

IDENTIFY (X) THE RELATED PRIORITY/SECTOR.

HNHB LHIN System Integration Priorities and project leads:

_____ Health Promotion/Disease Prevention
(D. Jones, HNHB LHIN)

_____ Children and Youth (D. Buchanan)

_____ Mapping Independent Living for LTC
Population (J. Narduzzi, C. Kinnon
& W. Walker)

X Geriatric Access & Integration Network
(D. Jewell, P. Morden)

_____ Integrating Mental Health and Addiction with
Other Sectors (R. Anderson & L. George)

_____ Cross-Sectoral Palliative/End of Life Care
(I. Fell, D. Thomson)

_____ Performance Monitoring (D. Jones, A. Iskiw,
HNHB LHIN)

_____ I & CT/e-Health Strategy (B. Katherisan,
P. Mandy, HBHB LHIN)

_____ Community-Based Networks (S. Stewart,
J. Gillman, HNHB LHIN)

_____ Community Engagement (M. Emo, HNHB LHIN)

Ministry of Health priorities:

_____ Critical Care (P. Krause, HNHB LHIN)

_____ Diagnostic Services (A. Iskiw, HNHB LHIN)

_____ Wait times (A. Iskiw, HNHB LHIN)

_____ Access to care (A. Iskiw, HNHB LHIN)

Part A: EXECUTIVE SUMMARY:

Frail seniors are one of the most vulnerable segments of our population. Planning for an effective, needs-based, sustainable health system must take account of the needs of this target group.

Hamilton Niagara Haldimand Brant Local Health Integration Network (HNHB LHIN) has a higher proportion of seniors than the Ontario average. In the next 12 years, the number of seniors is forecasted to increase by 76,000 – roughly the size of the population of Niagara Falls.

The need for health care services and supports increases with age, hence seniors are the highest users of health care resources. However, frail seniors – older adults who have conditions that limit their independence and are at risk of needing a higher level of care – are challenged to navigate the current health care system and access the services/supports they require. The current system of services/supports for frail seniors is fragmented, inefficient and often difficult to access. Capacity issues and bottlenecks limit the ability for clients to transition smoothly from one part of the system to another (e.g. clients awaiting placement in long-term care or rehabilitation may reside in an acute care bed after their acute needs have been met). Although many excellent services exist, they are not always well-coordinated and both seniors and service providers may be unaware of them.

Based on this current reality and acknowledgment of the potential for improvement, development of an integrated service delivery model for frail seniors emerged as the top priority in the 2005 HNHB LHIN Integration Priority Report. Committed and concerned stakeholders have come together to form the Geriatric Integration Network (GAIN) and work collaboratively with ensure that planning an improved system of care for frail expeditiously. Significant momentum already exists for this representatives from a cross-sectoral group of service in a retreat (funded by GAIN stakeholders) to brainstorm GAIN.

As the HNHB LHIN works towards developing integration inclusion in its first Integrated Health Service Plan, GAIN areas where it can make important contributions to of care for frail seniors.

GAIN Vision
Optimizing the quality of life for frail seniors.

GAIN Mission
To provide quality care to frail seniors, including promotion and prevention, through an interconnected network of health care services.

Access and the HNHB LHIN to seniors moves ahead initiative with over 40 providers participating the common vision for

strategies for has identified two improve the delivery

First, GAIN is prepared to serve as an expert advisory group on issues related to frail seniors and the services they use. Since GAIN is comprised of stakeholders that reflect a range of professions, organizations and sectors it is in a position to offer objective, credible advice on issues spanning the full continuum of care.

Second, GAIN is well positioned to play a leadership role in developing an integrated service delivery model for frail seniors. GAIN has begun to lay the groundwork that would unite health service providers across the LHIN under a common vision, mission, guiding principles and strategic goals. A high level plan has been developed with a planning horizon that extends to March 2010 and milestones at six months, 18 months and three years. The current areas of focus for this plan are:

- Development and evolution of the GAIN itself – A plan to further develop the network to ensure a solid foundation for the evolution to a strong governance structure that can support transformation of the service delivery system. This approach is needed to address the population based performance indicators for which the GAIN should be collectively responsible.
- Development and implementation of a patient-centred service delivery system that is based on best practices in case management/service coordination. This will require a concerted effort to create the foundation service delivery model which in turn will require the detailed design of the various component parts. This planning, design and implementation will be rolled out over a three year period.
- Communication strategies will be critical to success. Communication objectives will evolve over time from building awareness, to reporting progress to reporting results.

Clearly, a system improvement of this magnitude will require resources to support effective planning, implementation and evaluation of the service delivery model.

The process for continuing to plan and implement the health solution will begin with continued engagement of an external advisory support team to drive the creation of the integrated service delivery plan for frail seniors. The process will consist of four major steps:

1. Conduct an environmental scan of the current system, including demographic analysis, an inventory of services for frail seniors in the HNHB LHIN, and review of any relevant documentation on the current system.
2. Scan other jurisdictions for ideas and insights on frail senior integrated service delivery models.
3. Create and assess alternatives for the HNHB service delivery model, and select appropriate approach.
4. Develop a detailed project plan that outlines how to smoothly transition from the current system to the new GAIN/HNHB LHIN frail seniors service delivery model. The plan will detail: points of access and system navigation; the basket of services to be offered; methods for assessing the appropriate level of care for a patient; provider interaction within the model and across the frail seniors care continuum, including communication and information sharing; linkages to the HNHB LHIN e-health strategy;

accountability framework and performance measurement of health outcomes (e.g. improved functional status), system outcomes (e.g. reduction in alternate level of care days) and network outcomes (e.g. governance structure in place).

The integrated service delivery model will first and foremost make a significant difference in the quality of life for the frail seniors who require health care services. It will also ease the burden of their community of support – family and friends who are often ill equipped, but challenged to provide care when the system fails. Health providers will benefit from the new model by being part of an overall system that is efficient and complementary, rather than redundant and disjointed. Providers will also benefit from the network of professionals that will meet within the network, to share experiences and best practices. System capacity will increase and utilization will improve with the development of a delivery model that allocates resources more efficiently. The proposed GAIN solution is aligned with the HNHB directions and priorities and will address services for frail seniors across the entire continuum of care, creating a seamless, integrated system that will be easy to access and navigate.

Part B: Issue Statement:

1. Describe the problem to be addressed.

Frail seniors are elderly people who have conditions that affect their independence and place them at risk of needing a higher level of care than is currently required.¹ Quantitative data, Figure 1 below, from an environmental scan of the HNHB LHIN shows that the proportion of seniors (people aged 65+ and 75+) in the HNHB LHIN is greater than the provincial average². The number of seniors is expected to increase by over 76,000 by 2018³, which is approximately equivalent to the current population of Niagara Falls. Seniors are living longer and presenting with more complex issues that require higher levels of care. It is well known that increasing age is the greatest predictor of risk for serious illness and use of health care resources.

Figure 1 – Population Analysis for Seniors

Seniors Population (2004)	Hamilton Niagara Haldimand Brant	ONTARIO
% aged 65+	14.6%	12.8%
% aged 75+	7.1%	5.9%

Findings from a community engagement event with providers highlighted significant issues with connectivity between organizations within the current system as well as difficulties with access and navigation of the system. Furthermore this target population of frail seniors is often viewed as the cause of the usage of ‘Alternative Level of Care’ days in hospitals as they wait for appropriate placement within the system.

There are many services for seniors within the HNHB LHIN that provide quality care to many consumers; however, opportunities for improvement exist. Many of the current providers in the LHIN operate in isolation or in small groups, unaware of the competencies and skills of other local providers. While attributes of individual service providers may be in the best interest of seniors, a coordinated strategy is needed to ensure a continuum of services that is seamless and meets the requirements of frail seniors.

¹ Source: Inform Alberta

² HNHB LHIN proportion of seniors 15.2% vs. Ontario 12.9%. Source: Statistics Canada 2001 Census.

³ Population Projections from 2005 to 2018, HCM Group Inc. Special Project.

Access to services and geriatric expertise across the HNHB LHIN is variable at best and cumbersome to navigate for consumers and their community of support (family and informal care givers). Many frail seniors and their community of support are unaware of the range of the services available within the LHIN and also uninformed of often simple prevention and promotion information that could enhance their health and quality of life, as well as increase the probability of needing a higher level of care.

The current system does not meet the expectations of the new provincial government mandate nor the public in terms of equitable access, seamless movement through the system, and sustainability. Thus greater coordination and partnership are critical to success.

2. Why is this a problem? Describe its impact or effect on people, providers and/or system capacity.

While there are excellent service providers in the HNHB LHIN, the current disjointed system has resulted in significant inefficiencies and redundancies, as well-intentioned health care providers administering services in isolation without awareness of other available local resources. In addition to efficiency issues, this lack of communication and coordination has serious implications for the frail seniors who access these services as finite resources are not deployed in a manner that maximizes patient outcomes.⁴ Health service providers, who operate independently without a common vision, mission, and decision-making guiding principles, are not taking maximum advantage of collective knowledge and best practices that can be more readily shared through a collaborative network of providers. The result is a system of providers that are not functioning to their collective potential, and there is a sense that the standard of care could be raised with a more coordinated approach.

A system that is difficult to access and navigate causes unnecessary hardship and stress to frail seniors and their community of support who are already facing difficult circumstances due to their health condition(s). A lack of prevention and promotion strategies has resulted in many frail seniors being admitted to hospitals while relatively few seek assistance from geriatric services, largely because they are unaware that the services even exist.⁵

An absence of integration, coordination, and communication has put strains on system capacity. The problem, if ignored, will only worsen, as the seniors population in the HNHB LHIN is predicted to grow by over 76,000 people by 2018⁶.

⁴ Retreat Comments, June 21, 2006

⁵ Ibid

⁶ Population Projections from 2005 to 2018, HCM Group Inc. Special Project.

Part C: Health Improvement Solution

1. Describe the health improvement solution.

The Geriatric Access & Integration Network (GAIN) will unite health service providers across the HNHB LHIN under a common vision, mission, guiding principles and strategic goals. Significant momentum currently exists for this initiative with over 40 representatives from a cross-sectoral group of service providers participating in a retreat to brainstorm the common vision for GAIN. The solution is multi-faceted and the current planning horizon extends through to March 31, 2010. There are three areas of focus for the GAIN:

- Development and evolution of the GAIN itself – A plan to further develop the network to ensure a solid foundation for the evolution to a strong governance structure that can support transformation of the service delivery system. This approach is needed to address the population based performance indicators for which the GAIN should be collectively responsible.
- Development and implementation of a patient-centred service delivery system that is based on best practices and effectively applied to the demands of the HNHB LHIN. This will require a concerted effort to create the foundation service delivery model which in turn will require the detailed design of the various component parts. Again this planning, design and implementation will be rolled out over a three year period to ensure the demonstration of outcomes within that time horizon.
- Communication strategies will be critical to success. Sharing information and education on the GAIN will be vital to achieving the goals outlined below.

The participants of the retreat mapped out a series of ambitious, but achievable goals. These goals clearly describe the health improvement solution proposed by the network, and set out the roadmap for the next three years, including:

Area of Focus	Six Months	Eighteen Months	Three Years
The Network – GAIN	<ul style="list-style-type: none"> ▪ Develop the working structure for the GAIN 	<ul style="list-style-type: none"> ▪ GAIN is a fully functioning planning and advisory group 	<ul style="list-style-type: none"> ▪ GAIN has evolved into the functioning governance structure for integrated service delivery

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<p>The Patient/ The Community of Support/ The HNHB LHIN</p>	<ul style="list-style-type: none"> ▪ Create the integrated service delivery model for elderly persons with complex needs which align with the Vision, Mission and Goals of the GAIN ▪ Complete the Preliminary Service and Provider Inventory for HNHB LHIN 	<ul style="list-style-type: none"> ▪ Utilizing Detailed Design Teams complete the detailed planning including: community engagement, design and implementation planning for all aspects of the integrated service delivery model ▪ Implementation of Quick Wins, including but not limited to: <ul style="list-style-type: none"> ○ Common transfer protocol and documentation ○ LTC resource centre ○ Strategies for working with Family Health Teams ○ Physician capacity ○ GEM - nurse in every Emergency Department 24/7 	<ul style="list-style-type: none"> ▪ Execution of all implementation plans according to the approach determined by the Detailed Design Team and approved by the joint governance structure of the GAIN 	
<p>Communica- tion Strategy</p>	<ul style="list-style-type: none"> ▪ Building Awareness 	<ul style="list-style-type: none"> ▪ Reporting Progress 	<ul style="list-style-type: none"> ▪ Reporting Results 	

2. How will it make a difference? To whom or what? (e.g., people, providers, system capacity, etc.)

An integrated service delivery model for seniors, led by the GAIN and the HNHB LHIN, will first and foremost make a significant difference in the quality of life for the frail seniors who require health care services. It will also ease the burden of their community

of support, who are often ill equipped, but challenged to provide care when the system fails. With a coordinated prevention and promotion strategy, these frail seniors will be healthier, and when necessary, will be aware of suitable services that are available to them and have the appropriate knowledge to access them.

Health providers will benefit from GAIN through the integrated service delivery model that will be developed, which will enable individual providers to be part of an overall system that is efficient and complementary, rather than redundant and disjointed. Providers will also benefit from the network of professionals that will meet within the network, to share experiences and best practices. Through stewardship, the health providers participating in the network will assume accountability for desired health outcomes and population health indicators for the target group.

System capacity will increase with the development of a delivery model that efficiently allocates resources in an intelligent and logical manner. The execution of the prevention and promotion strategy should begin to reduce service needs, as seniors and their community of support become even more informed of options to improve their health and reduce their risk of illness or injury.

3. Why is this the right solution? (e.g., best practice?)

The Ministry of Health and Long Term Care's (MOHLTC) mandate for Local Health Integration Networks is premised on engaging local health providers and the public in meaningful conversation through community engagement. The focus is on the local needs by working with providers to increase coordination across the system to ensure that consumers move easily through the system, understand service offerings, and have equitable access to those services. These are foundations that will achieve positive results and will be used to create a truly integrated health 'system' for frail seniors. GAIN shares this philosophy, and has already created great momentum, generating strong participation across local health professionals, who understand the needs of the frail seniors within the HNHB LHIN and have collectively committed to achieving best practices for the delivery of services to this 'at risk' group. The GAIN solution will address services for frail seniors across the entire continuum of care, creating a seamless, integrated system that will be easy to access and navigate. In order to facilitate access and navigation, the solution will be developed upon best practices in case management/service coordination for frail seniors. The solution will also include the redistribution of resources based on best practice and population health needs. Finally, GAIN will place a renewed emphasis on prevention and promotion, which will lead to a more informed population that will yield positive effects on system capacity over time.

The chosen process (which was already been initiated) to achieve this solution is proven and embraces LHIN and MOHLTC principles for Ontario's transformed health care system.

4. Describe the readiness for this solution.

a. Why now?

With the creation of LHINs, Ontario is leading a health care transformation that is focused on creating an integrated system that ensures equity of access, high quality of service delivery, seamless movement through the system and is sustainable for the future. To build on this momentum of change, GAIN has developed a plan to create a system for some of the most vulnerable people within the HNHB LHIN and the heaviest users of health services. This high 'at risk' group should be one of the highest priorities for system redesign and improvement efforts going forward. The initial work of the HNHB LHIN has supported shifting the culture of health providers to one of more cooperation, collaboration, and honest open dialogue. This momentum must be leveraged now, as this window for fundamental change will not last long, and thus the GAIN is prepared to seize the moment.

David Jewell, St. Peter's Family of Services and Pat Morden, Shalom Village, are engaged as the co-chairs of the GAIN initiative and are willing to continue within this capacity to lead the change mandate outlined within this document. To date the co-chairs have raised over \$20,000 (See Appendix B for a list of supporters for this segment of the journey) to re-launch this vital initiative and secure the necessary external support to facilitate the retreat and the completion of this deliverable to the HNHB LHIN. The collective will is there to work together, but support will be needed for GAIN to be successful in achieving its mandate for change.

b. What resources can be leveraged to implement the solution?

The most critical resource that will be leveraged is the HNHB LHIN service providers who focus on the frail senior population. It is this set of service providers that understand the issues facing this vulnerable group, and they have the collective knowledge to help guide the development of a system that can optimize the quality of life for frail seniors.

There are numerous service providers for frail seniors within the HNHB LHIN that will be identified during an initial environmental scan and inventory of services and these will be utilized in the development of the delivery model through the application of best practices appropriate to the needs of the HNHB LHIN.

Various service providers have already expended financial resources to retain an external advisory partner, who have excellent experience with LHINs, and more importantly, with the design of geriatric service delivery models. This commitment, both financial and through participation, by over 40 individuals from HNHB LHIN service providers clearly indicates a movement for change.

Part D: Evaluating the Health Improvement Solution

1. How will we know the solution is making a difference?

a. Identify the key measures of success.

As the GAIN solution evolves, success will be measured on the progress of developing frameworks, governance structures, processes, and partnerships. After the integrated service delivery model for frail seniors has been executed, possible outcome measures could include:

- Access to services;
- Patient/community of support satisfaction;
- Health outcomes;
- Proportion of frail seniors who are able to stay at home vs. long-term care homes;
- Functional status;
- Reduction in ALC days;
- Emergency room visits; and
- Unplanned hospitalization rates.

Part E: Describe the Process

1. Describe the Process Used to Develop this Health Improvement Solution.

a. Who was involved? How were they involved? What was the scope of involvement?

The Current State of the GAIN Solution

GAIN began as a result of the outcomes from the October 2004 Workshop led by the MOHLTC Health Results Team. From the Workshop, integration priorities were selected and the written report was delivered February, 2005. Five Clinical and five Administrative Priorities were selected and GAIN was identified as the top priority. As a result of work completed to date, cross-sectoral support exists from front line clinical staff, managers and executives who represent many of the key influence leaders

along the continuum of care.

In June 2006, an external advisory partner was engaged to assist GAIN to develop the health improvement solution. The support team facilitated a GAIN retreat at which over 40 representatives (See Appendix A for a full list of attendees) of the HNHB LHIN service providers worked collaboratively to create the vision, mission, decision-making guiding principles, and goals for the network. In this retreat, participants were divided into smaller working groups in order to have meaningful and detailed discussions on issues facing frail seniors and how a system could be developed to solve these problems.

The results from this retreat created the foundation and momentum for GAIN going forward:

Target Consumer

The network will target frail seniors who have conditions that affect their independence and place them at risk of needing a higher level of care than is currently required.⁷

Vision

Optimizing the quality of life for frail seniors.

Mission

To provide quality care to frail seniors, including promotion and prevention, through an interconnected network of health care services.

Guiding Principles for Decision-Making

1. The frail senior and their community of support are at the centre of all we do. We deliver service by being sensitive to the whole person and their distinctive needs (physical, mental, emotional, spiritual, and cultural).
2. The model and services must ensure ease of access to necessary information regarding services and options available to inform responsible choice for individuals and their community of support.
3. The focus of the services and how they are delivered is on optimizing quality of life.
4. Collectively we are stewards who take responsibility and share accountability for the desired outcomes of service delivery to frail seniors.
5. The network of services must ensure easy entry and uncomplicated movement through the system with smooth transitions between providers.

⁷ Source: Inform Alberta

6. The design, development, and execution of the model should be based on evidence-informed best practices to ensure the achievement of desired outcomes.
7. To ensure sustainability, the design, development, and execution of the model should efficiently and effectively use available resources, including volunteers and the frail senior's community of support.
8. Regardless of geographic location, all frail seniors should have equitable and timely access to needed services and care.

The Road Ahead for the GAIN Solution

With the vision, mission, guiding principles, and goals (6 month, 18 months, and 3 years) now established for GAIN, the network will continue to leverage the strong participation of HNHB LHIN health providers. The process for continuing to plan and implement the health solution will begin with continued engagement of an external advisory support team to drive the creation of the integrated service delivery plan for frail seniors.

The process will consist of four major steps:

1. Conduct an environmental scan of the current system, including an inventory of services for frail seniors in the HNHB LHIN, and review any documentation pertaining to the current system in the LHIN. The environmental scan will include specific characteristics of the frail seniors demographic as well as an analysis of the population health factors.
2. Scan other jurisdiction's systems for integrated service delivery models focused on frail seniors.
3. In consultation with GAIN membership, and adherence to the decision-making guiding principles, create and assess alternatives for the HNHB service delivery model, and select appropriate plan.
4. Develop a detailed project plan that outlines the detailed design approach and an understanding of how to transition from the current system to the new GAIN/HNHB LHIN frail seniors service delivery model including communications and marketing strategies and timelines for execution. The plan will detail:
 - Points of access and system navigation;
 - The basket of services to be offered;
 - Methods for assessing the appropriate level of care for a patient;
 - Provider interaction within the model and across the frail seniors care continuum, including communication and information sharing;
 - Information needs and minimum connectivity requirements, including linkages to the HNHB LHIN e-health strategy;
 - Travel challenges facing the population;
 - Accountability framework to ensure ownership of responsibilities, sustainability, and mitigating risk; and
 - Performance measurement of the network, and most importantly of the health outcomes for the population of frail seniors

in the HNHB LHIN.

Appendix A – List of Attendees for the Retreat June 21, 2006

Last Name	First Name	Title	Agency
Alderson	Jodie		St. Joseph's Centre for Ambulatory Care
Ali	Mohamed	Dr.	Niagara Health (Welland)
Anderson	Christine	Director Seniors Health	HHSC
Bach	Linda		St. Joseph's Centre for Ambulatory Care
Baird	Vickie	Senior VP Planning & Corp Services	St. Peter's
Bliss	Michele		Niagara
Bryson	Deb	Psychogeriatric Consultant	Alzheimer Society
Buck	Susan	DOC	Park Lane Terrace
Castonguay	Marcel	Executive Director	CSC Hamilton
Edwards	Lynne		SAM Program
Emo	Marion	Senior	LHIN 4

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Last Name	First Name	Title	Agency
		Director Service Integration	
Fell	Ingrid		CCAC
Ford	Patricia		St. Joseph's Hospital
Gadsby	Shawn	Dir of Nursing	St. Joseph's Villa
Gray	Bonnie	Case Manager	CCAC
Hall	Brad	Director Clinical Operation	Con Med Health Care Group
Hesch	Paul	Clinical Mgr Critical Care & Outpt Rehab	West Lincoln Memorial Hospital
Hughes	Karen	Case Manager	St. Joseph's Health Care
Humphrey	Janis	Prog Dir	St. Peter's
Janjic	Mike	Administrator	Clarion LTC Home
Jennings	Jane	NP	St. Joseph's Healthcare Hamilton
Jewell	David		
Joshi	A	Associate	McMaster University

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Last Name	First Name	Title	Agency
		Professor	
Julian	Kit		
Lawson	Lori		St. Joseph's Hospital
Marshall	Dale		VON
McPherson	Wendy		Niagara Health
Merzanis	Angela	Executive Director	Millenium Manor
Morden	Pat		Shalom Village
Mulzer	Gail		Community Rehab
Nelson	Marg	Dir of Rehab	JBMH
North	Janis		VON
Okimi	Rosemary		Heritage Green Nursing Home
Parsley	Sherry		Hamilton CCAC
Potts	Yelena		St. Joseph's
Refrano	Jane		
Reis	Cathy	Clinician	HHS
Rickard	Kathy	Manager, Supportive Housing	Edeweiss

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Last Name	First Name	Title	Agency
Riddle	Julie	Social Worker	Brant Community Healthcare system
Safranyos	Richard	Dr.	Niagara Health (Welland)
Sage	Lynn		St. Peter's
Saville	Debora		
Smith	Ronelda	Manager Client Services	Haldimand CCAC Simcoe
Soluk	Rita	Director Resident Care	Leisureworld
Stanger	Willemien	Client Services Manager	Halton CCAC
Stewart	Shirley	Consultant	LHIN
Tettman	Maureen	Director	St. Joseph's Villa
Tocher	Shelley		St. Joseph's Ambulatory Health Services
Tremblay	Andrea	Executive Director	Foyer Richelieu LTC Facility
Triemstra	Carolyn		
Tribble	Karen		
Walker	Wendy	Executive Director	Community Support Services of Niagara

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Last Name	First Name	Title	Agency
Welychka	Patty		Niagara Health
Wightman	Connie	Coord of Resident Care	Community Services Homes Regional Niagara
Wozney	Carrie	Discharge Planning	BCHS
Zomer	Joan	Administrator	Grace Villa

Appendix B – List of Contributors to Fund the Retreat and the Completion of this Document

- **Millennium Trail Manor**
- **Halton CCAC**
- **Brant CCAC**
- **CCAC Niagara**
- **Hamilton CCAC**
- **Haldimand-Norfolk CCAC**
- **West Lincoln Memorial Hospital**
- **St. Peter's Family of Services**
- **RGP Central**
- **Shalom Village**