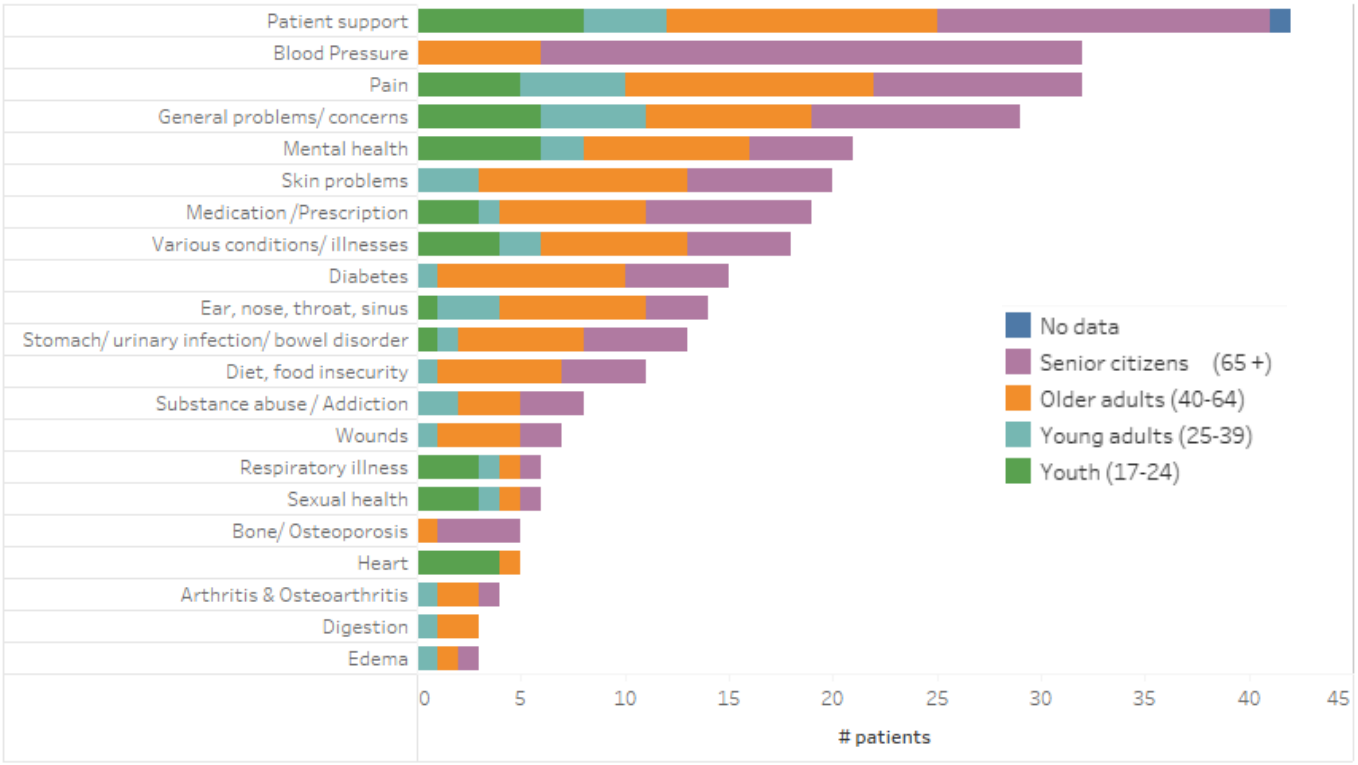
The figure on the following page shows the patient health issues by the general age groups and is presented in the same order as the table above.

The association between the health issues and age for the program patients is generally insignificant as evidenced by the representation of the age groups across the health areas. Based on the contingency table statistical analysis, many of the observed counts are close to what the expected counts would be when there is no association between variables.

However, in view of the above, there are some notable exceptions where the relationship between the health issues and age becomes significant and the observed counts are further from what otherwise might be expected. These are summarized below:

- The patients receiving the blood pressure examinations do not include those under the age of 40 years (i.e., solely older adults and senior citizens).
- Half the assessed health issues do not include youth under the age of 25 years. These issues include blood pressure; skin problems; diabetes; diet, food insecurity; substance abuse/ addiction; wounds; bone/osteoporosis; arthritis & osteoarthritis; digestion; and edema.
- Those with heart issues are mainly youth between the ages of 17 -24 years.

Figure 7. Health Issues by General Age Groups



7.4.2.2 Health Issues and Clinic Location

The figure on the following page shows the patient health issues by the location of the clinics and is presented in the same order as the chart above.

Similar to previous statistical analysis, the association between the health issues and clinic location is generally insignificant as evidenced by the distribution of location across the issues. Many of the observed counts are close to what the expected counts would be when there is no association between variables.

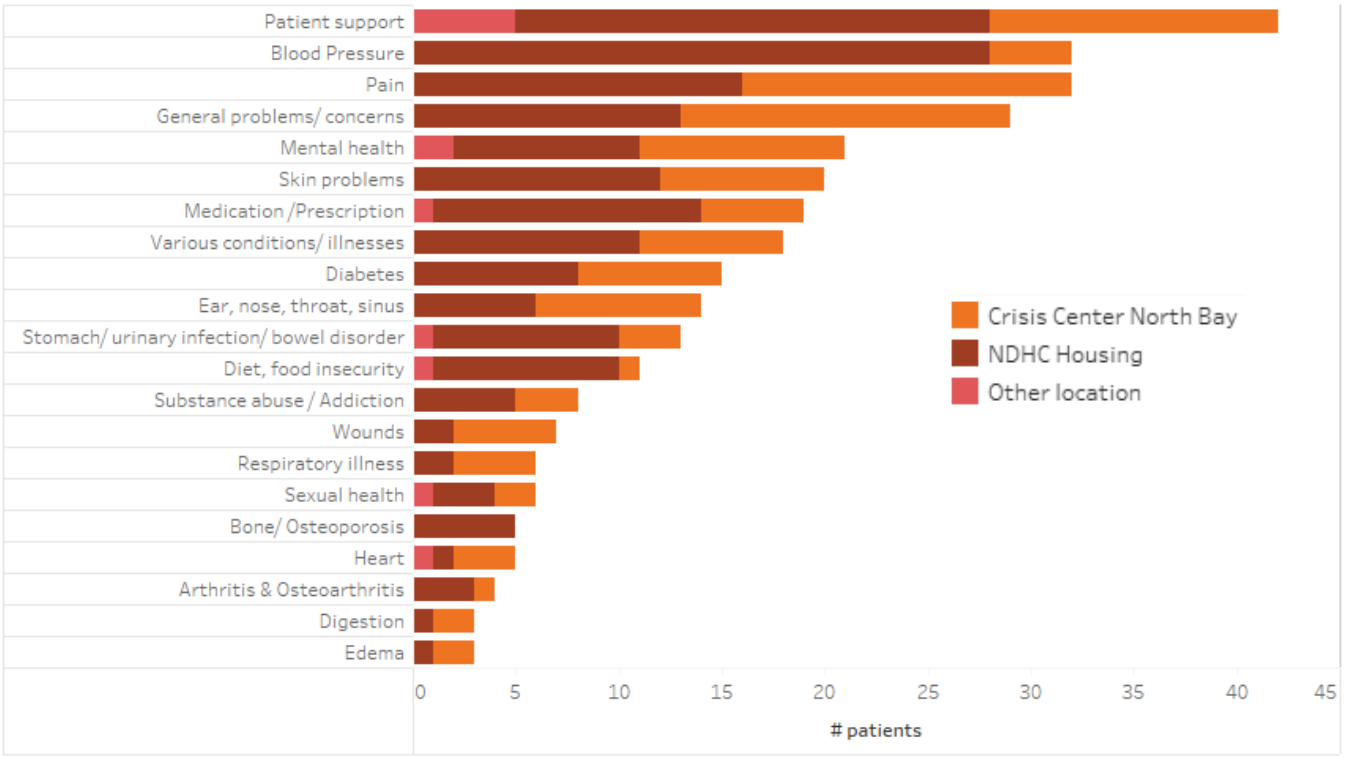
However, there are some notable exceptions where the relationship becomes significant and the observed counts are further from what is expected if there were no association. These are summarized below:

- The blood pressure issue is strongly linked to location, with proportionately more patients attending the NDHC clinics for this issue and fewer attending the shelter clinic. This is consistent with previous findings and the older population associated with the blood pressure issue.

- Patients with diet and food insecurity issues were more likely to attend an NDHC clinic than a shelter clinic during the program, which is somewhat surprising.

- On the flipside, patients experiencing pain tended to be over-represented at the shelter clinic and under-represented at the NDHC clinics.

Figure 8. Health Issues by Clinic Location

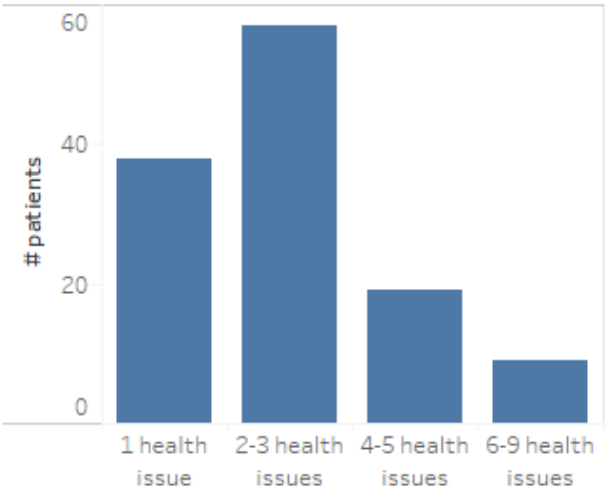


7.4.3 Distribution of Patient Health Issues

As mentioned earlier, some of the patients who attended the mobile health clinics had more than one health issue and attended multiple clinics during the period. On average, the patients attending the clinics had three unique health issues although the number varies between 1 and 9 issues.

The table below shows the number of program patients grouped by the number of health issues they experienced during the program.

Figure 9. Distribution of Patient Health Issues

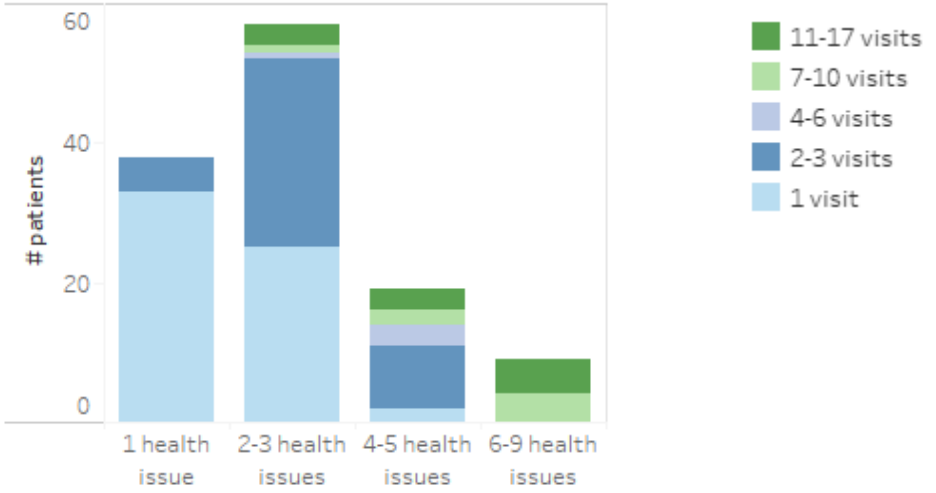


A little under one-third (31.0%) of the patients had one health issue while close to another half (46.5%) had 2-3 issues. The remaining patients (22.5%) had between 4 - 9 issues or concerns and can be considered patients that are more complex with greater health needs. Most of those in the 6-9 issue group have mental health issues along with various other illnesses and health concerns.

7.4.3.1Patient Health Issues and Visits

Intuitively, the number of visits to the mobile health clinics is related to the number of health issues and concerns the patients have. So generally, the higher the number of health issues and concerns, the higher the number of clinic visits and vice-versa. This notion generally holds true for the program patients where there is a moderate correlation between the number of patient health issues and clinic visits as shown in the figure below: [10]

Figure 10. Patient Health Issues and Clinic Visits



Generally, the patients with fewer health issues made fewer visits to the clinic than those with more health issues, although there is some unexplained variation from this pattern and other factors such as the type of health issue, severity, etc. also needs to be considered.

The majority (87.0%) of patients with just one health issue or concern visited the health clinic once, and account for a little over half the patients with a 1-time visit. The remaining (13.0%) patients with one health issue made 2-3 clinic visits.

For the patients with 2-3 health issues, 44.0% attended a clinic once while close to the same number (47.0%) attended the clinics 2-3 times. The remaining (8.0%) patients in this group vary significantly from the normal or expected (linear) pattern. These patients made a relatively large number of four or more visits to the clinics and include a small number of outliers with over 10 visits. This example illustrates

[10] In a simple statistical model the relationship between clinic visits and health issues is somewhat linear and of moderate strength when taking the statistical outliers into account (correlation coefficient, r = 0.84 or 0.69 with outliers removed). If the number of patient health issues is considered a predictor of the number of clinic visits, close to half of the variation in clinic visits is explained by the number of health issues. Additional information and data is needed to determine which is the predictor variable and which is the outcome. For example, a larger number of health issues could lead to more clinic visits through increased patient need and complexity, but more clinic visits could lead to fewer health issues through the provision of effective primary care.

how some of the patients - even those with fewer health issues - can have greater needs and require multiple clinic visits.

Turning to those with a larger number of health issues, over half (58.0%) the patients with 4-5 issues made a relatively small number of three or less visits to the clinics, including a small number with just one visit. This example illustrates the opposite to the above, i.e., how some of the patients - even those with relatively more health issues - have fewer needs and require fewer clinic visits. The remaining (42.0%) patients in this group attended the health clinics four times or more.

The remaining patients with between 6-9 health issues account for just 7.0% of the total patient population but represent half those visiting the clinics between 7 -17 times. This group also received proportionately more health services (below.)

7.5 Health Care Services Provided

The following section turns to the health care and services provided by the nurse practitioner to address the patient issues and concerns described above. The types of services provided during the clinics were recorded in the patient database by the nurse practitioner and correspond closely to the health issues and concerns described earlier.

Over the course of the program, the nurse practitioner provided 34 unique health services to the patients. As with the health issues and concerns, some patients received multiple services during the clinic visits and attended multiple clinics throughout the program. Additionally, many services are common amongst patients. Thus, this translates into over 1,000 health services provided during the program period (this count changes when the data is aggregated into groups – see below).[11]

The following sections describe the health services received by the patients as recorded by the nurse practitioner. Similar to the previous analysis around the health issues, the individual services have been rolled-up into broad service categories based on common, underlying themes. The thematic analysis is subjective and based on the analyst's judgment and general interpretation of the health services provided.

7.5.1 Patient Health Services

The patient health services were rolled-up and combined into eight categories based on similarities in the type of care and service provided, and the general area of health (see Appendix 4 for service category roll-up). One of the categories – general support – reflects general services around the provision of primary care and counselling/advice that do not necessarily fit into the other categories. In addition, as with the previous analysis, the 'categories' can also be viewed as 'services' for the purpose of this report and reference going forward.

[11] When rolling-up the health services into groups, some patients received services that fall into the same group. Thus, the number of unique patients in each group is smaller when the data is aggregated at the higher level of detail.

The table below shows the grouped health services by the number of unique patients in descending order. Again, some patients received multiple services through multiple clinic visits, so the total number shown in the table includes duplicate patients across the services and is greater than the program's actual number of patients (in this case, the number of patients is also the same as the number of health services. Alternatively, another way of thinking of this is, the program's 123 patients received about 600 services.) [12]

Table 11. Patient Health Care and Services

Service (group)	# patients
General support	123
Care Plan	110
Assessment	104
Complementary interventions	79
Diagnostics	71
Medication/Prescription	55
Chronic illness monitoring	36
Referrals and Consultations	30
Total	**608**

All the patients received *general supports,* which as noted in Appendix 3, include a wide range of individual services such as counselling, providing patient advice, and carrying out general administrative duties.

Most (90.0%) of the patients also had *care plans* prepared by the nurse practitioner which revolved around discussing treatment, case coordination and conferencing, care plan review, and document management.

The nurse practitioner conducted *assessments* on 84.5% of the patients, which rounds off the top three health services provided during the program. Most of the assessments conducted were general assessments followed by intermediate and psychological assessments.

Complementary interventions include other health modalities (e.g. massage, chiropractic, acupuncture, etc.) and were provided to about two-thirds of the program patients.

The remaining health services provided to the patients include performing *diagnostics* (57.5%), providing *medication and prescriptions* (44.5%), *chronic illness monitoring* (29.0%) and *referring patients* and *organizing consultations* (24.5%).

Cross-referencing the above health services with the patient health issues described earlier, shows the services widely distributed and generally spread out across the various issues. In many cases, the respective patients typically received the same suite of health services for their various health issues. Additionally, the number of patient clinic visits, health issues, and services are strongly correlated and interrelated. Given the strong connection between the patient health issues and the subsequent

[12] The health service description is missing in about 8.0% of the 2,400 + records in the patient services database. This has little effect on the results as the missing service descriptions are duplicated data that become redundant when aggregated for unique counts and rolled-up at the group level.

services provided to the patients, the relationships examined earlier between variables such as age, clinic location, patient issues, and visits, hold true for the services also.

8.0 Rostered Patients

By the end of the pilot period, the North Bay Led Nurse Practitioner Clinic had rostered a little over half (68) of the patients described in the sections above, who were previously unattached to primary care.

The table below shows the number of rostered patients by the clinic location and other sources:

Table 12. Rostered Patients

Location	
Community Paramedic referrals	4
Community partner referrals	25
Emergency shelters	12
Infants/Unattached children	16
NDHC housing	11
Total	68

A little over one-third of the patients (or one-fifth of all program patients) became rostered at the nurse practitioner clinic through referrals from community partners. Approximately 16.0% were also rostered through emergency homelessness shelters (the Crisis Centre North Bay and Northern Pines).

Conclusion and Recommendations

9.0 Conclusion

The Mobile Nurse Practitioner Pilot Program is an innovative program designed to connect vulnerable and unattached (orphan) residents of Nipissing District to primary care and other services, through the provision of mobile health clinics. The program is a partnership between the District of Nipissing Social services Administration Board (DNSSAB) and the North Bay Nurse Practitioner-Led Clinic (NBNPLC), and funded through provincial emergency pandemic funding.

While the program partners intended to implement the program in April 2021 for a period of one year, timing constraints and start-up delays resulted in late implementation and the program was not operational until July 2021. In addition to delaying - and shortening - the period for providing health services to patients, the late start up had other consequences that included a change to the program scope, and problems with funding and staff retention issues at the nurse practitioner clinic.

Despite the late program start up and implementation issues, the program evaluation evidence and results indicate that the program achieved two of the main outcomes, which are to *enable primary care to vulnerable and unattached residents*, and *connect clients that have other service needs, with community service providers for the continuity of care*. It is not clear whether the third program outcome, to *reduce hospital and ER admissions/ readmissions* was achieved based on the program information and data available.

The program evidence shows that the mobile health clinics provided direct access without barriers to vulnerable and marginalized patients, including those who were unattached to primary care and likely would not have received care, otherwise. Over the nine-month operating period the nurse practitioner provided 153 mobile outreach clinics located in emergency shelters and social housing. The clinics were attended by 123 patients, ranging in age from youth (17 years) to senior citizens (65 +). Some of the patients had multiple health issues and concerns, and visited the mobile clinics multiple times, while receiving multiple health services. By the end of the pilot period, 68 unattached patients were rostered in to a Primary Health Team through the program and nurse practitioner clinic.

Through patient consultations and referrals, the nurse practitioner also connected patients with other health-related needs to community service providers and health specialists for the continuity of care. This included collaborating with community paramedics on mutual referrals for people needing care. Additionally, the clinic's system navigator helped patients access community resources and programs.

In view of the above and the successes of the program, there are lessons learned and things that can be improved upon or done differently if the program is continued or becomes permanent.

Upon implementing the program, it became evident that some of the target locations for the mobile clinics did not require the program's outreach on a regular basis as the expected patient need was not there. Conversely, the high-need locations could have done with more clinics and hours to increase patient care and health outcomes. Additionally, the nurse practitioner found themselves seeing patients who already had a primary care provider, detracting from the program's main goal and target population. Closely related, at times the nurse practitioner's scope of practice was under-utilized. For

example, many of the patient's health issues and reasons for visiting the clinics are within a registered nurse's scope of practice and a nurse practitioner may not be necessary on a full time basis.

Conducting more detailed research and program planning at the outset would help to maximize program resources and reduce some of the problems encountered during implementation. This involves collecting input and feedback from the target population and clinic locations to verify program assumptions and assess the actual need for primary care. The enhanced planning would also include increasing program involvement and collaboration with community partners. In terms of evaluating the program, a formal research design provides a more structured and systematic approach to measuring the program results and outcomes.

10.0 Recommendations

In view of the program evaluation and evidence, the following are Board recommendations:

Continue the mobile health clinic program with consideration of the program changes and improvements below:

- Reestablish program management and a formal steering committee to review the final report, program data and evidence, and recommendations moving forward.
- Conduct further program research and analysis to optimize program resources and the nurse practitioner's time, by concentrating on the service locations and patients most in need.
- Obtain patient input and feedback to further inform program planning and service delivery.
- Operate the mobile health clinics at select locations where there is demonstrated need and provide more frequent clinics and support.
- Review the program model with an option of including registered nurses for patients requiring a different scope of practice. The nurse practitioner would be available for high-need patients and locations that require an expanded scope of practice.
- Develop a screening tool and process to confirm patient need at the clinic, and redirect those who currently have a primary care provider.
- Develop the data system and process necessary to collect, analyze and present program data, and measure performance and results.

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Appendix

1. **Program Logic Model**

Inputs/ Resources	Program Component	Implementation Activity	Outputs	Intended Outcomes
Funding: $ 150,000 SSRF (phase 2) *Staff:* DNSSAB; Community Paramedics; Partners/ service providers *Site facilities /space* *Vehicle*	North Bay Nurse Practitioner-Led Clinic	Provide direct and indirect patient care by conducting mobile health clinics, patient outreach, and referrals.	- Patient needs identified - # patients (by location) - Target population penetration rate - Type of health services provided (reason for visit) - # referrals from service providers - #/hrs. outreach - # /hrs. clinics - Hrs. patient care - # walk-ins - # unattached patients rostered (clients connected to PHC)	Enable primary care to vulnerable and unattached / under-serviced residents in Nipissing District.
		Identify key community partners/ service providers and establish working relationships and referral process.	- # service providers involved with program - # patient referrals to other service providers	Connect patients (above) that have other, related service needs, with community service providers for continuity of care.
		Coordinate patient care and service system navigation.	- # patient follow-ups/ follow-up rate - Patient retention rate - # patients declining supports - Patient turnover rate - Hospital readmission rate	Reduce the likelihood of patient hospital and ER admissions/readmissions.

2. Mobile Nurse Practitioner Pilot Program Operating Schedule

Monday	Tuesday	Wednesday	Thursday	Friday
AM **Admin time** Attend meetings, community tables Touch base with DNSSAB and partners re: Pilot project Connect with external community providers re: clients/connections	AM **OUTREACH** Direct patient care	AM **IN-CLINIC @ NPLC** **Direct Patient Care** See drop ins, scheduled appts requiring in-office equipment, privacy etc.	AM **OUTREACH** Direct Patient Care	AM **Indirect patient care** - Review incoming labs/corresponden ce - Phone calls - Complete advocacy letters - Patient forms completion
PM **Indirect patient care** - Review incoming labs/corresponden ce - Phone calls - Complete advocacy letters - Patient forms completion	PM **OUTREACH** Direct Patient Care	PM **Physician Consult Time**	PM **OUTREACH** Direct Patient Care	PM Patient Care Planning, week wrap up, any drop -ins prior to weekend? Review key metrics/tracking Reporting week-end “remarkables” Debrief with partners re: any concerns etc. *Leave this open for emerging needs.*

3. Program Committee Survey Questions

Mobile Nurse Practitioner-Led Clinic Pilot Program

Program Context: Outcomes and Target Population

Before starting the survey, please read the following which provides some context for the questions that follow:

Program Intended Outcomes

- **Enable primary health care to vulnerable and unattached residents in Nipissing District.**
- **Connect those (above) that have other, related service needs, with community service providers for the continuity of care.**
- **Reduce hospital and ER admissions/ readmissions.**

Target Population

The pilot program aims to service vulnerable residents of Nipissing District who have limited, or no access to individual primary health care. This population includes those experiencing low income, poverty, homelessness, and/or housing insecurity (whether through provisional accommodations or the risk of losing housing). In keeping with the project scope and reasonable service expectations during the pilot period, the initial target population was limited to those experiencing homelessness and living in shelters or on the streets (e.g. encampments), and social housing tenants living in NDHC housing.
Now for the survey questions!

* 1. *Please enter your name* (linking your name to the survey results will provide additional context for the report, as it relates to your level and area of involvement with the pilot program, field of work, etc.).

2. *Was the program implemented according to plan or the Steering Committee's direction?*

- ◯ Yes
- ◯ No
- ◯ Unsure

3. *Please describe why the program was not implemented as planned* (include any changes that were made to program implementation and the reasons for the change):

4. *Looking back, would you have done anything differently to implement the program?*

- ◯ Yes
- ◯ No
- ◯ Unsure

5. *Please describe what you would have done differently to implement the program:*

6. *Based on your experiences and observations implementing and/or operating the program, would you recommend that the 'pilot' program be extended or made permanent?*

- ◯ Yes
- ◯ No
- ◯ Unsure

7. *Please state the reason for your answer above (i.e., 'Yes', 'No' or 'Unsure') regarding whether or not to extend or make the program permanent:*

8. *Based on the program's intended outcomes and target population (provided at beginning of survey) would you make any changes to improve the program going forward?*

- ◯ Yes
- ◯ No
- ◯ Unsure

9. *What changes would you make to improve the program?*

Outcomes: Enabling Primary Health Care

10. *Based on your experiences and observations implementing and/or operating the program, please indicate whether or not the following intended outcome was achieved:* ***Enable primary health care to vulnerable and unattached residents in Nipissing District.***

- ◯ Achieved
- ◯ Not achieved
- ◯ Unsure

11. Please indicate why you think **enabling primary health care to vulnerable and unattached residents in Nipissing District** was achieved:

12. Please indicate why you think **enabling primary health care to vulnerable and unattached residents in Nipissing District** was not achieved:

Outcomes: Connecting Patients to Other Service Providers

13. *Based on your experiences and observations implementing and/or operating the program, please indicate whether or not the following intended outcome was achieved:* ***Connect clients that have other, related service needs, with community service providers for the continuity of care.***

- ◯ Achieved
- ◯ Not achieved
- ◯ Unsure

14. Please indicate why you think **connecting those (above) that have other, related service needs, with community service providers for the continuity of care**, was achieved:

15. Please indicate why you think **connecting those (above) that have other, related service needs, with community service providers for the continuity of care**, was not achieved:

Outcomes: Reducing Hospital Visits

16. *Based on your experiences and observations implementing and/or operating the program, please indicate whether or not the following intended outcome was achieved:* ***Reduce hospital and ER admissions/ readmissions.***

- ◯ Achieved
- ◯ Not achieved
- ◯ Unsure

17. Please indicate why you think **reducing hospital and ER admissions/ readmissions**, was achieved:

18. Please indicate why you think **reducing hospital and ER admissions/ readmissions** was not achieved:

4. Health Care and Services Provided by Nurse Practitioner

Service (group)	Service
General support	Advocacy
	Basic support
	Breast feeding counselling
	Client intake/interview
	Community services information
	Family planning/birth control
	Forms completion
	Health advice/instructions
	Health card registration services
	Individual counselling
	Recommendation/assistance
Care Plan	Care plan documentation
	Case conference
	Case management/coordination
	Chart review
	Discuss treatment plan
	Mental health care
	Preventive care
Assessment	General assessment
	Intermediate assessment
	Psychological assessment
	Repeated assessment
Complementary interventions	Complementary interventions
Diagnostics	Diagnostic test request
	Discuss diagnostic findings
Medication/Prescription	Dispense medication
	Medication prescription
	Medication reconciliation
	Medication renewal
Chronic illness monitoring	Chronic illness monitoring
Referrals and Consultations	External consultation
	External referral
	Internal consultation
	Internal referral

District of Nipissing Social Services Administration Board

Conseil d'administration des servicessociaux du districtde Nipissing

BOARD REPORT P03-23

☐ For Information or ☒ For Approval

Date: March 22, 2023

Purpose: **Response Time Standards**

Prepared by: Stephen Kirk, Chief, Paramedic Services

Reviewed by: Justin Avery; Manager of Finance

Approved by: Catherine Matheson; Chief Administrative Officer

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Alignment with Strategic Plan: Healthy, Sustainable Communities

☐ Maximize Impact ☐ Remove Barriers ☐Seamless Access ☒ Learn & Grow

RECOMMENDATION

THAT the District of Nipissing Social Services Administration Board (DNSSAB) accepts the Ontario Ambulance Response Times Standards (RTS) and compliance for 2022.

PURPOSE

The purpose of this report is to provide the District of Nipissing Social Services Administration Board (DNSSAB) with both the background for the Ontario Ambulance Response Time Standards (RTS) and detailed compliance results for the 2022 period. A letter detailing the response performance will be submitted to the Emergency Health Regulatory & Accountability Branch (EHRAB) of the Ministry of Health (MOH) Director by the March 31st deadline, as prescribed in the Ambulance Act Regulations.

BACKGROUND

In 2006, the Provincial government, in conjunction with the Association of Municipalities of Ontario (AMO) and the Land Ambulance Steering Committee (LASC), established a committee to review the current and future state for a number of subjects, including response time standards for Paramedics. On July 31, 2008, amendments to the

Ambulance Act were passed. One such amendment related to Response Time Performance Plans and methods for measuring regulatory compliance. Following a number of delays, Response Time changes were finally implemented for 2013.

Response Time Performance Plan Design

Under Regulation 257/00, each Direct Delivery Agent (DDA) responsible for the provision of land ambulance services is responsible to submit to the Emergency Health Regulatory and Accountability Branch (EHRAB) Response Time Performance Plan no later than October 31 of each year. This plan shall detail expected compliance with response targets for the following calendar year. The report shall break out target compliance based upon patient acuity as set out in the Canadian Triage and Acuity Scale (CTAS). The CTAS scale ranks patient acuity from CTAS 1(the most severe) to CTAS 5 (the least severe). A breakout of the acuity scale is detailed within this document.

By March 31st of each year, the DDA must submit a compliance report to the EHRAB Director that captures response time efficacy/compliance for the previous calendar year. DNSSAB reports response time metrics based upon district-wide performance.

CTAS Reaffirmed

To understand the RTS metrics, it is essential that readers have a rudimentary understanding of the Canadian Triage and Acuity Scale (CTAS). CTAS is a method for grouping patients according to the severity of their condition and is inclusive only of patients managed through the 9-1-1 emergency system. The CTAS scale is a medically validated scale used by hospital emergency departments across the Province. The CTAS scores are defined as follows:

CTAS 1: Severely ill, requires resuscitation

Requires resuscitation and includes conditions that are threats to life or imminent risk of deterioration, requiring immediate aggressive interventions (for example, cardiac arrest, and major trauma or shock states).

CTAS 2: **Requires emergent care and rapid medical intervention**

Requires emergent care and includes conditions that are a potential threat to life or limb function, requiring rapid medical intervention or delegated acts (for example, head injury, chest pain or internal bleeding).

CTAS 3: **Requires urgent care**

Requires urgent care and includes conditions that could potentially progress to a serious problem requiring emergency intervention, such as mild to moderate asthma, moderate trauma or vomiting and diarrhea in patients younger than two years.

CTAS 4: **Requires less-urgent care**

Requires less-urgent care and includes conditions related to patient age, distress or potential for deterioration or complications that would benefit from intervention, such as urinary symptoms, mild abdominal pain or earache.

CTAS 5: Requires non-urgent care

Requires non-urgent care and includes conditions in which investigations or interventions could be delayed or referred to other areas of the hospital or health care system, such as sore throat, menses, conditions related to chronic problems or psychiatric complaints with no suicidal ideation or attempts.

Patient acuity of inter-facility activity is not considered in the CTAS system of scoring, while such workload negatively influences emergency resource response capacity.

Response Time Standard Targets

As detailed earlier, DNSSAB is required to report the projected response time standard targets to the MOH by October 31st of each year. The 2022 targets were submitted in October of 2021, and the 2022 target results detailed on the table below will be submitted by March 31st of this year. Additionally, target noncompliance must be accompanied with detailed assessment findings and proposed methods to reach target response times.

MOH ADRS Data Set **Patient Severity***	**Target Time**	**Actual Time**	**Target Response Met**	**Call Volume By CTAS**
SCA (Sudden Cardiac Arrest)	6 minutes, **40% of time**	6 minutes, **53.33%** of time	Yes	90
CTAS 1	8 minutes, **70% of time**	8 minutes, **74.92%** of time	Yes	302
CTAS 2	16 minutes **90% of time**	16 minutes, **89.20%** of time	No	3,175
CTAS 3	16 minutes **90% of time**	16 minutes, **89.04%** of time	No	4,098
CTAS 4	16 minutes **90% of time**	16 minutes, **91.61%** of time	Yes	2,895
CTAS 5	16 minutes **90% of time**	16 minutes, **91.28%** of time	Yes	1,204

CTAS 1 volume inclusive of SCA calls

*Data source utilized for this report was Interdev I-Medic Patient records

CURRENT ISSUES/CHALLENGES

The RTS process for calculating Paramedic Service response efficiency is far more appropriate than the historic “MOH 1996 90th percentile” model, previously in place. That Standard simply required services to maintain their response times, as they existed in 1996 and did not account for system evolution, demographic deviations, nor funding changes.

Despite the modernization of response measures, there is a wide acknowledgement that the current process has its own challenges. The current model places a greater focus on response to sudden cardiac arrest patients, patients who represent less than 0.7% of the total patient population and one where successful resuscitation is rare when the event is not witnessed.

It is also important to note that formal data points utilized for assessment of RTS compliance are compiled by the MOH Central Ambulance Communications Centers through manual inputs, and then shared with Paramedics for inputting into the patient records system. These inputs are subject to delays do to extreme stress and conflicting priorities. A more accurate assessment tool would be “real time” system monitoring, something being developed and made available only now across Ontario.

The ability of a Paramedic Services to achieve the 6 or 8-minute response timeframe a high percentage of the time remains a challenge due to issues ranging from static deployment modeling to rural geographic limitations. A target compliant response within 6-minutes form notification excludes distances beyond 6 to 8-KMs from a Paramedic Station.

Sudden Cardiac Arrests (SCA) compose less than 0.7% of the total volume of Paramedic responses, and while these events are of significant risk to the patient, capacity to respond to these calls should not be the greatest organizational metric of success. Slight changes to response times would have significant impact on success metrics. Each call would alter the overall performance rate by nearly 1.5%.

Reliance on allied agencies through tiered response agreements have allowed for improved access to defibrillation. While the volunteer Fire Department design does pose continued risk to success due to response time capacity, Public Access Defibrillator (PAD) programs have shown some success for communities. Unfortunately, the majority of SCA calls to not occur in public locations, meaning that AED devices are not immediately available.

Non-urgent inter-facility utilization of Paramedics has a direct negative impact on resource, and collaboration with partner agencies to leverage the non-urgent system to reduce dependency on EMS will ensure emergency resources available for use in the deployed community. At the beginning of 2023, local hospitals have engaged in internal

and external resources to address the pressures of non-urgent transfers and reduce the dependency on Paramedic Services to support this.

Paramedic Services has seen an approximate 18% increase in overall call volume in the last two years. This has added significant pressures on resource availability. DNSSAB anticipates some relief with the expected reduction in request for non-urgent transfers. A more fulsome assessment of deployment models is required and will be considered for the 2024 budget.

Lack of 24/7 on-site coverage in communities has a direct impact on RTS target compliance. Paramedics who are at an “on call” state have 10 minutes to become mobile, while Paramedics who are at an “on site” state have two minutes to become mobile. Obviously, a mandated 6-minute response to SCA events, or an 8-minute response to CTAS events are not achievable during an “on call” state. On-call deployment currently exists in three communities across Nipissing District. The District’s Paramedic Service is motivated to complete a full review of current scheduling models to determine opportunities to improve response time.

The RTS system allows DDAs to choose both the target response time, and the target response compliance percentage for CTAS 2, 3, 4, and 5 calls. This multiaxial approach presents a challenge to service comparisons. Target compliance is less an issue with lower acuity events and staff plan to evaluate a method to ensure target times are more closely matched to patient acuity.

The RTS plan for 2023 has been reassessed, amended, and submitted in October 2022 to support a more accurate evaluation of response within the district. If Paramedic Services were to apply the RTS criteria submitted for 2023 to the data for 2022, full compliance would be achieved. Ongoing evaluation of systemic improvement opportunities continue and will be reflective in future RTS plans.

CONCLUSION

Recent overall call volume increases support the challenges with achievement of RTS success. Paramedic Services have experienced recent capacity issues in meeting the response time standards and more fulsome evaluation must be conducted. The assessment of the current service model and strategic design of direct delivery of Paramedic services across Nipissing District will examine factors that could improve response times to the most serious incidents, while leveraging partnerships to ensure public safety is principle.