ADDITIONAL HUMAN RESOURCES REQUEST BUSINESS CASE

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Algoma
Nurse Practitioner-Led Clinic

FOR CONSIDERATION

BUSINESS CASE FOR A 1FTE NURSE PRACTITIONER (PRIMARY CARE & MENTAL HEALTH AND ADDICTIONS)

PURPOSE
The purpose of this business case is to request base funding for 1.0 FTE Nurse Practitioner (NP) as part of the Algoma Nurse Practitioner-Led Clinic, to provide proactive outreach to Sault Ste Marie's unattached population and those living with mental health and addiction issues.

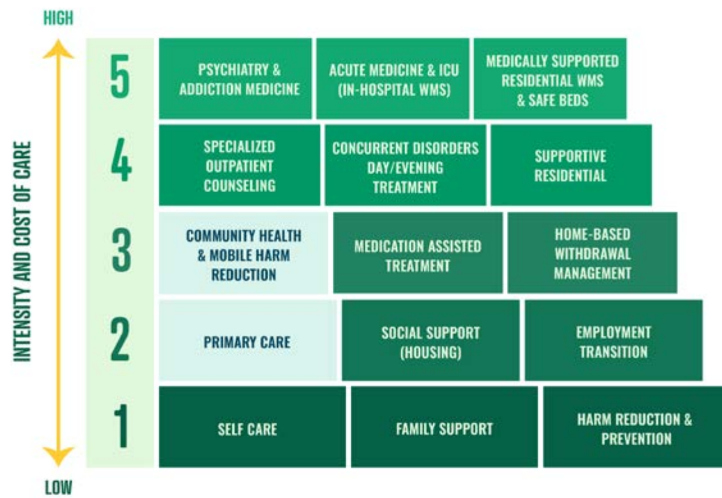
ABOUT THE ALGOMA NPLC
The Algoma NPLC is a non-profit agency that provides primary care to residents of Sault Ste. Marie and surrounding area who are currently unattached to a primary care provider (Nurse Practitioner/ Physician). The clinic provides accessible comprehensive, patient-focused care to patients across the lifespan, including health promotion, disease prevention, chronic health, and mental health management. Members of the clinic will be registered to a nurse practitioner and will have access to the clinic's multidisciplinary team which includes a registered nurse, registered practical nurses, social worker, pharmacist and administrative staff. The team works collaboratively to aid patients in navigating the health system to coordinate integrated care within established community partnerships.

Currently, the Algoma NPLC is the only primary care clinic in Sault Ste. Marie and surrounding area with an explicit focus, or funding model, that allows it to focus on the needs of unattached patients.

BACKGROUND
Under the umbrella of the Algoma Ontario Health Teams, 8 partners across health and social services, decided to come together to address the unmet needs of an underserved community in Sault Ste Marie. These partners include: District of Sault Ste. Marie Social Services and Administration Board (DSSMSAB), Sault Ste. Marie Police, Algoma Family Services, Ontario Health North, Superior FHT, CMHA Sault Ste Marie, and Sault Area Hospital. After conducting an environmental scan and looking at data, such as EMS utilization, the group decided to focus on a more community-based approach. When compared with the rest of Ontario, Algoma communities experience 2x the rate of hospitalization for self- harm, drug toxicity and opioid toxicity and the rate of hospitalization for mental health and addictions is 554 per 100,000 residents versus 184 in the rest of Ontario. This points, not only to a high burden, but an overreliance on acute-based services, as was reinforced in the North East LHIN Addiction Services Review.

Due to increasing homeless and underhoused population in Sault Ste Marie who suffer disproportionately from mental health and addictions issues, the area of focus identified was primary care nursing, mental health & addictions, and peer support to ensure that they receive integrated health and social services where they need them.

Figure. Focus of Intervention: Community Health, Mobile Harm Reduction and Primary Care



COMMUNITY WELLNESS BUS

The Community Wellness Bus is an evidence-based primary care outreach model that leverages organizational programmes and expertise, particularly in primary care and mental health and addictions.

The objectives of the Community Wellness Bus are to:

- To provide outreach services to meet community members where they are at
- To deliver culturally sensitive care and be a pathway for individuals to access health and social services
- To improve community safety with an added presence and community engagement
- To re-build trust with the community and enhance well-being

The program has been designed to complement staffing in primary care, mental health and addictions and ensure that staff are not only able to do on-site medical assessments, but can provide support for appropriate health and social referral services. The idea is to develop a more proactive model of care, that will meet people where they are at, whether that is a shelter, soup kitchen, etc. particularly after hours (4pm onwards) to build trust with the community and offer earlier interventions in the community, rather than relying on police, paramedics and hospital-based services.

CONSIDERATIONS:

- The focus of the Community Wellness Bus is in alignment with the Algoma OHT and will be part of its 2021-22 operating plan, as it is consistent with an integrated care approach that includes proactive outreach to marginalized populations
- Investment in the primary care component (NP) will leverage existing funding, including for an RN (mental health and addictions) from SAH, as well as mental health and peer support workers from CMHA. The DSSMSAB is providing the bus and partners will be aligning resources to support programming for the roll out in Spring 2021.

- Currently, the missing piece is access to primary care, for on-going oversight that is grounded in the scope of practice of a NP. The newly funded position, would address a number of community concerns, including attachment to primary care and provide a Sault Ste Marie and area wide resource for mental health and addictions grounded in a community-based model.

EXCERPT FROM COMMUNITY WELLNESS BUS REPORT

Executive Summary

The Algoma Ontario Health Team (AOHT) highlighted both mental health and addictions and unattached patients as target populations as part of its application. Although not an initial focus, several AOHT partners have come together to respond to community needs and have sought to accelerate this work. Initiated by the District of Sault Ste. Marie Social Services Administration Board (DSSMSSAB), in partnership with Algoma Family Services, Algoma Nurse Practitioner-led Clinic, Canadian Mental Health Association, Ontario Health North, Sault Area Hospital, Sault Ste. Marie Police Services, Superior Family Health Team, as well as independent physicians and community partners.

The research identified the Downtown Area as a diverse underserved population experiencing unmet needs through data analysis and local stakeholder engagements. As such, the AOHT partners have recommended developing the Community Wellness Bus, a model of care that is internationally validated. This will be a piece of the health care puzzle to support the continuum of health and social services that aims to improve health access, patient outcomes, and reduce the gaps in the addictions & mental health continuum of care. It is meant to provide an outreach service, including primary, mental health, and preventative care, directly to underserved community members located in the downtown core who are some of the community's most marginalized members. While providing essential health services, the bus will also send referrals where deemed appropriate, provide necessities, and build community relationships while improving community safety by being a welcoming presence.

The underserved community's unmet needs are affected by evident barriers related to mental health and addiction and social determinants of health. The highlighted determinants of health are Indigenous health, homelessness, and food insecurity. Also, the circumstances of the COVID-19 pandemic increased the vulnerability of the Downtown Area community. The analysis discovered gaps that can be served with an adapted primary health care model combined with mental health and addictions and outreach principles. In this model, the Nurse Practitioner will be responsible for providing primary care to this unattached and underserved population. The Nurse Practitioner will be part of a multidisciplinary, multi-organization team. The team will strive to provide comprehensive biopsychosocial support to the members of this community. The Nurse Practitioner will provide comprehensive health assessments, individualized treatment plans including prescribing, and support continuity of care through collaboration and referrals. The Nurse Practitioner will provide episodic primary care to clients in the program and assist with transfer of care to more permanent services. Finally, the Nurse Practitioner will work collaboratively and consult with addictions specialists and experts in the field for the provision of evidence-based care.

Background

Algoma Ontario Health Team's (AOHT) application highlighted the need to prioritize "conditions better managed in the community" patients, alongside those living with mental health and addictions issues and unattached patients – all of whom are impacted by social determinants of health (SDOH). COVID19 has further augmented the need to act upon some of these issues, shinning a light particularly on mental health and addictions. As such, municipal, social services, and health system partners have been working to identify creative solutions to improve health outcomes for the priority populations in Sault Ste. Marie (SSM). The nature of the problems faced by the community are complex and multifaceted; and as such, this community wellness bus is one of many initiatives that will be needed as part of a robust strategy.

SSM is part of the diverse Algoma sub-region. In 2016, it had a population of 73,368, which include Indigenous [11.3%], Francophone [3.9%], and a growing new immigrant populations, where cultural sensitive care is required. At a closer look, the Downtown Area of SSM has a diverse community at higher risk of food insecurity, homelessness, racism, and stigma – all barriers to accessing health care. The population is socially disadvantaged, and there are challenges in collecting data to accurately reflect the population's needs.

Downtown Area individuals who do access some or multiple services may enter the health care system through primary care, out-patient services, hospitalization, or community crisis interventions. Sault Ste. Marie mental health and addictions and social services programs cluster in the Downtown Area. Downtown Area families use 22.9% more social assistance than the rest of SSM residents – where mental health needs are prioritized.

Sault Ste. Marie Population – Statistics Canada 2016

11.3% Indigenous

9.5% French Speaking

2.7% Visible Minority

Downtown Area socially disadvantaged members with comorbidities would also require alternative means to access primary, mental health, crisis, and preventive care where current primary health care (PHC) models cannot address their health needs. With fewer specialists in the region, such as respirologists and cardiologists, there is a utilization increase of the Sault Area Hospital (SAH) to treat comorbidities – which the community has a higher risk of developing. The added healthcare barriers and negative experiences also limit the interaction between the Downtown Area community and the healthcare system. To address these gaps, providing a new innovative community health program would help address the inequity.

The Underserved Community of the Downtown Area

There is no set consensus of which populations are considered underserved in Canada. To define the term, three core concepts are considered: underserved, equity, and access. Underserved refers to individuals or groups that may have difficulty obtaining care, receive a lower standard of care, receive treatment differently, or receive treatment inadequately. Equity in health means the fair and just distribution of services. And access is about the accessibility of services.

All three concepts impact the healthcare interactions for the Downtown area's underserved community members, deeming them as undeserved. The experiences will be analyzed in the research, and identify the factors shaping the health system obstacles.

Mental Health and Addictions

In the broader context, 1 in 10 residents in Canada frequently uses emergency departments (ED) for mental health and addictions with 4+ visits a year. 32% are for mental health conditions, 19% for substance use and addictions, and 49% for both mental health and addictions – a possible indication that people did not receive timely and appropriate care for mental illness or addiction in the community. Ontario has a 10.2% average of ED use, 2.6% higher than the rest of Canada. Mental illness and addictions comorbidities increase the likelihood of ED visits or hospitalization for repeated high-cost users. The increase is regardless of ambulatory care sensitive conditions (ACSC) – the indirect measure of access to primary care and system capacity to manage chronic conditions, which excludes mental health data.

In Algoma, hospitalization from mental health or addictions is three times higher than the rest of Ontario. Self-harm is 2.25 times and to die by suicide is 1.6 times higher relative to the rest of Ontario. Hospitalization from drug toxicity is two times higher, and opioid toxicity is 3.1 times higher in Ontario. It is also 0.4% higher to receive opioid addiction treatment.

In 2016, there were two times more opioid overdose-related deaths in Algoma than the rest of Ontario. In Algoma, alcohol and tobacco are the most commonly used substances. 4 out of 10 residents have used illicit drugs in their lifetime, and over 1 in 4 are identified as heavy drinkers, impacting mental, physical, social, and financial health.

In the Downtown area, multiple crisis services help the community related to mental health and addictions. Many police and ambulance respondents provide de-escalation, first aid, and opioid crisis care as part of the Sault Ste. Marie & Area Drug Strategy (SSM Drug Strategy). Depending on the urgency, patients use the SAH ED for urgent mental health and addiction treatment services. The area has gained increased attention in the news as the SAH leadership collaborates with community partners to address mental health and addiction services in the area.

Currently, there are a few services that support the Downtown area community through outreach work, such as the John Howard Society, Ontario Aboriginal HIV/AIDS Services, Group Health Centre (Hep Care Program and HIV/AIDS resource program). From SAH, the Psychiatric Medication Clinic is piloting an outreach service on Fridays. From March to October 2020, it supported 137 patients in the community, which include individuals with community treatment orders.

The Canadian Mental Health Association (CMHA) SSM and other social service programs provide multiple community mental health support centralized near the Downtown area. While these programs are vital and regularly used, community members have highlighted that changes to mental health and addiction services have impacted their access to care. While remodeling of the local delivery of mental health and addictions may have gaps, the partners are continuously working together to identify opportunities to improve access to care.

> *"The methadone clinic closing affected my anxiety and depression. Losing my primary care doctor is a big loss. Now I have to sometimes travel up to 1.5 hours to get to the hospital from downtown."*
>
> \- Brandi

Provincially, with the launch of the Road to Wellness strategy, the Ontario government recognizes these multiple challenges facing mental health and addictions services. The challenges include long wait times, little understanding of what services are available and where to find them, uneven service quality between providers and regions, fragmented and poor coordination, lack of evidence-based funding, and absence of data – limiting effective oversight and accountability. In addition, the gaps of mental health and addictions services have been highlighted by the COVID-19 pandemic, which has been highlighted by Northern Ontario's five largest cities. To better serve patients with conditions better managed in the community, addressing the multiple challenges, and decrease any anxieties faced by changes in the community, new models of care would be necessary.

Social Determinants of Health

Health and social inequities impact both mental and physical health for underserved community members. The Downtown area community has a higher need for medical and social services. Negative effects of SDOH, such as poverty, lack of social status, lack of access to health services, racism, and adverse childhood experiences, exacerbates disparities. Due to the identified needs, the prevalence of mental health and addiction comorbidity alongside chronic diseases are higher and would need alternative methods of care to decrease avoidable hospitalizations, as measured with ACSCs. Some of the most common and potentially preventable chronic diseases are urinary tract infection, pneumonia, heart failure, COPD, and cellulitis, increasing commonality with underserved populations.

Homelessness and Food Insecurity

Statistics do not capture the whole story of homelessness and food insecurity but can provide vital information to understand the downtown area. Income is a marker for disease severity and 15.3% of the Algoma population is living below the low-income level, higher than the Ontario rate. There is a higher financial dependency of 54.4%, 3% higher than the rest of SSM, and 8.2% higher than the rest of Ontario. Aboriginal, 2SLGBTQ+, immigrants, and veterans are also more significantly impacted by homelessness.

Many homeless individuals tend to shift between unstable housing and homelessness, impacted by financial hardship, physical or mental health problems, substance use, and lack of social support. Many individuals are "vulnerably housed," referring to persons living in poor-quality, temporary, or precarious housing, such as single-room occupancy hotels or rooming houses. As of September 1, 2020, there were 1,511 people waitlisted for social/subsidized housing in SSM. In 2020, Harvest Algoma, which is the community's main food bank distribution channel distributed 1,650,000 pounds of food assisting shelters, food banks, soup kitchens, etc.

"I know how to get food from the Salvation Army or get milk and baking at a local church on Thursday morning. I see new people in downtown and I worry they don't know where to go for help. There are times when you have to ask for help if you wanted it."

People who are homeless suffer from multiple risks to their health. There are higher rates of substance use and mental illness, higher development of serious bacterial infections, and increased mortality than low-income individuals in the general population. The increased barriers contribute to 38% of homeless individuals unable to receive necessary care. In the 2013 Street Needs Assessment Toronto report with 1981 respondents, 69% indicated that they accessed health and treatment services in the past six months. 46% used hospital ambulatory care and emergency services, and 43% also used health clinics. 1 in 4 utilized an ambulance in the past six months. It also indicated that individuals experiencing long-term homelessness were 7% more likely to have visited emergency rooms. Due to unstable housing (lacking fixed address or telephone number), lack of funds to attend necessary medical appointments, care avoidance due to stigma contributing to underutilization of health services, and even being uninsured, it becomes difficult for this population to access primary care services.

Paul's Story

Paul is a 62-year old French and Indigenous man living alone in an apartment in SSM. He has managed Type 2 diabetes and high blood pressure. He takes quite a bit of medication, but he is currently in reasonably good health. His care is currently managed by a nurse practitioner but does miss his retired physician, who had a deep historical knowledge of his addiction journey.

Paul has been sober for 19 years. He was surrounded by alcohol use by his family at a young age. He started using substances at the age of 15 and alcohol since he was 17. His alcoholism affected his job security and relationship in his adult years. After his second job loss, he received treatment for the second time and has been sober since. After his recovery, he started to support other individuals suffering from alcoholism at an Alcoholics Anonymous group.

He recalls one of his best memories growing up was being surrounded by his aunt who, embraced her Indigenous culture. He understands the healthcare gaps for the Indigenous community, as he is also affected, and acted on his vision to bring healthy foods to Pow Wows to improve the community's health. Currently, he is passionately helping homeless individuals at a local indigenous service program in SSM.

Indigenous Health

In the broader context, there are significant health disparities for Indigenous peoples in Canada. These disparities include a higher prevalence of Type 2 diabetes mellitus, cardiovascular disease, cancer, infectious diseases, mental illness, addictions, and substance use, which are higher rates in Northern Ontario than the rest of Ontario in the same age range. Also, poor environmental conditions and intergenerational effects of colonization have negatively impacted the relationship between Indigenous peoples and medical establishments. Some negative experiences from the system include implicit biases that affect health outcomes.

In a more in-depth analysis of Northern Ontario's First Nation community, 53% of all deaths occurred before retirement age, 31% higher than the rest of Ontario. Death rates were 13% higher for men compared to women. By the time this population dies, more than half of the community's people had at least four chronic diseases.

In SSM's downtown population, 15% identifies as Indigenous, 13% higher than the rest of Ontario. Most of the Aboriginal community are in the Downtown area and SSM West End. The average age of the Aboriginal population, which includes First Nations [34], Métis [36], and Inuit [38], in SSM is 35 years, ten years less than non-Aboriginals. Multiple health care conditions and environmental factors both contribute to the smaller age average.

To support Indigenous health and improve cultural safety, complimenting care with effective communication and sensitivity to the patient's political, economic, social, linguistic, and spiritual realm while respecting traditional medicines and health perspectives are vital. Also, working alongside aboriginal partners is essential to improve health equity. In combination with complimented evidence-based care, 4 out of 10 deaths could be potentially avoidable through effective public health strategies and improved health care access.

"Indigenous" is the most widely accepted umbrella term and used frequently in international context.

"Aboriginal" is also frequently used but may not include all Indigenous identities.

Children and Youth

1 in 5 children will experience some form of mental health and addiction problem, while First Nations youth die 5-6 times more often than non-Indigenous youth. In addition, youth living in low-income neighbourhoods have higher rates of suicide, ED visits for self-harm, acute mental health care services use, and rate of schizophrenia.

COVID-19 Pandemic

Many routine and elective services have been suspended around the world, where many have disrupted outreach services and treatment of mental health and addiction disorders. There is also a greater risk of contacting COVID-19 for underserved people who have underlying chronic conditions and dependent on drop-in centres or sleep in homeless shelters where it is difficult to physically distance.

"COVID-19 has absolutely exaggerated the opioid crisis. You can't even go to a park without seeing needles."
Appendix A - Paul

Overview of Current Care Models

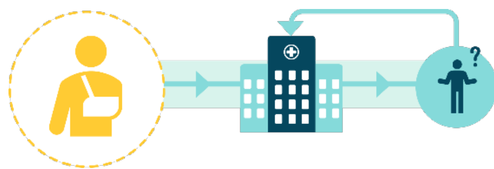
The underserved community in the downtown area confronts multiple barriers to accessing care with current primary healthcare models. Living in precarious living situations and with historical systemic distrust, many members of this population struggle to be part of a rostered primary healthcare practice. By being unattached to primary healthcare, this largely limits their health utilization to outreach-based health services, social services, and hospital-based services, making this a very hard to reach population. With decreased continuity of care due to lack of continuous follow-up by primary healthcare, it exacerbates many complex and interrelated physical and mental health and addiction needs. Currently, patients may receive intermittent care throughout their care continuum but may not receive appropriate follow-up due to barriers. Though some may never be "attached" to primary healthcare as seen in Figure 1's current state underserved patient journey, these gaps can be addressed with adapted PHC models that involve

proactive outreach that increase the chance for improved continuum and whole person care.

Together, mental health and addictions with SDOH impact multiple comorbidities and access to care. PHC models address care needs with three inter-related and synergistic components to improve health & well-being: (1) multisectoral policy & action, (2) empowered people & communities, and (3) primary care & essential public health functions as the core of integrated health services.

Figure 1. Current State and Future State for the Underserved Patient Journey

Existing State



Future State

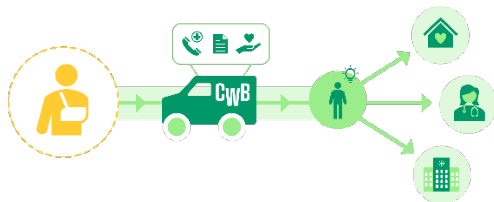


Figure 1. Shows current PHC model and the future adapted outreach PHC model with mental health and addiction principles. Future state improves continuity of care for underserved patients with improved connectivity.

To include mental health and addictions effectively, adding these six principles of comprehensive mental health and primary care would bolster the current PHC model:

(1) Primary health care should be equitable and accessible to people with mental health and addiction problems and illnesses;

(2) Mental health and addiction care should be a core component of primary care;

(3) Primary care practitioners should be knowledgeable and confident in providing high-quality health care to people with mental health and addiction problems and illnesses;

(4) High-quality primary care should be provided to people with mental health and addiction problems, and illnesses in collaborative and integrated environments;

(5) The primary care system should be accountable to people with mental health and addiction problems and illnesses; and

(6) Primary care policies and programs should be based on evidence and best practice, and research in the area should be supported.

Also, utilizing an outreach approach can increase the opportunity to connect with the underserved experiencing negative SDOH. Combining PHC models with a community-based health model would be beneficial as it highlights the importance of community-based outreach, advocacy, and community collaboration to promote health. The increase in outreach services' visibility is essential when increasing awareness, a chance to provide information, education, and services to underserved populations where they are. It will be an opportunity to advocate with and on behalf of underserved people and build trust. Together, it will also create a strong partnership between community organizations frequently accessed by underserved populations. The potential of an adapted PHC outreach care model can be seen in Figure 1's future state.

In the context of mental health care in SSM, it utilizes an adapted Continuum of Mental Health and Addictions Services framework to review current health system capabilities with five tiers, as seen in Figure 2. Tier 1 emphasizes preventative treatment options with higher access volumes and generalized applicability while Tier 5, the highest level of service intensity, focuses on specialized care including psychiatry, inpatient, and residential services with lower services volumes based on need. In the middle, Tier 3 demonstrates the need for care that requires moderate intensity mental health and addiction specific care. Some Tier 3 activities would include mental and physical health assessment/monitoring, medication management, and medical assistance with withdrawal symptoms. Needs-based planning completed by the Central Algoma Mental Health and Addictions partners has identified a gap in Tier 3 level of care. An adapted PHC outreach care model, can provide a new opportunity to address this gap while complimenting Tier 1 and 2 services in SSM.

Figure 2. Adapted Addictions & Mental Health Continuum of Care

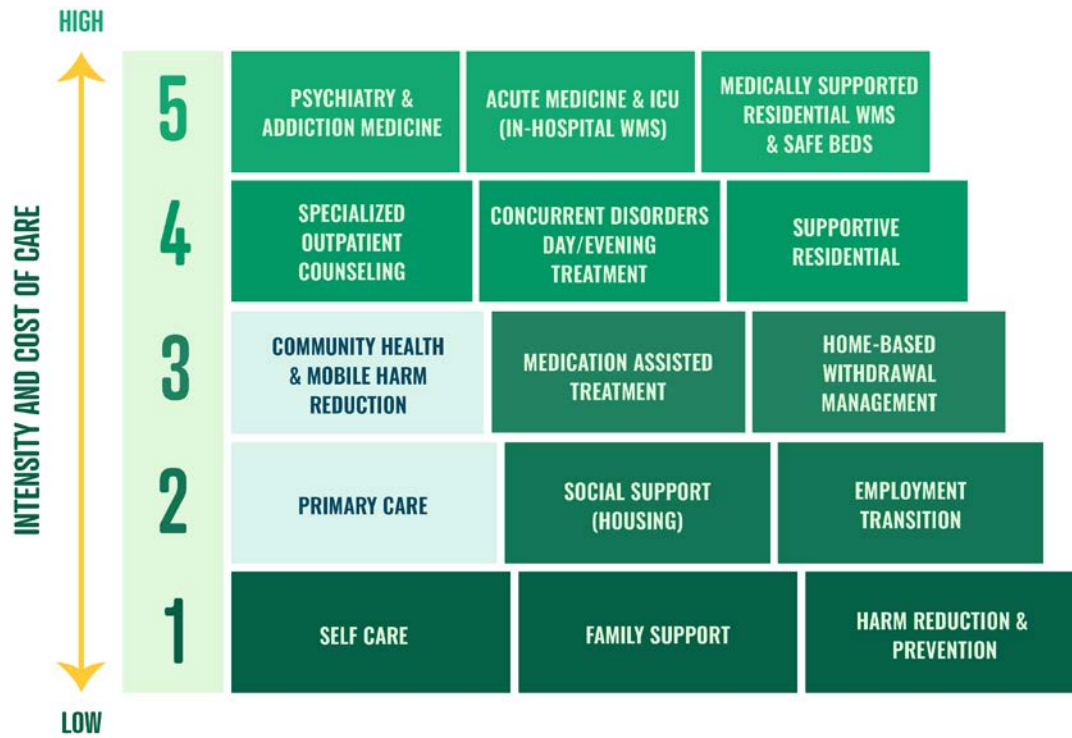


Figure 2. Contains the 5 Tiers of the Addictions & Mental Health Continuum of Care. The arrows represent care needs care and service volumes from low to high.

High-quality primary care is necessary for mental and physical well-being. Some common Ontario primary care models are Community Health Centres (CHCs), Family Health Groups, Family Health Networks, Family Health Organizations, Family Health Teams and Nurse Practitioner-Led Clinics. The CHC model is successful as it had the least ED visits associated with its model while providing care to the most disadvantaged populations. Yet, barriers to access care are limited to current models of PHC, and individuals with less income are less likely to have a primary care provider, while considering Algoma residents have less regular health care contact than the rest of Ontario. Without appropriate access to services or alternatives to after-hours care, it can increase ED utilization. While considering current system capabilities and exploration of potential Tier 3 programs, there is an excellent opportunity to support underserved members and the health care system with the adapted PHC outreach program in the downtown area. As mentioned previously, in our model the Nurse Practitioner will be responsible for providing primary care to this unattached and underserved population.

Examples of Existing Outreach Care Models

Outreach care models function outside of facilities while leveraging their organizational policies, programs, and expertise. There are two types of outreach models: Fixed and

Mobile outreach services with differences seen in Table 1. They are adaptable programs that can directly provide primary care services to communities, who often experience access issues. There is evidence that early and proactive outreach that includes system navigation can increase primary care use and potentially decreasing ED use while improving health and social outcomes.

International

Other locations globally also utilize extensions of facility-based primary care services that reach underserved community members, where community-based prevention includes outreach services. For example, the Health Outreach Service with Essex Partnership University with the NHS Foundation Trust is based in the UK and provide healthcare services and send team members to community settings, at hostels, on the street, or in the home. The Pi:Lu Bus in South Australia's Riverland is also providing a mobile outreach provide to deliver healthcare services directly for Aboriginal and Torres Strait Islander People. Outreach models are also used globally in response to the COVID-19 pandemic.

Table 1. Fixed and Mobile outreach programs.

*Activities	Fixed	Mobile
Medical Assessments	✓	✓
Early detection of health care needs	✓	✓
Referrals to ED, primary care, or social services	✓	✓
Direct Care	✓	
System Navigation	✓	✓
Fixed location (i.e. clinics, drop-in centres, shelters)	✓	
Different locations usually accessed by underserved individuals		✓
Vehicle based		✓
Team Access	✓	✓
Convenience		✓

Canada

Outreach services to support underserved community members have been achieved in Canada in multiple ways. One method has been sending community liaison officers to the community. An outreach social worker develops and maintains relationships with community-based agencies and provides direct services to clients where needed, such as the Ontario Hepatitis C Team: The Ottawa Hospital and Regional Hepatitis Program. This service model is similar to the SAH's Psychiatric Medication Clinic service expansion to provide outreach service to underserved patients in the community.

Mobile health clinic programs are also across Canada. The Doctors of the World provide the Mobile Health Clinic programs in Montreal and Victoria, which support underserved communities. There is the Waterloo Region Community Health Van, a registered charity that provides outreach services to its local community in the Waterloo region that includes nursing care, naloxone kits, food and clothing provisions, and other support work. In Toronto, Sherbourne Health's The Rotary Club of Toronto Health Bus, also known as the Sherbourne Health Bus program, has been active for more than ten years and provides outreach services provided by a nurse practitioner, mental health counselor, program workers, and other specialized health care and service providers throughout the week. These programs report visits which have been continuously used by community members. All these programs provide a great example of working models utilized in Canada to provide essential primary, mental health, and preventative care on wheels while increasing continuity of care.

The mobile health clinics utilize adapted PHC models that include mental health and outreach principles that can directly provide necessities and send social and medical referrals to improve the care continuum.

Valuable lessons learned from the patient experiences with the Health Bus are: (1) being cared for with respect and dignity, (2) being served by competent professional nurses, nurse practitioners and (3) being able to access healthcare and services with ease.

"I try to offer all people with the basic concept of love that I am able to define as respect and dignity"

The Community Wellness Bus

While there are multiple ways to address the challenges of downtown's underserved community, the Community Wellness Bus has been identified as a new outreach delivery model due to the collected evidence and potential to support the community while leveraging existing partnership between the District of Sault Ste. Marie Social Services Administration Board (DSSMSSAB), Algoma Family Services, Algoma Nurse Practitioner-led Clinic, Canadian Mental Health Association, Ontario Health North, Sault Area Hospital, Sault Ste. Marie Police Services, Superior Family Health Team, as well as independent physicians and community partners. The unique partnership will be able to enable an adapted PHC model to send referrals that will improve the continuum of care between crisis, preventative, specialized, mental health and addictions, and primary care, while improving access to social services, such as housing, for the underserved community. It will help the health system by filling key system building blocks to contribute to the health system overall goals and outcomes.

The Community Wellness Bus, with its adapted PHC model with integrated mental health and addictions and outreach principles, will improve access, health system responsiveness, and improve coverage for the underserved community. This will be done by identifying critical hot spot locations where services are being utilized regularly by the community. The services will include service offers that provide physical and mental health and addiction care closer to the community while giving essentials products for preventative care. The new provided outreach care will be part of crucial Service

Deliveries and providing essential products as part of Medical Products, both of which are part of the system building blocks, which all contribute to strengthening the health system, as seen in Figure 3. The program will complement other programs in the health system to synergistically produce overall goals/outcomes.

Figure 3. The WHO's Health System Framework.

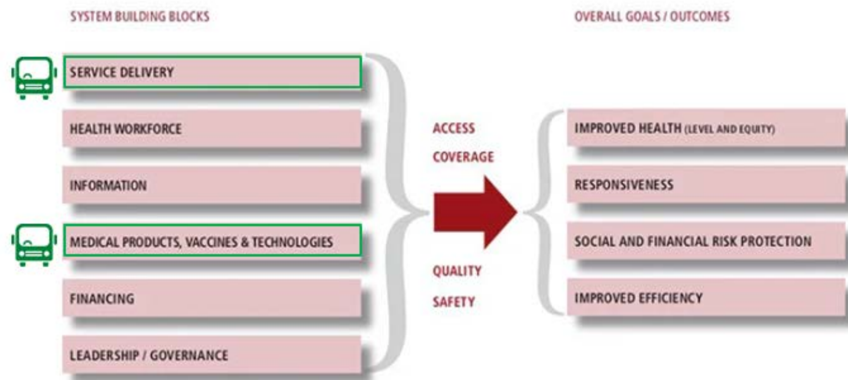


Figure 3. A framework to assess the process of strengthening health systems. Bus icon indicates which system blocks the Community Wellness Bus will be part of. Shows 6 System Building Blocks to Achieve 4 overall goals and outcomes.

Description of the Program

The Community Wellness Bus program will improve access and outcomes for underserved community members, prioritize mental health and addictions, improve health care for individuals with conditions better managed in the community, and improve community well-being. It will be a new program that aligns with the gaps in the current SSM health system and be a way to support patients. It will aid underserved community members in their continuum of care in the community and provide an opportunity to reintegrate back into the health care system in other means than the hospital system. The program will be run amongst the identified partners and provide program management to deploy trained clinical staff to provide care, information, and essentials to the community in different SSM locations, as seen in Figure 4.

Figure 4. Community Wellness Bus Program Workflow

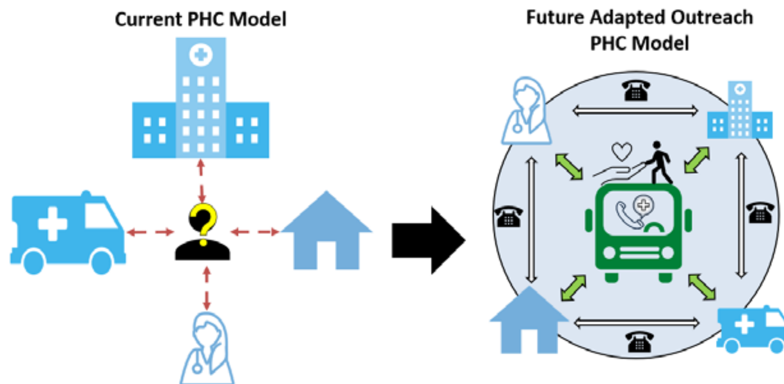


Figure 4. Community Wellness Bus and expected service delivery flow to the community.

Objectives

- To provide outreach services to meet community members where they are at
- To deliver culturally sensitive care and be a pathway for individuals to access health and social services
- To improve community safety with an added presence and community engagement
- To re-build trust with the community and enhance well-being

Partnerships

Recent collaborative partnerships and strategic alignment are supported by the SSM Drug Strategy between the AOHT members and community partners, including Algoma Family Services, Algoma Nurse Practitioner-led Clinic, CMHA, the City of Sault Ste Marie, DSSMSSAB, Ontario Health, Sault Area Hospital, Sault Ste Marie Police Services, Superior Family Health Team, as well as independent physicians and community partners to launch an outreach program to improve health care and mental health access while enhancing trust and engagement

Service Delivery Model

The program's initial launch is planned for afternoons and evenings to provide care outside of general core hours, as many social and health care programs close around 4 pm. A Program Manager would manage the service to coordinate the outreach service and staff training. The Community Wellness Bus is scheduled for targeted locations, such as a chosen shelter on Monday evenings, to care for and connect with underserved community members as part of regular and consistent programming. There will be three critical roles with assigned activities, as seen in Table 2: a Registered Nurse, Nurse Practitioner (NP), a Registered Mental Health and Addictions Workers (i.e., Social Worker), and a Peer Worker. These roles will provide respect and dignity alongside competent and culturally sensitive care while considering the identified scope of practices available.

Table 2. Community Wellness Bus Roles and Activities

*Activities	Nurse Practitioner	*Registered Nurse	*Registered Addictions Services Worker	*Peer Worker
Medical Assessments	✓	✓		
Primary care	✓			
Referrals to ED	✓	✓		
Referrals to Mental Health and Addiction Services	✓	✓	✓	
Wound Assessments	✓	✓		
Health Teaching	✓	✓	✓	
Clinical Liaison	✓	✓	✓	
Mental Health and Addiction counseling	✓		✓	
General peer outreach				✓
1:1 health bus promotion				✓
General feedback collection on gaps				✓
Case Management	✓	✓	✓	
Crisis planning and management	✓	✓	✓	✓
Community Engagement	✓	✓	✓	✓
Community based program referrals	✓	✓	✓	✓
Distribution of provisions	✓	✓	✓	✓
Patient Queue management	✓	✓	✓	✓
Providing general information	✓	✓	✓	✓
Individual assistance	✓	✓	✓	✓

Table 2. Shows specified roles with regular activities. *Roles and activities are subject to iteration depending on the implementation plan, engagement feedback, and evaluation recommendations.

Locations for Outreach

As identified with the needs of underserved community members, targeting locations where they are accessing existing services, such as social services, will increase the change of community encounter. Following the downtown area's demographic needs and available services, the Community Wellness Bus will potentially stop at seven locations matched with Figure 5: (1) Soup Kitchen, (2) St. Vincent, (3) Pauline's Place, (4) Gore St. (Old NRC), (5) 345 St. George's, (6) Near Housing/Ontario Works, and (7) at various community events in the downtown core. The program would regularly run at specific days and times to ensure consistency.

> *"How to help the community? Having a station or a moving hub. Maybe like the Neighbourhood Resource Centre. Where you can give out information, where you can eat, sleep, get care, etc. – under one umbrella, would help so much."*
>
> \- **Brandi**

Figure 5. Initial Downtown SSM and Potential Community Wellness Bus Stops

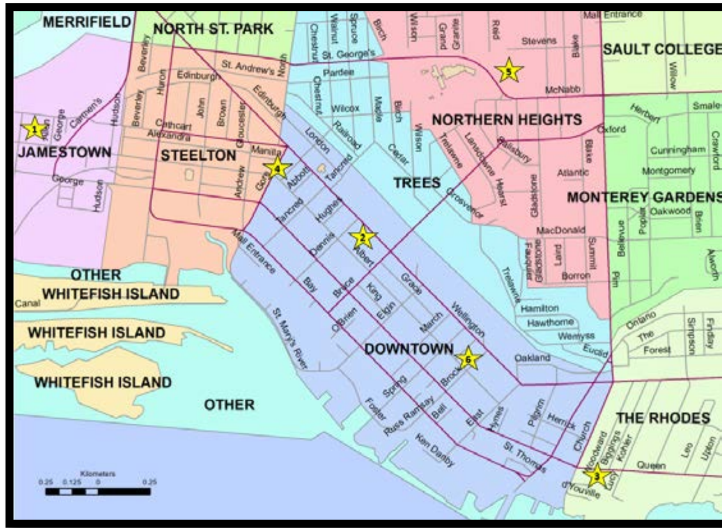


Figure 5. Represents potential locations for Community Wellness Bus stops. The numbers match with the listed location spots, as mentioned above.

Limitations

Due to the Community Wellness Bus traveling remotely to areas dependent on schedule and targeted location, the program will be accessed episodically by underserved community members. While this may be, the care will improve trust over time and bridge new relationships between community members and the health and social systems that provide care. The care can help prevent the progression of chronic disease and link people to appropriate health/social services to reconnect with services and support them in their care continuum.

Long Term Outcomes	Performance Indicator	Data Source
Receive updated training for staff	# of staff trained	Staff list
	# of sessions provided in a month	Org. Development list
Providing outreach services up to 6 locations	# of bus visits to a set location	Schedule
Decrease unnecessary ER visits	# of hospital visits attached to postal code	KPI
Decreased unnecessary 911 calls	# of related calls to downtown	KPI
Improved patient satisfaction with health system	# of Qualitative surveys completed	Survey
	Community feedback	Informal documentation, patient experience stories, surveys
Patients accessing medical/social care easier	# of Qualitative surveys completed	Survey
Linking more community with health system	# of referrals	KPI

Impact

This program will improve the continuity of care for underserved community members who may suffer from mental health and addictions and conditions better managed in the community. It will improve health outcomes and equity while increasing collaborative work

with community partners. The clinical training will build clinical capacity to provide adequate care with respect and dignity. It will also support the health system by improving health system utilization with this innovative outreach program. The direct work will also improve access to other health and social services related to SDOH impacting the community. More importantly, the engagement will rebuild trust between the community and the health care system.

Recommendations

The Community Wellness Bus, with its adapted PHC outreach care model, has a high potential to support underserved community members and the broader health system. This model recognizes the importance of primary care. Accordingly, the presence of a Nurse Practitioner on the team is essential to its ability to positively impact this community.