NAME OF GROUP/FHT *From dropdown list, select the name of the participating group or FHT, as registered with the Ministry or select 'solo fee-for-service' if not part of a group practice. If a group is not found in this list, add it to Other (column H).*	PHYSICIAN NAME *(Last name, First name) If all physicians in group (column A) are included in the application, note as N/A*	PRACTICE MODEL *Select model type from dropdown list . If 'other' is selected, please specify model type in Other (column H).*	NUMBER OF PHYSICIANS *For participating physician groups, please indicate the number of physicians who are part of the group.*	NUMBER OF PHYSICIAN FTEs *For participating physician groups, please indicate the number of physician FTEs.*	PRACTICE SIZE *For participating physicians, please indicate current practice size (i.e., active patient base); participating physician groups should indicate the practice size for the entire group.*	OTHER *If the listed physician or physician group works in a practice model that is not listed, please indicate the model type here. Note here if a FHT is a member but not its associated physician practice(s) and vice versa.*
PEM - HIGHLANDS FHO	N/A	FHO - Family health organization	25	24.0	32,464	
PEM - ORANGEVILLE FAMILY MEDICAL CENTRE FHO	N/A	FHO - Family health organization	10	10.0	15,500	
FHT - DUFFERIN AREA FAMILY HEALTH TEAM	N/A	FHT - Family Health Team				
PEM - BOLTON FHO	Gagnon, Michael	FHO - Family health organization	11	1.0	1,250	
PEM - BOLTON FHO	Kacer, Milan	FHO - Family health organization	11	1.0	1,200	
PEM - BOLTON FHO	Meghory, Yehiel	FHO - Family health organization	11	2.0	3,750	
PEM - BOLTON FHO	Quint, Saul	FHO - Family health organization	11	1.0	1,100	
PEM - BOLTON FHG	Popa, Brindusa	FHG - Family health group	2	1.0	2,800	
PEM - BOLTON FHG	Tita, Ioana	FHG - Family health group	2	1.0	2,400	
OTHER, PLEASE SPECIFY	Cino, Peter	Other	1	1.0		hospital based Chief of Staff at HHCC
OTHER, PLEASE SPECIFY	Dhillon, Rupinder	Other	1	1.0	200	hospital based Nephrologist/ Chief of Int Med.
OTHER, PLEASE SPECIFY	Hafazalla, Basem	Other	1	1.0		hospital-based Chief of Obstetrics
OTHER, PLEASE SPECIFY	Kim, Ashley	Other	1	1.0		hospital-based - Plastic Surgeon
OTHER, PLEASE SPECIFY	Lane-Smith, Mark	Other	1	1.0		hospital-based - Specialist Clinic, Surgeon
OTHER, PLEASE SPECIFY	McKinnon, Jeff	Other	1	1.0		Pres of Med. Staff Hosp. based Internal Med./Gastro
OTHER, PLEASE SPECIFY	Moodley, Preveshen	Other	1	1.0		hospital-based - Urologist
OTHER, PLEASE SPECIFY	Murphy, Mark	Other	1	1.0	1,000	hospital-based
OTHER, PLEASE SPECIFY	Riddell, Douglas	Other	1	1.0	60,000	Solo - Otolaryngology
OTHER, PLEASE SPECIFY	Scotton, Paul	Other	1.0	1.0		Hospital based. Chief of Emergency
OTHER, PLEASE SPECIFY	Seto, Ray	Other	1	1.0	30,000	Solo - Ophthalmology
OTHER, PLEASE SPECIFY	Singwi, Sanjeev	Other	1	1.0		Hospital based anesthesiologist . Chief of anesthesia
OTHER, PLEASE SPECIFY	Umeh, Jude	Other	1	1.0		Ob./Gyn
OTHER, PLEASE SPECIFY	Vasudeva, Prathibha	Other	1	1.0		Ob./Gyn
OTHER, PLEASE SPECIFY	Wang, Grace	Other	1	1.0	1,800	hospital-based - General Surgeon
FFS - SOLO FEE-FOR-SERVICE	Dhir, Karan	FFS - Solo fee-for-service	1	0.5	750	

NAME OF ORGANIZATION *Provide the legal name of the member organization*	TYPE OF ORGANIZATION *Select type from dropdown list, if 'other' please specify type in column C*	OTHER ORGANIZATION TYPE	LHIN/MINISTRY FUNDING RELATIONSHIP(S) *Indicate all existing contracts or accountability agreements between the organization and LHINs, MOH, or other ministry.* *(e.g., MSAA with ESC LHIN, contract with MCYS, etc.)*	PRIMARY CONTACT *NAME* *(Last name, First name)*	PRIMARY CONTACT *TITLE* *(e.g., Director)*	PRIMARY CONTACT *Business / Practice Address*	PRIMARY CONTACT *City / Community (e.g., Toronto)*	PRIMARY CONTACT *Postal Code*	PRIMARY CONTACT *EMAIL* *(e.g., name@email.com)*	PRIMARY CONTACT *PHONE* *(e.g., 416-123-4567)*
1-to-1 Rehab	COMMUNITY SUPPORT SERVICES		Contracted Service Provider - Central West LHIN	Hayes, Stephanie	Chief Executive Officer				shayes@1to1rehab.ca	
Alzheimer Society Dufferin	HOME CARE SERVICE PROVIDER ORGANIZATION		MSAA - Central West LHIN	Vanderhorst, Heidi	Board Chair	1-25 Centennial Road	Orangeville	L9W 1R1	h.vanderhorst@DAFHT.ca	519.941.1221
Bayshore Home Care Solutions	HOME CARE SERVICE PROVIDER ORGANIZATION		Contracted Service Provider - Central West LHIN	Cottrelle, Stuart					scottrelle@bayshore.ca	
Bethell Hospice	OTHER, PLEASE SPECIFY	Residential Hospice	MSAA - Central West LHIN	Paan, Margaret	Executive Director	15835 McLaughlin Roa	Inglewood	L7C 1H4	mpaan@bethellhospice.org	905.838.3534 x 2244
Calea	PHARMACY		Contracted Service Provider - Central West LHIN	Esterhammer, Martin					mesterhammer@calea.ca	
Caledon Community Services	COMMUNITY SUPPORT SERVICES		MSAA - Central West LHIN	Armstrong, Ian	Board Chair	Royal Courtyards, Upper Level, 18 King Street West	Bolton	L7E 1E8	gaguiar@ccs4u.org	905.951.2300 x 266
Caledon Meals On Wheels	COMMUNITY SUPPORT SERVICES		MSAA - Central West LHIN	Sevigny, Christine	Executive Director	1-10 McEwan Drive West	Bolton	L7E 1H1	christine.sevigny@cmow.org	905.857.7651
Canadian Mental Health Association Peel Dufferin	MENTAL HEALTH AND ADDICTION ORGANIZATIONS		MSAA - Central West LHIN	Fradley-Davis, Patrick	Board Vice-Chair	601-7700 Hurontario S	Brampton	L6Y 4M3	fradleydavisp@cmhapeel.ca	905.451.1718
Canadian Mental Health Association Peel Dufferin - CFAC	OTHER, PLEASE SPECIFY	Client & Family Advocacy Group	MSAA - Central West LHIN	Bratkovic, Nancy Landadio, Teresa Malankon, Chenthoori Sajiha Sampson, Julie	Client and Family Advisory Council Members	601-7700 Hurontario S	Brampton	L6Y 4M3	bratkovicn@cmhapeel.ca teresa.landadio@rogers.com chenthoori@gmail.com sampson@wightman.ca	905.451.1718
CANES	COMMUNITY SUPPORT SERVICES		MSAA - Central West LHIN	Gunning, Gord	Chief Executive Officer	200-10 Carlson Court	Toronto	M9W 6L2	gord.gunning@canes.on.ca	416.743.3326 x 229
CarePartners	COMMUNITY SUPPORT SERVICES		Contracted Service Provider - Central West LHIN	Knight, Linda					linda.knight@carepartners.ca	
CBI	COMMUNITY SUPPORT SERVICES		Contracted Service Provider - Central West LHIN	Rilling, Bernie	VP Finance	3300 Bloor Street West West Tower, Suite 900	Toronto	M8X 2X2	brilling@cbi.ca	416-231-0075 x 33100
Central West LHIN	HOME CARE SERVICE PROVIDER ORGANIZATION		MLAA - Ministry of Health	McLeod, Scott	Chief Executive Officer	199 County Court Boul	Brampton	L6W 4P3	scott.mcleod@lhins.on.ca	905-796-0040 x 2251
Circle of Care	COMMUNITY SUPPORT SERVICES		Contracted Service Provider - Central West LHIN	Lucki, Carey	Chief Executive Officer	4211 Yonge Street, Sui	Toronto	M2P 2A9	clucki@circleofcare.com	416.635.2860
Closing the Gap	COMMUNITY SUPPORT SERVICES		Contracted Service Provider - Central West LHIN	McDonald, Leighton	President & CEO	2810 Matheson Blvd E	Mississauga	L4W 4X7	leighton.mcdonald@closingthegap.ca	
Dufferin Area Family Health Team	OTHER, PLEASE SPECIFY	Family Health Team	MOH	Akula, Priya	Board Chair	One Elizabeth Street, Suite L1	Orangeville	L9W7N7	drhariakula@gmail.com	519.938.8802
Dufferin Area Family Health Team - PAC	OTHER, PLEASE SPECIFY	Patient & Family Advocacy Group	MOH	Borden, Bob	Community Board Mer	One Elizabeth Street, Suite L1	Orangeville	L9W7N7	b.borden@bell.net	519.938.8802
Dufferin Child and Family Services	OTHER, PLEASE SPECIFY	Child protections services, mental health and addictions, family services	MCSS, MCYS	Martin, David	Board Treasurer	655 Riddell Road	Orangeville	L9W 4Z5	dave.martin@mississauga.ca	519.941.1530
Dufferin County	MUNICIPALITY		MSAA - Central West LHIN	Pritchard, Sonya	Chief Administration O	55 Zina St	Orangeville	L9W 1E5	spritchard@dufferincounty.ca	519-941-2816
Dufferin County Paramedic Service	COMMUNITY SUPPORT SERVICES	Emergency Medical Services, Community Paramedic Program	MSAA - Central West LHIN	Reid, Tom	Chief	325 Blind Line	Orangeville	L9W 4W9	treid@dufferincounty.ca	519.941.9608 x 1
Extendicare	LONG-TERM CARE HOMES		LSAA - Central West LHIN	Guerriere, Michael	President & CEO	200 Robert	Shelburne	L0N 1S1	mguerriere@extendicare.com	519.925.3746
Family Transition Place	COMMUNITY SUPPORT SERVICES		MSAA - Central West LHIN	Hambleton, Nicole	President	20 Bredin Pkwy	Orangeville	L9W 4Z9	Nicole.dietitian@gmail.com	416-884-8696
Headwaters Health Care Centre	HOSPITALS		HSAA - Central West LHIN	Daub, Stacey	President & CEO	100 Rolling Hills Drive	Orangeville	L9W 4X9	sdaub@headwatershealth.ca	519.941.2702 x 2200
Headwaters Health Care Centre	HOSPITALS	Board	HSAA - Central West LHIN	Ker, Lori	Board Chair	100 Rolling Hills Drive	Orangeville	L9W 4X9	lori.ker@gmail.com	519.941.2410 x 2201
Headwaters Health Care Centre - Patient and Family Partnership	OTHER, PLEASE SPECIFY	Patient & Family Advocacy Group	HSAA - Central West LHIN	Nicolucci, Jennifer		100 Rolling Hills Drive	Orangeville	L9W 4X9	jinx00@gmail.com	519.941.2702 x 2200
Hospice Dufferin	OTHER, PLEASE SPECIFY	Community Hospice	MSAA - Central West LHIN	Riedler, Maureen	Executive Director	30 Centre St	Orangeville	L9W 2X1	mriedler@hospicedufferin.com	519.942.3313 x 1
March of Dimes	COMMUNITY SUPPORT SERVICES	Special Needs Services for Children	Contracted Service Provider - Central West LHIN	Daley, Marilyn					mdaley@marchofdimes.ca	
Region of Peel	MUNICIPALITY	Public Health Services	MSAA - Central West LHIN	Iannicca, Nando	Regional Chair	10 Peel Centre Drive	Brampton	L6T 4B9	nando.iannicca@peelregion.ca	905.791.7800 x 4310
RNS Health Services	COMMUNITY SUPPORT SERVICES		Contracted Service Provider - Central West LHIN	Campbell, Shannon		1111 Davis Drive, Unit	Newmarket	L3Y 9E5	scampbell@rnshc.com	
SEHC	COMMUNITY SUPPORT SERVICES		Contracted Service Provider - Central West LHIN	Sharkey, Shirlee					shirleesharkey@sehc.com	
Services & Housing in the Province	OTHER, PLEASE SPECIFY	Housing, Mental Health & Addictions	MSAA - Central West LHIN	Williamson, John	Board Member	969 Derry Road East Unit 107	Mississauga	L5T 2J7	sharon.fernandes@shipshey.ca	905.795.8742
Spectrum Healthcare	COMMUNITY SUPPORT SERVICES		Contracted Service Provider - Central West LHIN	Lord, Lori					lori@spectrumhealthcare.com	
SRT Med Staff	COMMUNITY SUPPORT SERVICES		Contracted Service Provider - Central West LHIN	Acton, Carolyn					cacton@srtmedstaff.com	
VHA Home Healthcare	COMMUNITY SUPPORT SERVICES		Contracted Service Provider - Central West LHIN	Annett, Carol	Chief Executive Officer	1515 Britannia Rd E	Mississauga	L4W 3C6	cannett@vha.ca	416-482-4609
VON	COMMUNITY SUPPORT SERVICES		Contracted Service Provider - Central West LHIN	Goodwin, Sharon	Senior Vice President, Home & Community Care				sharon.goodwin@von.ca	
Wellington Dufferin Guelph Public Health	MUNICIPALITY	Public Health Services	MSAA - Waterloo Wellington LHIN	Mercer, Nicola	Medical Officer of Hea	180 Broadway	Orangeville		sylvia.muir@wdgpublichealth.ca	
Wellington Dufferin Guelph Public Health	MUNICIPALITY	Public Health Services	MSAA - Waterloo Wellington LHIN	Bridge, George	Board	180 Broadway	Orangeville		sylvia.muir@wdgpublichealth.ca	

TEAM MEMBER *(Last name, First name)*	**OTHER AFFILIATED TEAM(S)** *List the other teams that the member has signed on to or agreed to work with.*	**FORM OF AFFILIATION** *Select from dropdown list to indicate whether the member is a signatory member of the other team(s).*	**REASON FOR AFFILIATION** *Provide a rationale for why the member chose to affiliate themself with multiple teams (e.g., member provides services in multiple regions).*
CMHA Peel-Dufferin	Brampton -Bramalea-Etobicoke OHT and Trillium OHT	SIGNATORY	Multi-region nature of care delivery
Services and Housing in the Province (SHIP)	Brampton -Bramalea-Etobicoke OHT and Trillium OHT	SIGNATORY	Multi-region nature of care delivery
Region of Peel	Brampton -Bramalea-Etobicoke OHT and Trillium OHT	SIGNATORY	Multi-region nature of care delivery
Wellington Dufferin Guelph Public Health	Guelph OHT	OTHER	Multi-region nature of care delivery
CANES Community Services	Brampton -Bramalea-Etobicoke OHT and Trillium OHT	SIGNATORY	Multi-region nature of care delivery

NAME OF GROUP *From the dropdown list, select the name of the participating physician group, as registered with the Ministry or select 'solo fee-for-service' if not part of a group practice. If a group is not found in this list, add it to Other (column F).*	**PHYSICIAN NAME** *(Last name, First name)* *If all physicians in group (column A) are included in the application, leave this column blank.*	**PRACTICE MODEL** *Select model type from dropdown list . If 'other' is selected, please specify model type in Other (column F).*
FFS - SOLO FEE-FOR-SERVICE	Any physicians that have not endorsed as members will be welcome and patriated into the OHT	

NAME OF GROUP *From the dropdown list, select the name of the participating physician group, as registered with the Ministry or select 'solo fee-for-service' if not part of a group practice. If a group is not found in this list, add it to Other (column F).*	**NUMBER OF PHYSICIANS** *For participating physician groups, please indicate the number of physicians who are part of the group. (e.g., 850)*	**COLLABORATION OBJECTIVES (E.G., EVENTUAL PARTNERSHIP AS PART OF TEAM) AND STATUS OF COLLABORATION (E.G., IN DISCUSSION)**	**OTHER** *If the physician group is not listed or works in a practice model that is not listed, please indicate here.*
FFS - SOLO FEE-FOR-SERVICE			

NAME OF NON-MEMBER ORGANIZATION *Provide the legal name of the collaborating organization.*	**TYPE OF ORGANIZATION** *Select type from dropdown list, if 'other' please specify type in column C*	**OTHER ORGANIZATION TYPE**	**COLLABORATION OBJECTIVES (E.G., EVENTUAL PARTNERSHIP AS PART OF TEAM) AND STATUS OF COLLABORATION (E.G., IN DISCUSSION)**
The Hills of Headwaters Collaborative OHT will remain open to other partners as the development and maturity evolves			

SERVICE	PROPOSED FOR YEAR 1 *Select Yes/No from dropdown list*	CAPACITY IN YEAR 1 *How many patients can your team currently serve?*	PREDICTED DEMAND IN YEAR 1 *Of year 1 population, how many patients are predicted to need this service?*	DESCRIPTION *Indicate which team member(s) will provide the service. If a proposed service differs from your existing scope, explain how you will resource the new service. If there is a gap between capacity and demand, identify plans for closing the gap.*
Interprofessional team-based primary care (Mental Health & Addictions)	Yes	2,200	8,652	Large MH team of providers currently have implemented a patient directed intake stream Developing single session clinics in partnership with local MH agencies in more rural areas of Dufferin Caledon. Partnership DBT program with CMHA now underway to reach more patients with moderate-severe conditions. ***Capacity Note:** There were 2200 MH appts in Q1, so expect ~8800 in a year. 8800/4 (average each seen?) = ~2200 patients (1520 were seen in 2018/19); ***Predicted Demand Note:** Latest PCPR says 19.9% of population has Mental Illness. Report has roster at 43,479
Interprofessional team-based primary care (Palliative Care)	Yes	200		Palliative survey underway with physicians (affiliated and non), to determine interest in supporting palliative patients, learning needs, and capacity ***Capacity Note:** Physicians supporting up to ~100 patients at any given time; ***Predicted Demand Note:** Presently developing EMR standardized tracking so that we can track palliative referrals moving forward
Interprofessional team-based primary care (Patients with Complex Care Needs)	Yes	400	2,173	Currently- 2 social workers, but we are creating the role of a mental health case manager and planning to recruit with an unfilled mental health counselor position ***Capacity Note:** Per provider approximately 400 ~ 31 patients with complex care needs were seen in Q1 this year; ***Predicted Demand Note:** 2173 PCPR roster of 43,479 and Health Links is ~5% of the patient population. 43479*0.05 = 2173
Physician primary care				
Acute care – inpatient				
Acute care – ambulatory				
				Services for Palliative Care and Complex Needs **Please see Appendix A** ***Capacity Note:** Numbers are approximate
Home care (Central West Home and Community Care)	Yes	2,000	2,000	***Predicted Demand Note:** Numbers are approximate
Home care (Services and Housing in the Province)	Yes	15	15	**Service: Home care - Patients with Complex Care Needs** (MaPLe Score mid to high 3-5) Assisted Living operates in partnership with Dufferin County providing services that proactively support frail seniors who wish to continue living independently in their own homes

Community support services (Caledon Meals on Wheels)	Yes	700	650	Complex Care, Palliative, Mental Health Friendly Visiting Coordinator and Volunteers Meals Coordinator, Delivery Driver and Volunteers Congregate Dining Coordinator and Program Facilitators NEW - Project Lifesaver – tracking for clients at risk of wandering (not currently resourced) – fee for service, fundraising
Mental health and addictions (CMHA)	Yes	200	150	Current State: Integration of community mental health services with acute mental health services. • Rapid Access Addictions Medicine Clinics; NP Led and co located with Dufferin Area Family Health Team • Integrated DBT program with Dufferin Area Family Health Team and community mental health HSP • Crisis intervention in the ED to support transition to the community Recommended year 1 to focus on clients attached to Intensive Transitional Team (ITT); a collaborative and responsive team specializing in organizing and delivering intensive supports required to effectively integrate care from HHC to a community setting which supports patients complex medical care needs as well as appropriate intensive mental health supports. This Crisis Worker will also provide assessments in the hospital and integrate supports at discharge to community-based services to prevent unnecessary ED visits. The ITT will support all complex transitions across all age ranges. Primary care will be an integral part of the model where primary care will transition as the lead coordinator with an ease to re-establish the ITT if the at-risk patient requires the short-term intervention again. *Capacity Note: 200 was the proposed # for the Intensive Transitional Team program. *Predicted Demand Note: Does Health Links best practice suggest what % of the clients with complex care needs have mental health and or addictions issues? Or would this be something we can pull

Mental health and addictions (Dufferin Child And Family Services)	Yes	458	480	**Service: North Dufferin Counselling Walk-In Clinic** In partnership with three primary care physicians, as well as Family Transition Place (FTP) and Dufferin Child & Family Services (DCAFS); a walk-in mental health clinic is being offered weekly in the Shelburne. This is a newly established partnership, with the first clinic having occurred September 25. DCAFS has offered a weekly walk-in clinic for the past 11 years, however it has been based in Orangeville. Knowing there are transportation barriers in this community, offering the service in Shelburne will increase accessibility. Further, offering the service in partnership with FTP and primary care will allow for a more holistic response to a patient's presenting needs. ***Capacity Note:** 18/19 data # unique clients served through DCAFS Orangeville located child/youth mental health clinic: 458 15% resided in the Town of Shelburne (not including surrounding areas such as Amaranth and Melanchthon) ***Predicted Demand Note:** 480 - % of those seen through the new North Dufferin Walk In Clinic will be measured to obtain baseline data; project a 10% increase in Town of Shelburne residents
Mental health and addictions (Dufferin Child And Family Services)	Yes	35	50	**Service: Circle of Security** In partnership with Dufferin Area Family Health Team (DAFHT) we will be providing primary care with information regarding the evidence-based attachment focused parenting program, Circle of Security, along with a checklist to enable ease of identifying candidates and a goal of increasing groups offered. Outcomes of Circle of Security includes increased parental knowledge on attachment based parenting which helps reduce risks related to harm; developmental lags; and mental health issues of both parent and child. ***Capacity Note:** 18/19 data 35 clients served by DCAFS through Circle of Security Program. ***Predicted Demand Note:** 50 clients served in partnership between
Mental health and addictions (Dufferin Child And Family Services)	Yes	172		**Service: Community Crisis Assessments** In partnership with elementary education partners, we are working together to increase crisis assessments occurring in the community as opposed to having children and younger youth attend the emergency department of the hospital (barring immediate medical issues/safety issues being identified). The goals are to reduce ED visits, reduce wait time for assessments, increase immediate community service connections. ***Capacity Note:** 18/19 # unique clients served by DCAFS through crisis: 172 #crisis assessments resulting in Form 1: 51

Mental health and addictions (Services and Housing in the Province)	Yes	52	52	**Service: Patients with complex care needs** Caledon: Developed a partnership with Oliver House to provide mental health and addiction supports to individuals residing at Oliver House. The first year of service will include the recruitment of a Registered Practical Nurse (RPN) with concurrent disorder capabilities and a part time Recreation Therapist (RT) to expand SHIP's High Support team to include Oliver House residents. The support will include a focus on primary care, mental health and addictions. ***Predicted Demand Note:** (maximum capacity at Oliver House)
Mental health and addictions (Services and Housing in the Province)	Yes	190	190	**Service: Patients with complex care needs** MH&A Dufferin Services Team which includes dedicated resources to support Intensive Case Management, Supportive Housing, Early Intervention, In-Sted and MH Consultation
Mental health and addictions (Services and Housing in the Province)	Yes	100	100	Caledon: Farm setting that also offers social rehabilitation for individuals with MH&A issues
Mental health and addictions (Services and Housing in the Province)	Yes	192	161	Intake Clinic at Hub – Edelbrock Through a community team approach, staff at the Edelbrock Intake Clinic provide immediate assessments, mental health support services, linkages, and referrals to appropriate services. In partnership with other Dufferin services, there are immediate warm transfers to specialty services within the partnership. ***Capacity Note:** 128 YTD for 2019/20 ***Predicted Demand Note:** Projected services recipients = 192 (128 YTD for 19/20) of those 84% have been identified to have MH/complex care needs.
Long-term care homes (Dufferin Oaks)	Yes	160	215	Currently on staff we have 1 Medical Director, 3 attending physicians, 2 part time nurse practitioners, 1 part time social worker, 1 full time Behaviour Support RPN along with a care team of RNs, RPNs, PSWs, Dietitian, Physiotherapist and support staff. ***Capacity Note:** Current capacity for LTC residents is 160 residents. Within a year we typically serve 215 (Dufferin Oaks). Mental Health – currently serving 54 residents (34%) with mental health diagnosis other than dementia Palliative - This past quarter, 4% of our residents were coded as palliative. It should be noted that residents being admitted to LTC are frailer with increasingly complex diagnosis which impacts their length of stay in LTC. ***Predicted Demand Note:** Resident profile 80% have neurological diseases 14.4% have a diagnosis of congestive heart failure 62% have a diagnosis of dementia 48% have musculoskeletal diseases such as arthritis and osteoporosis
Other residential care				
Hospital-based rehabilitation and complex care				
Community-based rehabilitation				

Short-term transitional care				
Palliative care (including hospice) Bethell Hospice	Yes	935		Hospice Residence – a team of Nurses, PSW's, a Social Worker and a Medical Director provide care to the end of life residents and families. The Community Program includes a team of Social Workers and Psychosocial Spiritual Care Consultants. Both programs are further supported by a large team of approximately 180 Volunteers lead by a Volunteer Coordinator and Volunteer Lead. ***Capacity Note:** In 2018/19 Bethell Hospice had 141 End of Life Residents in our 10 bed Hospice Residential Facility. In addition, 466 clients received care through the Community Program and 328 clients received Psychosocial Spiritual Care services. ***Predicted Demand Note:** It is expected that 2019/20 the needs will increase based on community growth and capacity with additional
Palliative care (including hospice) Hospice Dufferin	Yes	987	1,900	Social worker 1.0 f.t.e. Recreation therapist .6 f.t.e. Volunteer coordinator .4 f.t.e. ***Capacity Note:** Community hospice programs Q2 Bereavement 61 clients/320 visits; Q2 Volunteer visiting program 110 clients/575 visits; Individual Caregiver support 24 clients/92 visits ***Predicted Demand Note:** Community Hospice Program Bereavement Prediction 90 clients/700 visits; Volunteer Visiting 145 clients/ 980 visits; Caregiver support 45 clients/220 visits
Emergency health services (including paramedic)	Yes	12,000	9,378	**All members of DCPS will be involved in delivering service to the residents of the Hills of Headwaters.** **There is currently a gap in what is the predicted demand and our capacity, as we need to ensure that we are meeting our legislated requirements (911). The CP program also has the capacity to handle more patients, but we need to ensure that we are providing the right care to the right patients, not just filling gaps.** ***Capacity Note:** 12,000 – DCPS has the capacity to respond to 12,000 calls before service delivery would be significantly impacted. In order to maintain adequate service delivery and acceptable response times ~ 8,000 would be ideal without enhancing service levels. Community Paramedic: 1,460 – home visits & 2,190 patient contacts (phone check ins) ***Predicted Demand Note:** 6,578 – 911 requests for Dufferin County
Laboratory and diagnostic services				
Midwifery services				
Health promotion and disease prevention				

Other social and community services (including municipal services)				Dufferin County Community Support Services: Existing service scope includes: community housing and homeless services; Ontario Works Financial Assistance and Employment Supports; and Child Care Subsidy and Early Learning. Municipal services are for all population. All services are linked and are co-located in community hubs, i.e. Orangeville and Shelburne. Capitalize on existing partnerships and collaborations.
Other health services - Integrated Care (Dufferin Child and Family Services)	Yes	528	554	**Service: Integrated Care for the Intellectual Impaired/Developmental Delayed Population** In partnership with CW LHIN Homecare; DCAFS will host office space for a Care Coordinator with the intention of collecting data on joint patients to identify commonality, increasing ease of system navigation/coordination and reducing duplication of service. ***Capacity Note:** 18/19 data # unique DS Children served by DCAFS: 376 # unique DS Adults served by DCAFS: 81 Complex Special Needs Children served by DCAFS: 71 Total: 528 ***Predicted Demand Note:** 554 - % of those joint with Homecare will be measured to obtain baseline partnership data
Other health services - Clients with Complex Care Needs (Services and Housing in the Province)	Yes	30	28	Housing First is open to all residents of Dufferin County who are experiencing chronic homelessness or have been episodically homeless. The program supports individuals through a variety of services. ***Predicted Demand Note:** (95% of the clients served have MH

APPROXIMATE SIZE OF YEAR 1 POPULATION (FROM QUESTION 1.2):	

RISK CATEGORY *Select risk category from dropdown list*	**RISK SUB-CATEGORY** *Select risk sub-category from dropdown list*	**DESCRIPTION OF RISK**	**RISK MITIGATION**
RESOURCES RISKS	HUMAN RESOURCES	Lack of PSW services	Will work to align service provider needs within the Hills of Headwaters to ensure market share and economies of scale in resource planning.
RESOURCES RISKS	HUMAN RESOURCES	Stability in Home and Community Care	Continued focus on integrating and aligning Home and Community Care with the Hills of Headwaters.
RESOURCES RISKS	HUMAN RESOURCES	Continued lack of managed entry	Commitment to work with the Ministry and physicians to find innovative solutions to provide primary care to all Hills of Headwaters population.
PARTNERSHIP RISKS	COMMUNITY SUPPORT	Inability for large partner organizations supporting multiple OHTs to continue to be involved in more than one OHT	Continue to focus on partnerships and practical solutions with the Ministry and Ontario Health.
COMPLIANCE RISKS	REGULATORY	Certain regulations and policies pertaining to Long-Term Care and delivery of palliative care cause restrictions for effective delivery of services by primary care and Home and Community Care	Continue to flag and look for policy opportunities.

ROLE/FUNCTION	**ORGANIZATIONS** *Which organizations/members of the team will carry out the proposed role/function*	**Delivery Model** *What type of provider (dedicated home care care coordinator, FHT allied health professional, contracted service provider nurse, etc.) would be providing the service and how (in-person in a hospital, virtually, in the home, etc.*
Managing intake	Home and Community Care staffing and infrastructure (under transitional Ontario Health as initial step) along with marrying other relevant intake functions that other partners have to round out 24/7 access	Clinical Risk Identification completed by of Home and Community Care and Service Provider Organizations/Health Service Providers/FHT Resources and in Collaboration with Primary Care and Specialist developed as Central Intake model. This will be done physically and virtually. Central Intake model will use CHRIS as the consistent registry for year one patient populations as well as all other Home Care patient referrals and it will include HPG tool to send referral package to home care delivery partner. Where needed interpretation services will be available to support diverse needs of the community in a culturally appropriate manner. Assessments will be streamlined to reduce duplication across providers.
Developing clinical treatment/care plans	Home and Community Care in collaboration with primary care, Service Provider Organization and Community Support Sector partners	Each patient/client has an established Coordinated Care Plan that they design based on their personal goals. The care plan will be shared digitally in Year 1 through the existing CHRIS mechanism of completing and sharing care plans with all members of the care team. Clinical intervention care pathways informed by primary care and inpatient/outpatient acute care services providers. A portion of existing Hospital-to-Home and Rapid Response Nursing roles from Home and Community Care will be realigned to focus on Year 1 key populations as part of intense transition team. Short Term Acute Intervention from service provider organizations will serve as the lead coordinator and no other care coordination resources are required (once established pathway and outcomes are agreed to). Telehomecare models will be used to support remote and mobile health monitoring.
Delivering services to patients	Home and Community Care, Service Providers, Community Support Services, Health Service Providers, Interprofessional Care Resources	Innovative models of care will be expanded such as e shift model of care in home care delivery. Increase use of OTN Guest Link virtual care delivery across Home and Community Care. Neighbourhood Networks of Care will be planned and implemented in stages over three years.. Congregate models of care such as Assisted Living, Supportive Housing and Independent Living models of care to be expanded as funding resources allow. Outcome based bundled care pathways to be built and tested within year one focus areas. Lead clinical coordinator roles to be tested in order to establish accountability and performance monitoring. Nursing clinics to be implemented across the Hills of Headwaters Collaborative OHT area.
Add functions where relevant		

MEMBER	HOSPITAL INFORMATION SYSTEM INSTANCES *Identify vendor, version, and presence of clustering*	ELECTRONIC MEDICAL RECORD *Identify vendor and version*	ACCESS TO OTHER CLINICAL INFORMATION SYSTEMS *E.g., Other provincial systems such as CHRIS, or other systems to digitally store patient information*	ACCESS TO PROVINCIAL CLINICAL VIEWERS *ClinicalConnect or ConnectingOntario*	DO YOU PROVIDE ONLINE APPOINTMENT BOOKING? *Yes/No*	USE OF VIRTUAL CARE *Indicate type of virtual care and rate of use by patients where known*	PATIENT ACCESS CHANNELS *Indicate whether you have a patience access channel and if it is accessible by your proposed Year 1 target population*
CMHA Peel Dufferin	N/A	CRMS (CTSI Inc.), Version 2	- CHRIS via HPG - Catalyst (to support clients accessing addictions clients); enables access to GAINS assessment - HealthIM (to support clients accessing crisis services and streamline appropriate admissions to Emergency Dept.)	ConnectingOntario IAR (Integrated Assessment Record)	No	Phone and SMS text messaging (direct client service and interactions with other service providers)	No
County of Dufferin	N/A	N/A	Homelessness Case Management Information stored on the Homelessness Individuals and Families Information System 'HIFIS' (Federal software) Housing Tenant Case Management Information – Yardi (Commercial product available in North America) Ontario Works Case Management for Financial Assistance and Employment Supports – Social Assistance Management System 'SAMS' (Provincial software)	N/A	Yes	N/A	Yes
Services and Housing In the Province	Not Applicable	CRMS, V2	Yes, HPG.	Connecting Ontario	No	PCVC and 10 times/year	No
Dufferin Area Family Health Team		Telus, PS Suite	No	No	Yes	PCVC, rarely used	No
Caledon Community Services	Not Applicable	Not Applicable	HPG	No	No	None	No
Headwaters Health Care Centre	Meditech Client Server, 5.67, not supported	Meditech Client Server, 5.67	yes: Connecting Ontario Oncology Provincial Information System (OPIS) HDIRS OLIS REACH (provider portal for clinicians access to patient info) Cancer Care Ontario (eCTAS; ALC; wait times; ORRS) Hospital Report Manager (HRM) BORN Ontario Drug Benefit ENITS (emergency neuro imaging transfer system) PTAC (Provincial transfer authorization center) Ontario Breast Screening Program (OBSP) ECHN (electronic Children's health network)	Connecting Ontario, REACH	No	virtual ICU consults/rounding 50/year; MyChart- 300-400/month; mypocket health-unknown rate of use; care chart at home (oncology afterhours call line) unknown rate	Yes
WDG Public Health		Excelicare, 6	We have access to the Integrated Decision Support (IDS) Business Intelligence tool hosted by Hamilton Health Sciences. It includes hospital data, home care data (CHRIS), community health centre data and family health team data.	Clinical Connect	Yes		Yes
Family Transition Place			All agency client information digitally stored in agency Caseworks database (vendor: Coyote Software Corporation) Addictions Program information also recorded in provincial Catalyst database - DATIS (Drug and Alcohol Treatment Information System Male Sexual Assault information also stored in KASPER database - Sexual Assault Crisis Centre of Essex County (Support Services for Male Survivors of Sexual Abuse Program)	IAR (Integrated Assessment Record)	No		No
Dufferin Child and Family Services			Coyote - Caseworks CPIN (Child Protection Information Network)		No		No
Hospice Dufferin	No	Infoanywhere	No	No	No		No
Dufferin County Paramedic Service		Interdev, current version	CHRIS, EMR (DAFHT) family health team, MEDITECH, Remote monitoring (Future health)	No	No	Remote monitoring	No
Central West Home & Community Care		Health Shared Services Ontario/Xerox/AcuteNet; Version: CHRIS/Docushare/InterRAI Suite	Connecting Ontario, Hospital Meditech (HW and WOHC)	No	No	OTN; e-Shift (new program being launched)	No