Nipissing Wellness Ontario Health Team [NWOHT]

Annual Report 2025/26

nipissingwellness.ca info@nipissingwellness.ca 176 Lakeshore Drive, Unit #10 North Bay, ON P1A 2A8

BIEN-ÊTRE DU NIPISSING WELLNESS NBISIING MINWAY'YAAWIN

Équipe Santé Ontario Health Team
Ontario Bimaadzwin Niigaanwiwaad

"A universal health care system is only as equitable as the access it delivers to those who need it most — and for many Canadians, especially in rural and remote communities, access can depend on where they live."

We're here to help you navigate.

NIPISSINGWELLNESS.CA

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Équipe Santé Ontario Health Team | Ontario Bimaadzwin Niigaanwiwaad

NWOHT EXECUTIVE DIRECTOR'S REPORT

2025/26 was a year of meaningful progress for the Nipissing Wellness Ontario Health Team [NWOHT] and its partners. Having joined partway through the year, I've been honoured to build on the strong foundation laid by those who shaped this partnership.

Partners worked together to improve community health and well-being, with access to primary care remaining a top priority. Progress continued on connecting primary care, hospitals, community services, home and long-term care, mental health and addictions support, and public health. We also strengthened relationships with equity-deserving groups, Indigenous communities, and French-language service providers, moving us closer to a more inclusive, equitable health system.

We also strengthened the Primary Care Network through a new representative model that better reflects the diversity of primary care practices across Nipissing and gives greater voice to equity-deserving populations in planning and decision-making. Combined with continued work on attachment and timely access, these achievements help ensure people get the right care, in the right place, at the right time.

Publishing our 2026—2029 Strategic Plan marks an exciting new chapter for NWOHT. Developed with partners, it provides a shared roadmap for improving access to primary care, strengthening coordinated care, promoting health equity, building partnerships, and improving the health and well-being of our communities.

The accomplishments in this report belong to every partner and individual who contributed. Thank you to our healthcare providers, community organizations, governance leaders, patients, families, caregivers, volunteers, and NWOHT staff for your leadership, collaboration, and commitment to a healthier future.

Frank O'Driscoll
fodriscoll@nipissingwellness.ca
Executive Director
Nipissing Wellness Ontario Health Team

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Our Shared Purpose or Vision

Together, we create an equitable, accessible and connected health and care continuum for the people and communities of Nipissing.

Our Role or Mission

Facilitate collaboration and enable integrated health and care across the continuum to advance population health and wellbeing for all in Nipissing.

These values guide every decision, partnership and initiative:

- **Equity, Cultural Safety and Trust** — We ground every action in equity, cultural safety and trust, including through the lens of Indigenous, Francophone, rural, and other equity-deserving communities.
- **People-Centred Care and Co-Design** — We ensure people, families, and caregivers shape design and decision-making, not just receive the results of it.
- **Community-Focused and Socially Responsive** — We honour the strengths, needs, and lived realities of the communities we serve, recognizing that health is shaped by social, economic, cultural, and environmental conditions.
- **Collaboration** — We work across professional, sectoral, and geographic boundaries to advance shared priorities, convening and connecting rather than acting alone.
- **Accountability** — We measure what matters and report transparently, including when we fall short.
- **Innovation and Learning** — We build a digitally enabled, data-driven learning system that adapts and improves.

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Collaboration in Action

NWOHT Primary Care Network [PCN]

The 2025—2026 year was one of transformation and collaboration for the NWOHT Primary Care Network [PCN]. As primary care continues to evolve across Ontario, our PCN remains focused on strengthening leadership and fostering meaningful partnerships. We're also creating opportunities for providers to work together toward a shared vision of accessible, high-quality, patient-centred care for our community!

A significant milestone this year was the recruitment of a new Executive Director. The PCN played an active role in supporting this leadership transition, ensuring continuity, strengthening relationships, and positioning the organization for continued success.

Recognizing the importance of strong clinical leadership, the PCN also evolved its governance approach. We adopted a leadership model that includes greater representation from primary care leaders and organizations across the communities we serve. This collaborative model strengthens decision-making, ensures diverse perspectives are represented, and reinforces the critical role of primary care in shaping regional health system priorities.

To engage providers in defining the future of primary care, the PCN hosted its inaugural Primary Care Summit. Physicians and nurse practitioners in our communities were invited to this collaborative forum to discuss current challenges, identify opportunities, and collectively envision a stronger, more integrated primary care system for the Nipissing district.

Throughout the year, the PCN continued to bring providers and partners together. They identified innovative approaches that improve access to care while making the best use of existing resources. Through collaborative planning and shared leadership, the PCN advanced conversations focused on improving local cancer screening rates and attachment of patients without a primary care provider. This work included working with our Chronic Disease Clinic and our Community Care GAP Clinic. They also implemented routine updates to understand attachment trends, barriers to accessing care and promoting stability of our Health Human Resources [HHR].

Moving into 2026—2027, the NWOHT PCN remains committed to strengthening partnerships, supporting primary care leadership, advocating for HHR stabilization, equity, and patient outcomes. Together, we will build a sustainable primary care system that meets the needs of our communities today and in the future!

Jaymie-Lynn Blanchard BScN, MScNPHCNP
Clinic Director and Nurse Practitioner
North Bay Nurse Practitioner Clinic

Primary Care Network Co-Chair
Nipissing Wellness Ontario Health Team

Jaymie-Lynn Blanchard

NWOHT Primary Care Network [PCN]

This past year, we focused on strengthening healthcare partnerships to improve primary care access across Nipissing. By working closely with physicians, nurse practitioners, healthcare organizations, and provincial partners, we've continued building a stronger, more connected primary care system.

One highlight was helping Blue Sky Family Health Team, Powassan and Area Family Health Team, and the North Bay Indigenous Hub successfully secure funding for Integrated Primary Care Teams. We were also very glad to see North Bay named a Primary Care Training Centre site — an important step toward attracting and training future primary care providers in our community.

Innovation remained a priority for our Primary Care Network this year as well. We partnered with several health technology companies to test tools that reduce administrative work and give providers more time for patient care, including tools for clinical documentation, billing automation, and clinic workflow improvements. This work was recognized in a presentation submitted to the OntarioMD Educates Digital Health Conference 2026.

Beyond our local work, the Primary Care Network continued to represent Nipissing's needs at the provincial level. I took part in regional and provincial discussions with physician leaders, Ontario Health, the Ministry of Health, and the Ontario Medical Association, focused on key priorities like improving primary care access for unattached patients and addressing home care challenges in Northern and rural communities.

By continuing to strengthen partnerships, embrace innovation, and advocate for the unique needs of our region, we're helping build a more accessible, sustainable, and patient-centred primary care system for the people of Nipissing.

Dr. Daniel Garcia
MB BCh BAO, CCFP, MSc, BSc Kin [Hons]
Physician, General & Family Practice

Primary Care Network Co-Chair
Nipissing Wellness Ontario Health Team

Patient, Family, Caregiver Council [PFCC]

The Patient, Family, Caregiver Council [PFCC] ensures patients', families', and caregivers' voices are reflected in planning and improving local health services.

This past year, Council members continued offering valuable advice and lived-experience perspectives that helped shape NWOHT initiatives and strengthen patient-centred care.

Highlights from this past year:

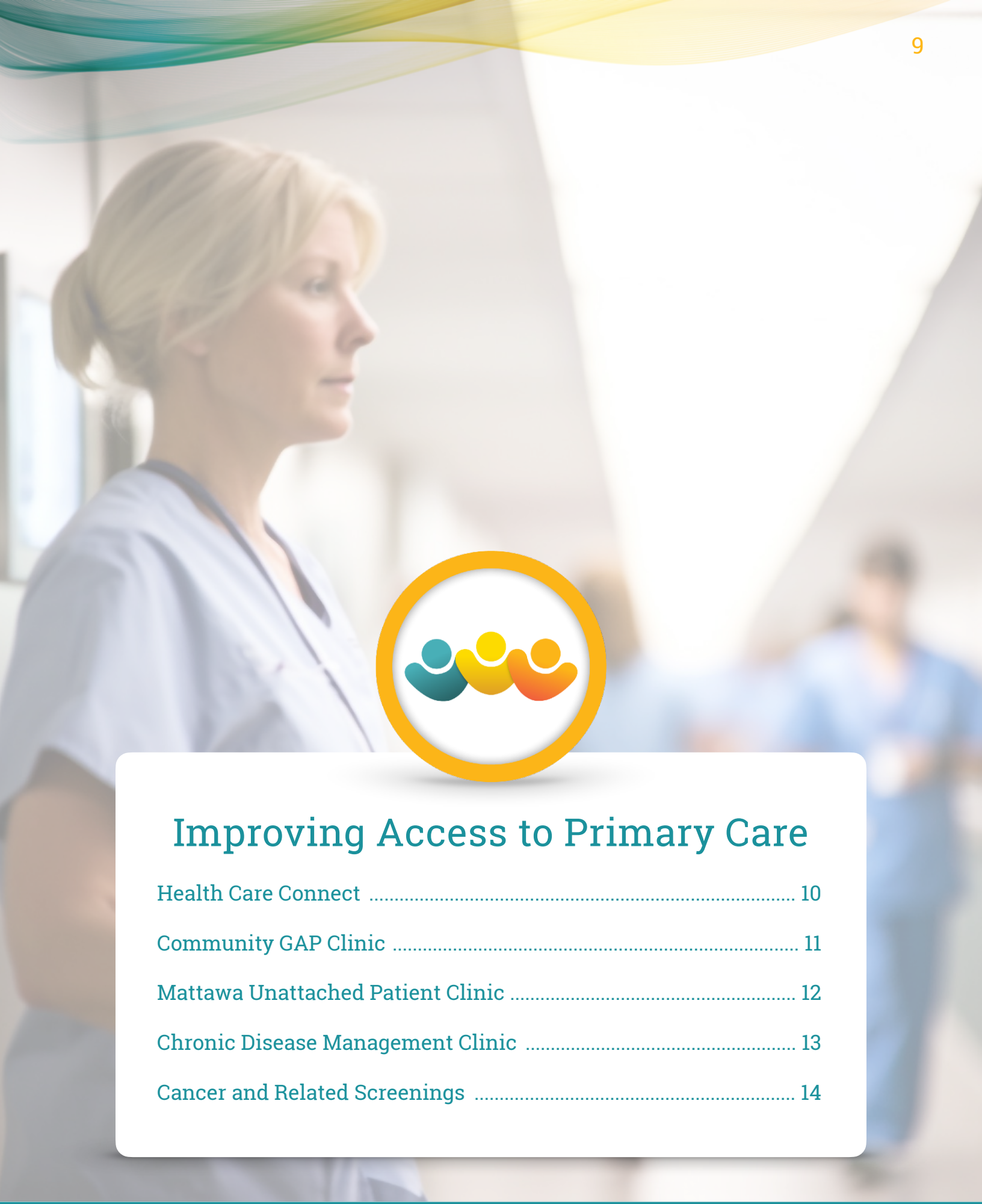
- Strengthened Council leadership by welcoming Blanche-Hélène Tremblay as the second PFCC Co-Chair
- Updated and approved the PFCC Terms of Reference to reflect the Council's evolving role within NWOHT
- Hosted an educational booth at the Aging With Confidence Seniors Information Fair at The Village
- Developed the PFCC's Annual Work plan, setting four strategic priorities:
  - Integrated Care
  - Patient Attachment to a Primary Care Provider
  - Community Engagement
  - Ongoing PFCC Education and Development
- Continued monthly Council meetings to provide advice and recommendations

Council members also heard from guest speakers and gave feedback on NWOHT initiatives, including Health Care Connect [HCC] outreach and regional planning.

These discussions helped keep patient and caregiver experiences at the centre of planning and decision-making.

The PFCC continued to advocate for equitable access to care, offering lived-experience perspectives on efforts to improve preventative cancer screening for people without a primary care provider and other vulnerable populations.

Through ongoing collaboration with NWOHT staff, community partners, and provincial networks, the Council continues to strengthen patient engagement and support a more connected, accessible, and person-centred health system.



Improving Access to Primary Care

Health Care Connect

Improving access to primary care remains a key priority for the NWOHT Primary Care Network. Over the last year, 1,950 people have been referred to a family physician or nurse practitioner through Health Care Connect, helping more individuals and families build an ongoing relationship with a primary care provider.

At a time when primary care capacity is under significant pressure across Ontario, this achievement reflects the remarkable commitment of physicians, nurse practitioners, and primary care teams throughout Nipissing. Despite rising demand and increasing healthcare complexity, local providers have continued welcoming new patients and improving access to consistent, coordinated care close to home.

A major milestone was also reached this year. Clinics in Mattawa, Sturgeon Falls, Bonfield, Astorville, and Corbeil cleared their Health Care Connect waitlists for patients who registered before January 2025.

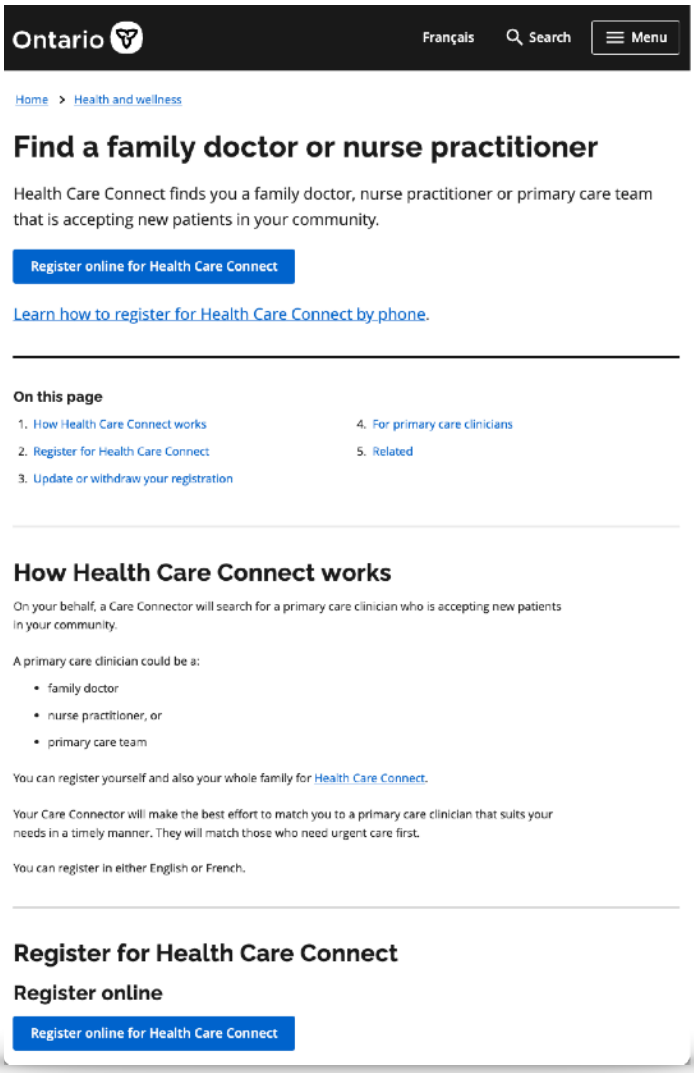
This reflects the strong collaboration between primary care providers, Health Care Connect, and NWOHT to improve patient attachment across our communities.

These successes would not have been possible without the ongoing partnership of:

- Local physicians
- Nurse practitioners
- Primary care teams
- Health Care Connect Care Connectors
- Ontario Health
- Community partners

Together, they continue to strengthen access to primary care for residents across Nipissing.

Don't have a primary care provider? You can register with Health Care Connect by visiting Find a family doctor or nurse practitioner ontario.ca or by calling 811.



Community GAP Clinic

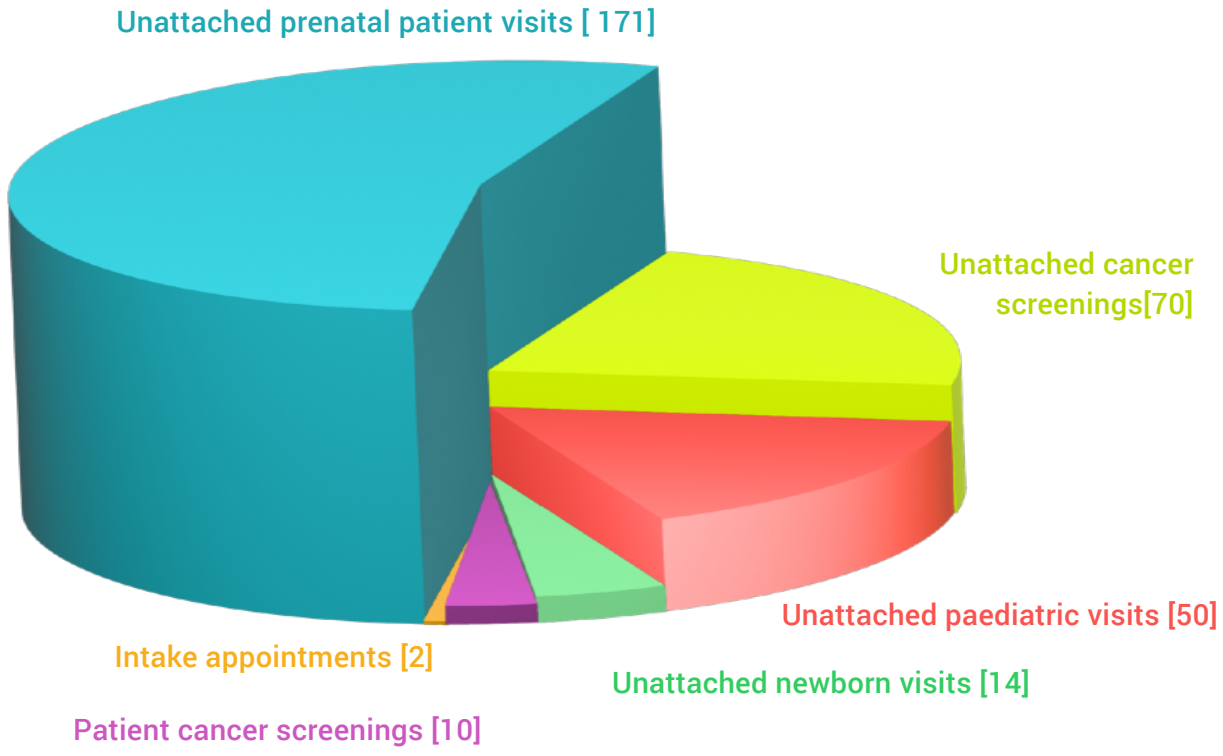
Through continued support and collaboration with the North Bay Nurse Practitioner-Led Clinic, our Community GAP [Gaining Access and Preventative Care] Clinic continues to play a vital role in bridging care for unattached pregnant and paediatric patients who need timely access to care. **The GAP Clinic completed 317 patient visits this year.**

524 Lakeshore Drive, North Bay ON P1A 2E4

89%

89% of patient survey responses show that the GAP Clinic helped them avoid going to the ER.

The GAP Clinic — 317 patient visits — 2025/26 fiscal year



Mattawa Unattached Patient Clinic

Mattawa's Unattached Patient Clinic provided primary care access for community members without a family physician or nurse practitioner, helping ensure residents without an ongoing provider could receive timely care while awaiting permanent attachment.

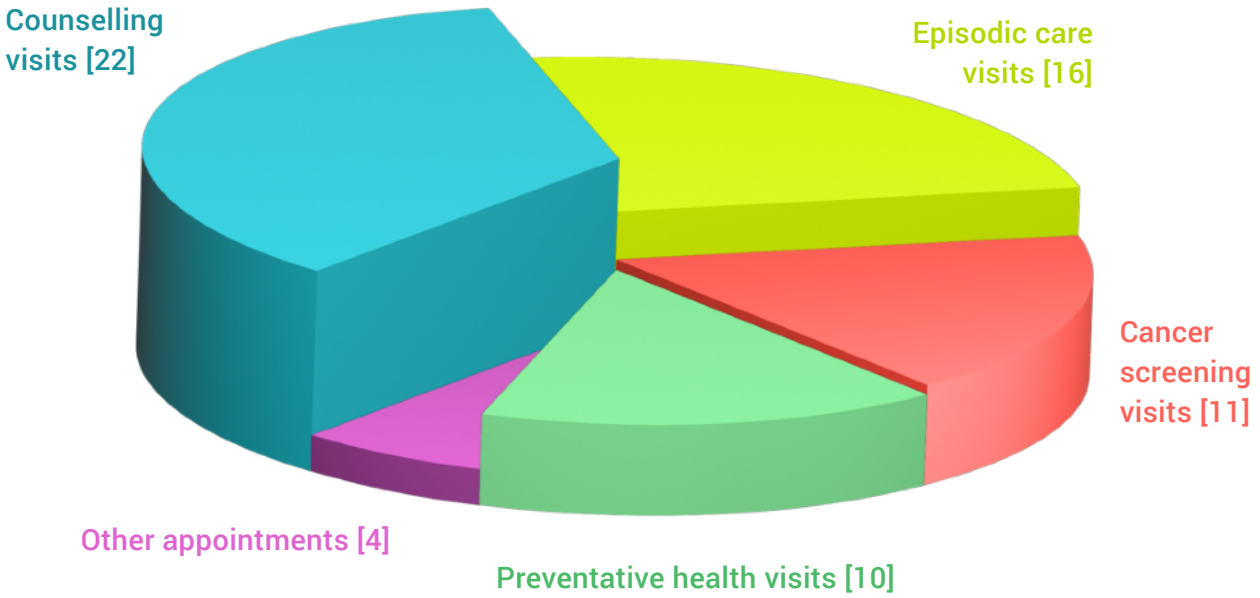
Services included preventative health care, cancer screening, assessment and treatment of episodic health concerns, counselling, and support with ongoing health needs.

By providing access to these essential services, the clinic reduced barriers to care and supported earlier identification and management of health concerns.

Between September 2025 and March 2026, the clinic completed 63 patient appointments, helping unattached individuals access care closer to home.

63 appointments

The Mattawa Clinic — 63 patient visits — 2025/09 to 2026/03



Chronic Disease Management Clinic

In partnership with NWOHT, North Bay Regional Health Centre operates the Chronic Disease Clinic to provide primary care for unattached individuals living with chronic or complex health conditions. The clinic helps ensure vulnerable patients receive timely assessment, treatment, follow-up, and care coordination while long-term attachment is pursued.

The clinic is referral-only and not open to walk-in or self-referred patients.Working closely with healthcare providers across Nipissing, it accepts referrals from hospitals, specialty clinics, the Regional Cancer Centre, the Community Paramedic Program, Ontario Health atHome, Health Care Connect, and other community partners.

During the fourth quarter of the 2025/26 fiscal year, the clinic completed 493 patient appointments, reflecting growing demand for accessible primary care among unattached individuals living with chronic disease.

By providing a bridge to primary care, the clinic reduces barriers to essential health services and complements ongoing efforts to connect patients with a permanent family physician or nurse practitioner.

493 appointments

North Bay Regional Health Centre | Centre régional de santé de North Bay

Cancer and Related Screenings

North Bay Regional Health Centre launched a new initiative in partnership with NWOHT to help people without a primary care provider access important cancer screening services. The program identifies individuals who are overdue for screening and connects them with the appropriate screening. This initiative supports screening for:

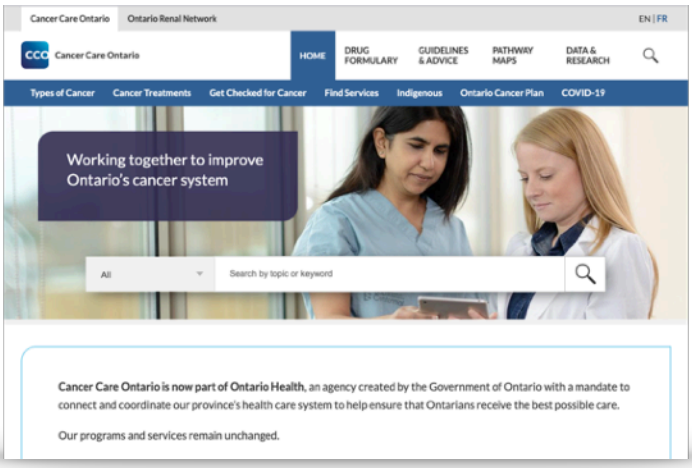
- Breast cancer
- Cervical cancer
- Colorectal cancer
- Lung cancer
- Abdominal aortic aneurysm

Since launching in February 2026, 386 people have been offered cancer screening through this initiative.

386 people

Regular cancer screening is one of the most effective ways to detect cancer early, often before symptoms develop. Early detection can improve treatment options, lead to better health outcomes, and, in some cases, prevent cancer from becoming more advanced.

To learn more about Ontario's organized cancer screening programs and find out if you are eligible, visit cancercareontario.ca



Coordinating Care Across the System

Navigation Community of Practice

The Navigation Community of Practice is a collaborative network of healthcare providers, patient navigators, and community organizations working together to strengthen knowledge of local health and social services across Nipissing.

By sharing information, learning from one another, and building relationships between organizations, the group helps improve service coordination and supports patients in accessing the right care, in the right place, at the right time.

Throughout the year, members took part in virtual learning sessions featuring presentations from local organizations, deepening their understanding of available programs, referral pathways, and community resources.

These sessions increased awareness of local services and strengthened connections between organizations, making it easier for community providers to guide patients to the most appropriate supports.

Caredove and Northern Care Connect

Caredove is a digital navigation platform that helps connect people with health and community services across Nipissing. Through NWOHT's Find a Service directory, residents, healthcare providers, and community organizations can search for local programs and services based on location, service type, and individual needs, making it easier to identify the most appropriate supports.

The NWOHT website continued to see strong use as a source of health and system navigation information. During the third and fourth quarters of the fiscal year, the website averaged 1,134 visits per month and welcomed 3,609 new users, demonstrating growing public awareness of NWOHT programs, services, and navigation resources.

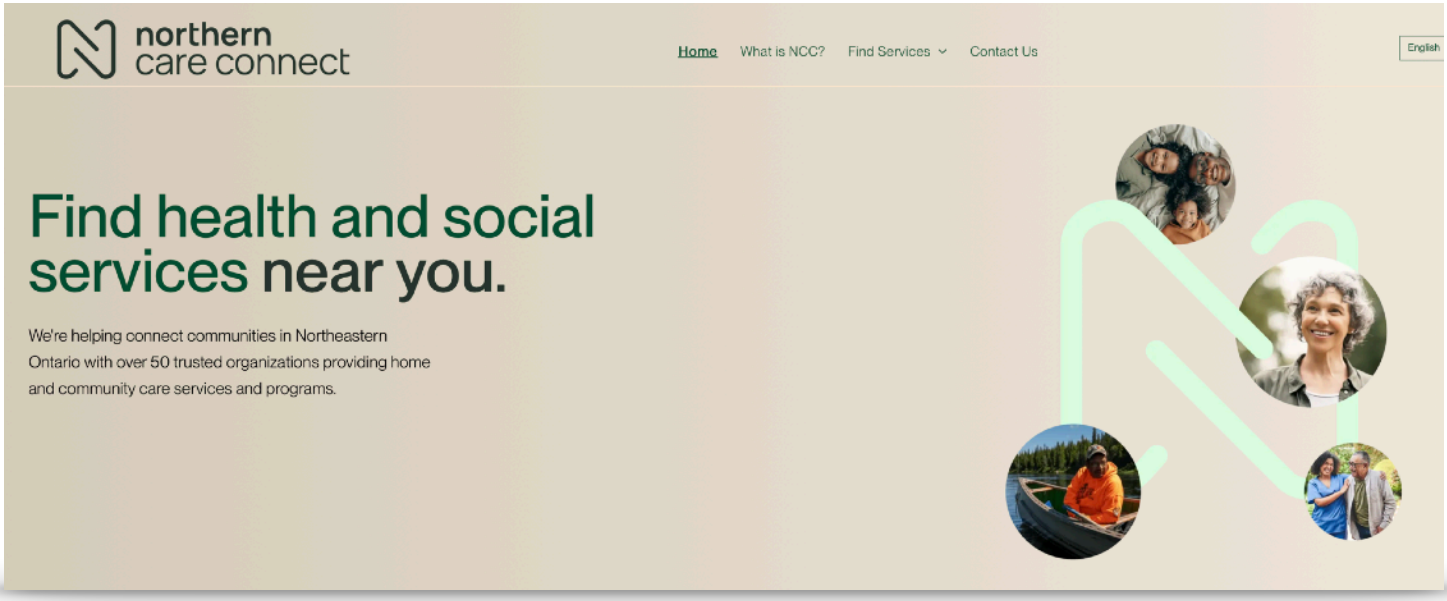
Powered by Caredove, **Northern Care Connect** continues to help people across Northeastern Ontario find the health and community services they need.

This initiative was developed through a partnership of seven Ontario Health Teams, with the goal of making it easier for people to connect with local supports and navigate the healthcare system more efficiently.

With information from more than 50 partner organizations, Northern Care Connect provides easy access to services including primary care, mental health and addictions, children's services, Indigenous health and wellness, home and community care, and social services.

By working together, Ontario Health Teams continue to strengthen access to reliable information and improve patient connections to care for people living in Northeastern Ontario.

northerncareconnect.ca



Hospital to Home

As part of the Home First Initiative, the Hospital to Home [H2H] Program continues to support patients transitioning safely from hospital to home through a restorative care approach. The program focuses on maximizing function, promoting independence, and helping patients achieve their recovery goals while reducing unnecessary hospital utilization.

Patients receive coordinated care from an inter-professional team including physiotherapy, occupational therapy, nursing, and personal support workers, providing individualized support that enables them to recover safely at home.

Fiscal year 2025/26 highlights:

- Supported 145 patients through restorative care to recover at home
- 124 patients successfully completed the program
  - 64% discharged independently with no further services required
  - 18% transitioned to ongoing community supports [Ontario Health atHome and outpatient rehabilitation]
  - 4% hospital readmission rate
  - 14% discharged for other reasons [relocation or patient preference]
- 92% of patients and families reported being satisfied with their care
- Average patient age: 77 years
- Average length of stay: 7 weeks

64% → 64% of patients were discharged independently with no further services required.

92% satisfied with care

The program continues to demonstrate strong outcomes by supporting patients to regain independence, preventing functional decline, and facilitating safe transitions home.

Home to Long-Term Care [LTC]

The Home to Long-Term Care [H2LTC] Program supports older adults with complex needs to remain safely in the community while awaiting long-term care placement.

The program provides coordinated support that helps prevent unnecessary hospital stays, easing pressure on acute care while ensuring patients receive the right level of care as they wait for a permanent LTC bed.

Fiscal year 2025/26 highlights

- Supported 55 individuals to remain at home while awaiting long-term care
- 31 patients discharged
  - 67.7% transitioned to long-term care from community
  - 9.7% transitioned to hospital for palliative care
  - 3.1% returned to hospital Alternate Level of Care [ALC, essentially LTC in hospital]
  - 9.7% transitioned to Ontario Health atHome services
  - 9.7% no longer required crisis supports
- More than 90% of patients reported being satisfied or very satisfied with their care experience
- Average patient age: 82 years
- Average length of stay: 9 weeks

The H2LTC program continues to provide a supportive, community-based alternative for individuals awaiting long-term care, helping patients maintain as much independence, agency, and quality of life as possible while supporting the Home First philosophy.

69% of those waiting transitioned to long-term care from home in an average of 9 weeks.

90% satisfied with care

SMILE

The Seniors Managing Independent Living Easily [SMILE] program continues to help older adults live safely and independently in their own homes by connecting them with personalized community supports and services. Delivered by VON Nipissing in collaboration with the NWOHT and community partners, the program supports clients in maintaining their independence while enhancing their overall health and well-being.

During the 2025/26 fiscal year, the SMILE program supported 275 unique clients across Nipissing. Through a coordinated approach to care, participants accessed a wide range of services including Meals on Wheels, transportation, housekeeping, household management, foot care, shopping, respite care, home safety supports, and other essential services that help clients remain safely at home.

The program continues to have a meaningful impact on the lives of those it serves:

- 98% of participants reported being satisfied or extremely satisfied with the SMILE program
- 93% said the program is helping them stay in their own home
- 81% reported that their overall health had improved since joining the program
- 87% reported improvements in their mental well-being
- 77% of SMILE clients have not been admitted to hospital in the past six months
- 57% of SMILE clients have not presented to the emergency department in the past six months

Throughout the year, SMILE continued to strengthen partnerships and enhance supports for clients by expanding social prescribing opportunities, collaborating with the Ontario Caregiver Organization to better support caregivers, and connecting participants with programs that promote social engagement, independence, and healthy aging. von.ca/en/smile

"Without this help I'm not sure where I would be. Thanks for letting me stay in my home."

~ SMILE program client ~

Best Care

Best Care delivers services across ten primary care clinics, improving access to evidence-based care for patients living with chronic disease.

In the 2025/26 fiscal year, 1,100 patients received comprehensive assessment, education, medical management, and self-management support through the Best Care program [chronic obstructive pulmonary disease (COPD), asthma, and heart failure].

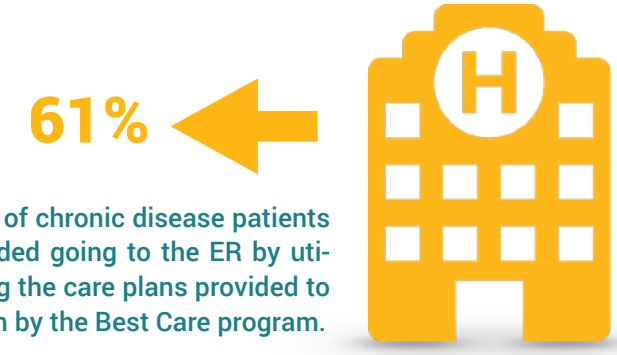
These patients were provided with individualized action plans, giving them the knowledge and tools to recognize worsening symptoms early and manage their chronic condition effectively.

The program demonstrated a significant reduction in health care utilization:

- Hospital admissions decreased from 60 before Best Care to 25 after receiving Best Care services **[58% reduction]**
- Emergency department visits decreased from 110 to 43 **[61% reduction]**
- Unscheduled or urgent primary care visits decreased from 507 to 251 **[50% reduction]**

These results demonstrate the value of integrating specialized chronic disease management into primary care and Best Care's contribution to improving access, enhancing quality of care, and empowering patients.

BestCare



61% of chronic disease patients avoided going to the ER by utilizing the care plans provided to them by the Best Care program.

Digital Innovation

Digital Health and Access

Online Appointment Booking [OAB]

NWOHT continues to expand the use of OAB, letting patients book primary care appointments online at their convenience while easing administrative workload for clinic staff.

- Five primary care clinics across the Nipissing District now offer OAB
- Public Health now offers OAB for their vaccination clinics
- Patients can book anytime, reducing phone wait times and improving access to care

Online Appointment Reminders

Automated reminders help patients keep track of upcoming visits and cut down on missed care, while also helping clinics fill last-minute cancellations more efficiently.

- Reduced missed appointments by 70%
- Fewer no-shows mean cancelled slots open up sooner for other patients

North East Virtual Care Clinic

The North East Virtual Care Clinic improves access to timely healthcare by offering phone or video appointments for non-emergency concerns, giving patients a convenient option when they're unable to reach their regular primary care provider.

- 597 virtual appointments provided to Nipissing residents this year
- Reach the Clinic at 1-888-684-1999 or nevirtualcare.ca

Bringing Care into the Community

Mobile Healthcare

Clinical Access Mobile Partnership [C.A.M.P.]

C.A.M.P. improves access to healthcare by bringing services directly to local communities.

Since launching on May 1, 2025, the mobile clinic has connected residents in rural, remote, and underserved areas with care services closer to home. Delivered with the District of Nipissing Social Services Administration Board, C.A.M.P. supports a range of outreach initiatives responding to changing community needs.

During its first year of operation, C.A.M.P. provided 95 outreach clinics, delivering services such as vaccinations and wound care while increasing access to care for residents who may otherwise experience barriers to receiving healthcare. The mobile clinic's flexible design allows it to support a variety of health initiatives and respond to community priorities.

The program's versatility was demonstrated during a power outage in Mattawa, when C.A.M.P. was deployed to provide on-site communications support for Mattawa Hospital. This response highlighted the mobile clinic's ability to support both healthcare delivery and community emergency response when needed.

Health Kits

Throughout the 2025/26 fiscal year, NWOHT partnered with the North Bay Indigenous Hub, North Bay Parry Sound District Health Unit, and the District of Nipissing Social Services Administration Board to distribute health kits to equity-deserving populations across the district.

The kits included winter accessories, feminine hygiene products, wound care supplies, and other essential items that promote health, support chronic disease prevention, and improve overall well-being.

By working together to deliver healthcare services and essential resources directly into communities, NWOHT and its partners continue to reduce barriers to care and improve access to services for residents throughout Nipissing.

Drug and Alcohol Strategy

This past year, NWOHT collaborated with the North Bay Parry Sound District Health Unit and community partners to support development of the Nipissing District Drug and Alcohol Strategy.

As part of this work, three ecosystem mapping sessions brought together healthcare providers, community organizations, system leaders, and people with lived and living experience to better understand the current landscape of substance use services across Nipissing.

These sessions identified ways to strengthen partnerships, improve coordination between organizations, reduce stigma, and make it easier for people to access support. The work also reinforced the importance of a coordinated, person-centred approach to prevention, harm reduction, treatment, and community safety.

Findings from the mapping process will help guide the next phase of the strategy, with continued focus on improving system navigation, supporting youth prevention initiatives, strengthening cross-sector collaboration, and building a more integrated continuum of care for individuals and families affected by substance use.

North Bay Parry Sound District Health Unit
Bureau de santé du district de North Bay-Parry Sound

Grief Support Group

This year, NWOHT collaborated with the West Nipissing Community Health Centre, Nipissing Serenity Hospice, and Connective Care: Counselling, Grief and Mental Health Support to launch a monthly Grief Support Group for West Nipissing residents.

The program offers a safe, welcoming space where people experiencing grief can connect with others, share their experiences, and access educational resources that support healing and overall well-being. Through this partnership, participants can also be connected with:

- Additional bereavement supports
- Individual counselling
- Peer support
- Specialized supports for children and families
- Community education initiatives

The first session was held in March 2026, marking the start of a collaborative effort to expand access to compassionate, community-based grief and bereavement supports in West Nipissing.

NIPISSING SERENITY HOSPICE
LA MAISON SÉRÉNITÉ DU NIPISSING

CENTRE DE SANTÉ COMMUNAUTAIRE DE NIPISSING OUEST
WEST NIPISSING COMMUNITY HEALTH CENTRE

Looking Ahead

We Look to the Future

NWOHT remains committed to strengthening a more connected, equitable, and person-centred health system for the people and communities of Nipissing.

Building on the progress made throughout 2025/26, we will continue working alongside patients, families, caregivers, healthcare providers, Indigenous partners, community organizations, and system partners to improve access to primary care, strengthen coordinated care, advance health equity, and support better health outcomes.

By continuing to build strong partnerships and work toward shared goals, we will create a more connected and responsive health system that is easier to navigate and meets the evolving needs of our communities. Together, we are building a healthier future for the people and communities of Nipissing.

Strategic Plan Overview

NWOHT PUBLISHED SEPTEMBER, 2026

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Équipe Santé Ontario Health Team
Ontario Bimaadzwin Niigaanwiwaad

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The views expressed in this publication are the views of the funding recipient [NWOHT], and may not reflect those of the Government of Ontario or Ontario Health.

For more information about the Ontario Health Teams,
visit www.ontario.ca/page/ontario-health-teams
or email ontariohealthteams@ontario.ca

nipissingwellness.ca info@nipissingwellness.ca 176 Lakeshore Drive, Unit #10 North Bay, ON P1A 2A8