



The Niagara Ontario Health Team-Équipe Santé Ontario Niagara (NOHT-ÉSON) is a steadily growing network of more than 50 health care providers, social service agencies, educational institutions and patient/client and family/caregiver representatives. We are committed to working as one coordinated team to provide exceptional service, support and care to you, no matter when or where you need it, now and for our future generations.



CONNECTING NIAGARA RESIDENTS TO PRIMARY CARE TODAY — AND BUILDING THE WORKFORCE FOR TOMORROW

For many Niagara residents, finding a family physician or nurse practitioner has meant waiting, wondering and trying again. Across the region, partners are working to change that experience by making the path to primary care clearer, more coordinated and more supportive.

The **Niagara Practitioners' Healthcare Alliance (NPHA)**, **Niagara Region Economic Development, Niagara Region**, local municipalities, primary care partners, and the NOHT-ÉSON continue to work together to help residents connect with providers who are accepting new patients, while also strengthening long-term physician recruitment efforts across Niagara.

This work is focused on two connected goals: helping residents access primary care now and ensuring Niagara continues to attract and retain the physicians, nurse practitioners and health professionals needed to serve a growing population in the years ahead.

"Access to a family doctor is one of the most important foundations of good health. By removing barriers and improving connections to primary care, we can prevent illness, reduce emergency room visits, and support better health outcomes for everyone in our region. These efforts are vital to building a healthier, more resilient Niagara," said **Dr. Azim Kasmani**, Medical Officer of Health for Niagara Region.

Helping residents get connected

Primary Care System Navigators now offer one-to-one support for residents who need help finding a family physician or nurse practitioner. Navigators can help people complete intake forms, identify nearby clinics, arrange a first visit and follow up to make sure the connection is successful.



The service is designed to meet people where they are — online, by phone or in person — and to provide support that is culturally safe, people-centred and solution-focused.

Residents who prefer to reach out to a doctor or nurse practitioner themselves can also use Niagara Region's **Find a Doctor webpage**, which lists doctors and clinics by municipality, along with contact information and locations. In Niagara, people can contact any doctor or clinic on the list, no matter where they live.

"Primary Care System Navigators meet people where they are—online, by phone, or in person—so no one has to figure it out alone. Working with Niagara Region's Find a Doctor page, we're turning information into real, timely connections for residents across Niagara," said **Tara Galitz**, Executive Director of the NOHT-ÉSON.

Residents can connect with a Primary Care System Navigator by contacting the NPHA at info@npha.ca or 905-354-9393.

To make this information easier to find, "Connect to Care" materials are also being shared across more than 1,600 community locations, including libraries, community centres, pharmacies, housing and settlement agencies, and other public spaces.

“Through the Niagara Practitioners’ Healthcare Alliance, we are working to make it easier for residents and new practitioners to find the information and support they need. For residents, that means helping them connect with a Primary Care System Navigator and take the next step toward finding a family physician or nurse practitioner. For new physicians and learners, NPHA serves as an information hub — helping them settle into practice and access the resources they need at their digital fingertips. As practicing physicians, Primary Care Network Leads and clinical preceptors with **McMaster University, Dr. Darija Vujosevic**, Clinical Lead for the NOHT-ÉSON, I see every day how team-based primary care, medical teaching and community connection can work together. We want learners to come to Niagara, learn here, stay here and build their lives here — because that is one of the ways we strengthen access to primary care for patients now and into the future,” said **Donna Blaney**, Co-Lead of the Niagara Practitioners’ Healthcare Alliance.

Niagara residents can also register themselves and/or their family with Health Care Connect online at any time, 24 hours a day, seven days a week. They can also register by phone at 811, though joining Health Care Connect does not guarantee an immediate match, and those with urgent needs are prioritized.

A changing primary care landscape

While many residents still experience challenges finding primary care, Niagara is seeing important progress.

More than 300,000 Niagara residents are now connected to family doctors and nurse practitioners through collective regional efforts. At the same time, physician recruitment remains an ongoing priority because Niagara’s population continues to grow, some physicians are approaching retirement, and the need for accessible primary care continues to evolve.

In a recent interview, **Jill Croteau**, Physician Recruitment Program Manager with Niagara Region, emphasized that recruitment in Niagara is a regional team effort involving municipalities, physician groups, health





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system partners and community organizations. She noted that there is significant activity underway across the region, including new and expanding practices, physicians accepting patients, and continued work to promote Niagara as a destination of choice for medical learners and practicing physicians.

Niagara Falls, in particular, has seen strong momentum, with new and expanding clinics creating additional opportunities for residents to connect to care, and communities across Niagara continue to be part of the broader regional recruitment and access strategy.

Croteau also highlighted that physician recruitment is not just about responding to today's needs. It is also about building a sustainable pipeline for the future.

Niagara's population has grown significantly in recent years, with tens of thousands of new residents moving to the region. When combined with physician retirements, population aging and changing models of care, this means Niagara must continue planning ahead.

That long-term planning includes ongoing work with medical learners and residents, international recruitment, and efforts to showcase Niagara as a welcoming and supportive place to practice medicine.

Looking ahead: training the next generation

One of the most promising developments is the approval of a new primary care teaching clinic for Niagara in partnership with McMaster University.

The clinic is expected to support a group of family physicians who will take on medical learners, helping to increase local training capacity and strengthen Niagara's future physician pipeline. By creating more opportunities for learners to train in Niagara, partners hope more physicians will choose to build their careers and practices here.

This type of initiative reflects a broader shift in how Niagara is approaching primary care access. The region is not only working to connect residents to providers today, but also investing in the relationships, recruitment strategies and training opportunities needed to support access over the next decade.

That includes promoting Niagara to medical students and residents, supporting new physicians as they establish practices, and working with partners to ensure recruitment efforts are coordinated across the region.

Working together for better access

Improving access to primary care is complex, and no single organization can solve the challenge alone. It requires coordination between health system partners, municipalities, primary care providers, community organizations and residents.

Through Primary Care System Navigators, Niagara Region's Find a Doctor webpage, physician recruitment efforts, and emerging training opportunities, Niagara is building a more coordinated approach to primary care access.

The message to residents is simple: support is available.

Residents looking for a family doctor or nurse practitioner do not have to navigate the process alone. Whether they use the Find a Doctor webpage, connect directly with a Primary Care System Navigator or access Health Care Connect, help is available to guide them through the next step.

At the same time, Niagara's partners are looking ahead — recruiting new physicians, supporting new practices, strengthening training opportunities and planning for the future needs of a growing region.

Together, these efforts are helping build a stronger, more connected primary care system for Niagara residents now and for years to come.



MOBILE COGNITIVE ASSESSOR PROGRAM SHOWS THE POWER OF PARTNERSHIP IN NIAGARA

A collaborative approach to dementia care is helping more people in Niagara access cognitive assessment earlier, while also connecting patients and caregivers to the support they need along the way. Niagara's Mobile Cognitive Assessor program is emerging as a strong example of how partnership can improve access and strengthen the continuum of care.

At the centre of the program is a partnership between the **Alzheimer Society of Niagara Region (ASNR)** and **Niagara Medical Group Family Health Team (NMGFHT)**, to improve access to cognitive assessment and dementia supports in Niagara. **Angela Monrad**, the Mobile Cognitive Assessor with ASNR, works closely with **Cindy Gabrielli**, a nurse practitioner at (NMGFHT), to support people in the community who need a cognitive assessment.

In her role, Angela brings a calm, supportive presence to what can be a stressful process. She noted that many people are nervous about cognitive assessment, and that being able to meet them in their homes allows her to offer a gentler, more reassuring experience.

"People are nervous. They're scared, right? And so if I can say, 'I'm here for you,' and come to their home and sit with them and be with them through that process... I can be that calm and be supportive."

The Mobile Cognitive Assessor program continues to respond to a clear and growing need in Niagara. The most recent program data for 2025-26 indicates the program has received 114 referrals and completed 83 total assessments, including 56 new assessments and 27 reassessments or follow-up visits. An additional 15



referrals were redirected to the Geriatric Assessment Program, the Niagara Seniors Mental Health Outreach Program or the Dual Diagnosis assessment teams due to the complexity of the individuals' needs, while the remaining referrals were determined not to be appropriate for the service.

Together, these numbers reflect both the demand for the program and the important role it plays in helping connect people to the most appropriate care. Demand has grown to the point that appointments are being booked a couple of months in advance, with discussions underway about expanding clinic availability.

The program is helping to fill an important gap in care. As **Sarah Putman**, Co-Lead of the NOHT-ÉSON's Dementia Care Working Group and Chief Operating Officer of Clinical Services for ASNR explained, many people delay cognitive assessments because of fear, stigma or uncertainty, even when changes are already affecting daily life.

She noted that people often wait until they are facing significant challenges, when "fear of the assessment equals a delay in getting supportive strategies to support living well with dementia." She also emphasized the importance of the language used around dementia, saying care should focus on helping



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people “live well” rather than reinforcing stigma.

That early access matters. Cognitive assessment and reassessment can help care teams track progression, monitor the impact of medications, identify changes that may require additional intervention and support ongoing safety planning. Just as importantly, it creates regular touchpoints for both the person living with dementia and their care partner.

“It’s not just the assessment, it is the whole wrap around care that we provide... It’s we have you now. We’ve got you now. We’re here for you now,” Angela added, describing the service as a wraparound model of care that helps connect people and families to the supports they need, whether that means linking them back to the Alzheimer Society, involving colleagues for additional support, connecting with **Ontario Health atHome**, or helping with future planning. She also offers follow-up meetings with patients and families after results are shared, giving relatives and friends an opportunity to ask questions, better understand the diagnosis, and begin navigating the next steps together.

With a referring medical practitioner and the required preliminary testing in place, the assessor can support individuals in a variety of settings based on their circumstances and needs. Every patient in the program receives a home visit for testing and assessment. This year, 23 homebound patients also received in-home results visits, ensuring access for people who may not otherwise have been able to return to a clinic setting. Angela has also supported referrals connected to Niagara’s shelter system, including one patient assessed in shelter and additional referrals currently in progress. This adaptability helps ensure that people who face barriers to traditional clinic-based care can still access timely cognitive assessment and support.

Sarah highlighted that willingness to meet people where they are, noting, “we are willing to work at any level to try to get someone the support they need,” adding that “that’s the nice thing about the mobile cognitive assessor too, is that she can go anywhere.”

For Niagara residents, that flexibility is making a difference. Sarah described the opening of the clinics to the broader community as “a game changer for access to assessment in the Niagara region.” She noted that Niagara now has five active memory clinics in addition to the Mobile Cognitive Assessor program, calling it “an amazing feat” and something other communities have noticed.

The benefits of the program also reflect broader strengths in Niagara’s dementia-care approach. **Casey Knight**, Co-Lead of the NOHT-ÉSON’s Dementia Care Working Group and Registered Nurse for the **Welland McMaster Family Health Team**, noted that caregiver support is a critical part of the overall process. She emphasized that cognitive assessment should not be viewed as a stand-alone event, but as an entry point to additional supports, services and connections that can help both patients and their care partners. Early connection to organizations such as the Alzheimer Society of Niagara Region and other community-based resources can make a meaningful difference in helping families better understand what lies ahead and where they can turn for help.

That supportive approach is reflected in the feedback families have shared with Angela. She said a response she often receives from patients and loved ones is gratitude.

“A common thing I get, even just from my very first visit, is that they really just say, ‘Thank you. This was so much easier than I thought it would be. I am so much more comfortable going through this process now because

you came to my home, you sat with me, you gave me the time.”

Those early connections are critical. By linking people sooner to education, navigation and community supports, the program helps patients and families better understand what lies ahead and where they can turn for help. It also reinforces the broader goals of dementia care in Niagara: earlier access, better coordination and stronger support for both patients and caregivers.

Another key strength of the program is the way access has expanded through collaboration across primary care and specialized services. The Niagara Medical Group and Portage Medical Family Health Teams have taken a significant step by opening access to non-rostered patients, broadening entry points into the system. Other clinics continue to contribute through coordinated referral pathways.

In parallel, partnerships with specialized services such as the Geriatric Assessment Program and Niagara Senior Mental Health ensure individuals are connected to the most appropriate level of care based on their needs. Together, this approach supports timely access

to cognitive assessment, reduces unnecessary wait times, and helps ensure people receive the right service at the right time.

Taken together, the Mobile Cognitive Assessor program is more than a clinical service. It is a partnership in action — one that brings together assessment, primary care, caregiver support, and community navigation in a way that is practical, responsive and patient-centred. In a region already making important strides in dementia care, it stands as a strong example of how collaboration can improve access and help people live better, longer, in the community.

Referrals to the MCA program can be made by any primary care health practitioner in through the completion of the memory clinic referral form available on the Niagara Medical Group Family Health Team’s **website**.

Completed referral forms should be faxed to 905-356-2765.

For more information, please contact the Niagara Medical Group Family Health Team at 905-356-2236, ext. 254.





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RECOGNIZING THE IMPACT OF POSITIVE LIVING NIAGARA'S CONSUMPTION AND TREATMENT SERVICES SITE

With provincial funding for **Positive Living Niagara's** Consumption and Treatment Services (CTS) site having ended on June 12, the NOHT-ÉSON is recognizing the significant contributions the service has made to health, safety and care in Niagara.

Since opening in St. Catharines, Positive Living Niagara's CTS site had played a vital role in supporting people who use substances, while also helping to reduce harm across the broader community. Between 2019 and 2025, the site recorded more than 88,000 visits and more than 1,500 overdose reversals. These numbers represent lives saved, relationships built and opportunities for people to access care that may not otherwise have been possible.

Consumption and Treatment Services are evidence-based health services. Positive Living Niagara's CTS site offered a supervised consumption space where individuals could use pre-obtained substances in the presence of trained harm reduction workers, staff with lived or living experience, community engagement and security workers, and paramedic staff. This distinction is important. The service existed to prevent deaths, reduce the spread of infectious diseases such as HIV and Hepatitis C, support safer practices, and connect people to health and social services.

For many individuals, the CTS site was not simply a place to reduce the immediate risk of overdose. It was also a relationship-based entry point into a broader system of care. Through the site, people could access overdose prevention and intervention, naloxone, safer substance use education, harm reduction supplies, wound recognition, drug checking, referrals to



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treatment and withdrawal management, mental health services, housing supports, primary care and other community resources.

These connections matter. People who use substances often face stigma, isolation and barriers to traditional health care settings. Low-barrier, non-judgmental services create opportunities for trust. That trust can become the first step toward treatment, stabilization, housing, primary care or other supports when a person is ready.

The closure of the CTS site will create gaps and risks for the people who relied on the service, for the Queenston neighbourhood, and for the broader health and social services system. In other communities, the loss of supervised consumption services has raised concerns about increased overdoses in public spaces, greater demand for emergency medical responses, added pressure on hospitals, and additional strain on outreach, harm reduction and social service providers.

The NOHT-ÉSON welcomes investments that expand access to mental health, addictions, supportive housing and recovery-focused services, including HART Hub services in Niagara. However, these services do not replace supervised consumption. HART Hubs and Consumption and Treatment Services serve different

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functions and support people at different points in their journey. They are complementary parts of a comprehensive continuum of care.

As Niagara moves through this transition, the NOHT-ÉSON continues to support evidence-based, compassionate and responsive care for people who use substances. Harm reduction services save lives, reduce stigma, protect community health and create pathways to support.



CAREGIVERS' VOICES POINT TO NEED FOR BETTER SUPPORT ACROSS NIAGARA

On April 7, the NOHT-ÉSON marked **National Caregivers Day** by recognizing the thousands of people across Niagara who provide care for loved ones, friends and neighbours — often quietly, and often without enough support.

To help better understand the experiences of caregivers in the region, the Palliative Care Working Group of the NOHT-ÉSON led a regional caregiver experience survey in collaboration with network partners. The findings are now available in the **Caregiver Experience in Niagara Executive Summary**, which highlights the voices of caregivers and identifies opportunities to strengthen supports across the system.

The survey findings show that caregiving is a critical and often invisible part of Niagara's health system. Caregivers support people at home, in hospital rooms, in long-term care settings and during some of the most difficult moments of life. Their responsibilities often include managing medications, coordinating appointments, providing personal care, navigating

The NOHT-ÉSON urges the Province to continue supporting evidence-based harm reduction services in the community. The network remains committed to working with partners across the region to protect health, preserve dignity and improve outcomes for vulnerable residents. As the CTS site closes, it is essential that people who use substances continue to have access to care and support in ways that are safe, respectful and grounded in evidence.





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services and balancing caregiving with work, school, family and other daily responsibilities.

While many caregivers described their role as meaningful, they also shared that caregiving can be overwhelming, confusing and difficult to navigate. According to the Executive Summary, many caregivers did not fully understand what to expect at the beginning of their caregiving journey, experienced difficulty accessing services when needed, and reported impacts on work, education and finances.

The report also notes that caregiving is often intensive and long-term. Many caregivers provide care primarily in the home, with some providing more than 40 hours of care each week. For many, caregiving is not something that can be “left at the end of the day” — it is a continuous role that affects physical, emotional, social and financial well-being.

Caregivers also identified significant challenges related to information, access and navigation. Many described a system that can be difficult to understand, especially at the start of their journey. The findings reinforce the need for earlier access to clear and practical information, stronger navigation supports, better coordination between providers and services, and more support before caregivers reach a point of crisis.

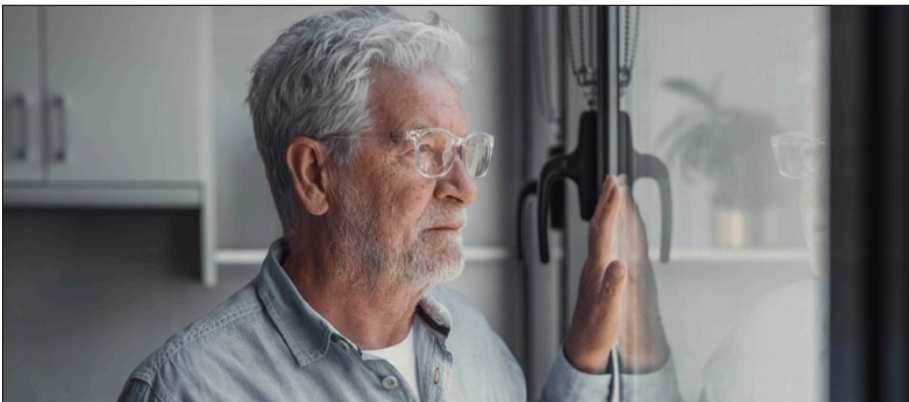
The survey also highlights the importance of equity, representation and ongoing engagement. Indigenous, Francophone, newcomer, diverse and equity-deserving communities require continued and intentional engagement to ensure their caregiving experiences are understood and reflected in system planning. Francophone caregivers, in particular, emphasized that feeling supported begins with being understood and being able to access information and services in their preferred language.

Across Niagara, organizations are working together through the NOHT-ÉSON and the **Caregiver Network of Niagara** to strengthen caregiver supports. This includes improving access to information, enhancing coordination, expanding emotional and peer support, improving access to respite, and ensuring caregivers are included as essential partners in care.

The release of the survey findings on National Caregivers Day was an opportunity to recognize not only what caregivers do, but what they carry. Their stories are helping to shape a more supportive, coordinated and responsive system across Niagara.

Caregivers are not alone, and their voices matter.

Read the Executive Summary [here](#).



“The challenge was not only whether services existed, but whether people could find them, understand them, and access them in time.”



CAREGIVING SUMMIT IDENTIFIES PRACTICAL NEXT STEPS TO STRENGTHEN SUPPORTS ACROSS NIAGARA

Caregivers are essential partners in care — but too often, they are left to navigate a complex and fragmented system on their own.

That message was heard clearly on February 24, when the NOHT-ÉSON and **Heart Niagara** co-facilitated **Partnering for Care: Building Stronger Systems for Caregivers** in Niagara Falls. The caregiving summit brought together caregivers, health and social service providers, community organizations and system partners to identify practical, Niagara-ready solutions to better support caregivers across the region.

The summit was designed to move beyond identifying what is not working and focus instead on what can be done next. Through lived experience, frontline insight and system-level discussion, participants explored how Niagara can build a more coordinated, compassionate and responsive caregiving system.

In the opening keynote, **Lauren Bates**, Chair of the **Ontario Caregiver Coalition**, described unpaid caregivers as the “hidden backbone” of Ontario’s home health care system. Her remarks highlighted the growing pressures facing caregivers, including an aging population, gaps in home care, unclear respite pathways, financial strain and the increasing demands placed on families and loved ones.

Throughout the day, participants reflected on what is working, what is missing and what would make the biggest difference for caregivers across Niagara’s 12 communities. A clear theme emerged: caregivers need a system that is easier to navigate, more consistent across communities and better coordinated around real-life needs at home.

Participants described a system that is often reactive rather than proactive. They pointed to uneven access to services across Niagara, fragmented respite options, poor continuity of care, information fatigue and persistent silos between organizations. In some cases, caregivers may receive information from multiple sources without a clear understanding of where to begin. In others, families may be required to repeatedly explain their situation to new providers or coordinate supports across disconnected services.

Respite was identified as a critical support for caregiver well-being, but participants emphasized that respite must be easier to access, more coordinated and more consistent. Caregivers need earlier information at diagnosis and discharge, proactive follow-up, simplified intake processes and clearer guidance on what supports are available. The idea of a “Roadmap to Respite” emerged as a practical next step to help caregivers know where to call, what to expect and how to access support without carrying the burden of navigation on their own.



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Participants also emphasized that caregivers must be recognized as part of the care team. Caregivers often hold essential information about a person's daily needs, routines and changes in health, yet their voices are not always included in care planning. Summit discussions highlighted the importance of asking whether a patient has a caregiver, inviting caregivers to share relevant information and ensuring they are connected to supports earlier in the care journey.

Financial strain and caregiver mental health were also identified as closely connected priorities. Participants discussed the need for practical financial supports, while also recognizing that financial relief must be connected to real pathways for services, equipment and social support. Caregiver mental health was viewed as an area requiring earlier and more consistent attention, including caregiver stress checks during discharge planning and initial home-care assessments.

The summit also explored how workplaces can better support employees who are balancing work and caregiving responsibilities. Participants identified

the need for caregiver-friendly workplaces, flexible leave options, reduced stigma, stronger mental health supports and better manager awareness.

Several immediate and longer-term priorities were identified through the summit. These include strengthening collaboration between home care providers and hospitals, improving safe and timely hospital discharge planning, implementing caregiver check-ins at discharge and first home-care contact, building toward a single "one place to call" for caregiver navigation and piloting follow-up models connected to respite and broader caregiver supports.

Over the next one to two years, participants identified opportunities to launch a full Roadmap to Respite, develop provider-facing referral guidance and caregiver-facing pathway materials, further explore financial hardship supports and examine models that could improve region-wide consistency in home and community-based care.

The summit reflected a shared commitment to turning conversation into action. Caregivers, providers, organizations and community partners came together not only to name the challenges, but to identify practical next steps that can help build a stronger caregiving system across Niagara.

A summary report from the summit is available [here](#).

The NOHT-ÉSON and Heart Niagara thank the caregivers, providers, organizations and community partners who contributed their lived experience, insight and commitment to the day. Their voices will help guide ongoing work to ensure caregivers across Niagara are better recognized, better supported and better connected to the care and resources they need.



GROWING THE NETWORK: NOHT-ÉSON WELCOMES NEW AND RETURNING PARTNERS TO STRENGTHEN HEALTH AND SOCIAL CARE IN NIAGARA

Over the past year, the NOHT-ÉSON has welcomed six new and returning partners to its network, bringing the total number of partner organizations to more than 50.

The growth reflects the NOHT-ÉSON's continued commitment to building a more connected, collaborative and person-centred health and social care system for Niagara residents. By bringing together organizations from across health care, children's services, mental health and addictions, developmental services, community supports, caregiving, transportation and social care, the NOHT-ÉSON is strengthening the relationships needed to improve access, coordination and outcomes across the region.

Each new partner brings unique expertise, experience and community connections to the network. Together, they help expand the NOHT-ÉSON's ability to identify gaps, align priorities and support more integrated planning across sectors.

Bethesda joined the NOHT-ÉSON following endorsement by the Planning Table in August 2025. As the region's largest provider of services for people with intellectual and/or developmental disabilities, Bethesda brings an important voice to regional health planning. Its services span childhood through adulthood and include clinical supports, autism services, behavioural therapy, speech-language



pathology, occupational therapy, supported living, respite and day programs. Bethesda's involvement helps ensure that people with developmental disabilities are represented in conversations about access, transitions, hospital pressures and integrated care.

Distress Centre Niagara was also endorsed as a new member in August 2025. For more than five decades, the organization has provided confidential support to people in emotional distress and crisis, including 24/7 telephone support and expanded text and chat services. Distress Centre Niagara also operates the Mental Health and Addictions Access Line, a coordinated entry point for adults seeking mental health and addictions support across the region, and is a local provider of Canada's 988 Suicide Crisis Helpline. Its participation strengthens the NOHT-ÉSON's work to improve mental health and addictions navigation, collaboration and crisis response.



The Canadian Red Cross – Niagara Branch was endorsed as a new member in October 2025. The organization brings additional community support expertise to the NOHT-ÉSON network, including transportation and services that help people remain living safely and with dignity in their homes. Its local transportation program helps support access to medical appointments, essential activities and



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Red Cross**



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community participation for people who may be unable to use public transportation or private means. As a NOHT-ÉSON partner, the Canadian Red Cross adds an important perspective on community-based supports, independence and access to care.

Niagara Children's Centre was welcomed as a partner following endorsement in January 2026. NCC provides services for children and youth living with physical, developmental, neurological and communicative disorders or delays, using a family-centred approach that supports children at home, school and in the community. The partnership creates new opportunities to better connect children, youth and families with the broader health and social care system and to improve coordination across services.



The NOHT-ÉSON is also pleased to recognize **Pathstone Mental Health's** return to the network, following endorsement in May 2026. Pathstone provides child and youth mental health services for children, youth and families across Niagara and serves as a key access point for those seeking mental health support. Its renewed involvement strengthens the connection between child and youth mental health, primary care, community services and broader system planning.



The Young Caregivers

Association was also endorsed in May 2026.

Based in Niagara and serving children, youth and young adults who provide care for family members, YCA helps young caregivers feel seen, supported and connected. Its programs include social and recreational opportunities, one-on-one counselling, clinical groups, life-skills programming and school-based supports. As part of the NOHT-ÉSON network, YCA hopes to increase awareness of young caregivers and build stronger pathways between health and social service partners.



Welcoming these new and returning partners reflects the NOHT-ÉSON's belief that improving health and social care requires strong relationships across the full continuum of support. No single organization can solve system challenges alone. By working together, partners can better understand community needs, reduce duplication, improve navigation and support more seamless experiences for patients, clients, families and caregivers.

As the network continues to grow, the NOHT-ÉSON remains focused on its shared vision: exceptional, connected care, now and for future generations.



HELPING MORE NIAGARA RESIDENTS TRANSITION SAFELY FROM HOSPITAL TO HOME

The **Let's Go Home (LEGHO)** program in Niagara received an additional \$125,000 in one-time funding from the **Ministry of Health** to support clients through March 31, 2026. This investment built on the program's \$500,000 base funding, helping expand capacity at a time when demand continues to grow.

LEGHO supports eligible older adults (65+) in hospital with a stable, non-emergency health condition and older adults (65+) living with dementia to return home safely after a hospital stay—and, where appropriate, to prevent avoidable hospital admissions—through a six-week bundle of coordinated community supports.

This past fiscal year, more than 315 clients qualified for the program, and the incremental funding was to support, at minimum, an additional 50 clients.

"An emergency department visit can start at about \$3,000 a day," said **Nadia White**, Program Manager with **Happy in My Home, Community Support Services of Niagara**, lead organization for the NOHT-ÉSON initiative. "By comparison, a six-week bundle of services can be a more cost-effective way to help someone recover, regain confidence, and live independently at home."

LEGHO is delivered through a coordinated network of partners. **Niagara Health** plays a key role by identifying eligible patients and initiating referrals through hospital discharge planning, while working collaboratively with community partners on process improvements and efficient transitions.

"Our Home First approach guides how we plan care once a patient no longer needs hospital-level services,"

said **Lisa Hildebrand**, Niagara Health's Director of Access and Flow and Regional Stroke Program.

"Hospitals are not the right place for recovery when care can be safely and appropriately provided at home, where patients are often more comfortable and supported. This investment is timely and important. It helps ensure people receive care in the right setting, at the right time, based on their clinical needs, while allowing hospitals to focus on delivering safe, high-quality care for patients who truly need to be here."

For individuals living with cognitive impairment, the **Alzheimer Society of Niagara Region** provides specialized dementia-focused navigation services and caregiver respite for the program's dementia stream, reflecting its expertise in dementia care.

"People living with dementia do best in familiar surroundings, not in busy hospital settings where symptoms can worsen," said **Teena Kindt**, CEO of the Alzheimer Society of Niagara Region.

"Supporting individuals to return home quickly and safely helps preserve their independence and reduces unnecessary stress. Through LEGHO, families are connected to our dementia specialized services much earlier, and care partners receive in-home respite to ensure no one is navigating this journey alone."

In addition, the program's community delivery model leverages partnerships with **Meals on Wheels** agencies across Niagara to support food security for clients, and brokered supports through home maintenance/repair services that can assist in complex situations such as hoarding-related safety concerns.

Program staff report that funding comes at an optimal time, as referrals are increasing due to cold and flu season.



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“We’re seeing referrals come in quickly,” said **Cherie Della-Gatta**, LEGHO Supervisor. “This funding bump will be beneficial to many people, and our team has put strategies in place to ensure we can respond and support as many individuals as possible.”

As the program has matured, partners have refined service design to better match local needs—through the introduction of Safety at Home assessments to reduce fall risk and promote safe living environments.

LEGHO is designed to be flexible and client-led. The six-week bundle includes a minimum of three services, and clients may choose which supports best meet their needs (for example, Meals on Wheels, homemaking,

transportation, respite and/or safety recommendations).

The program also supports caregivers by helping families understand available community services and navigate options beyond the initial six-week period.

“Even though it’s a six-week bundle, we often see people stay connected to supports long-term because families learn what’s available and how to access it,” said Della-Gatta.





PLANNING FOR THE FUTURE: NEW REPORT SUPPORTS DATA- INFORMED HEALTH SYSTEM PLANNING IN NIAGARA

The NOHT-ÉSON is pleased to share **Planning for the Future: A Data-Informed Health System in Niagara**, a comprehensive report designed to support coordinated, evidence-based health system planning across the region.

The report establishes a baseline understanding of Niagara's population health, service utilization and system capacity. By bringing together data, research and system expertise from across the region, it helps identify current pressures, emerging needs and opportunities for action over the next five to 10 years.

Developed collaboratively by **Brock University, Niagara College, the Niagara Health Knowledge Institute, Niagara Health and Niagara Region Public Health**, the report examines health system capacity across the continuum of care, including public health, primary care, emergency medical services, acute care, home and community care, long-term care, hospice and palliative care, mental health services and housing-related supports.

Using the Canadian Institute for Health Information's Stuff, Space, Staff and Systems framework, the report explores the material, physical, human and organizational resources required to meet the health needs of Niagara's growing and changing population.

Among its key findings, the report highlights several trends shaping health system capacity in Niagara. Population growth and aging are increasing demand across all health services, while chronic disease and multimorbidity are contributing to more complex care needs. Primary care unattachment remains a significant challenge, and mental health, substance use and

housing instability continue to place pressure on the broader system.

The report also notes rising demand for emergency medical services, ongoing hospital capacity pressures related to patient acuity, Alternate Level of Care days and diagnostic demand, as well as workforce challenges affecting multiple sectors across the continuum of care. Limited supportive housing capacity is also contributing to preventable health deterioration and downstream impacts on emergency and hospital services.

Together, these findings show that health system pressures in Niagara are deeply interconnected. Challenges in community care, long-term care, hospice, workforce capacity and housing all have direct effects on emergency departments, hospitals and other parts of the system.

Planning for the Future reinforces the need for coordinated, cross-sector planning to improve system performance and better respond to the evolving needs of people across Niagara. The report will help inform collective planning, decision-making and investment as partners work together to build a more connected, responsive and sustainable health system.

Read the full report: **Planning for the Future: A Data-Informed Health System in Niagara**.

