
Family Health Teams

Advancing Family Health Care

Introduction to Family Health Teams

June 2009

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Introduction

The **Application Kit** for Family Health Teams Wave 4 consists of four documents.

This is Document #1 of the Wave 4 Application Kit: *Introduction to Family Health Teams.*

This document provides an overview of Family Health Teams and the fundamental building blocks necessary to establish a Family Health Team.

Since April 2005, 150 Family Health Teams have been created in both urban and rural parts of the province, in three waves: 69 in April 2005 (Wave 1); 31 in December 2005 (Wave 2); and 50 in March 2006 (Wave 3). In Wave 4, the government will create an additional 20 Family Health Teams.

Who is Eligible to Apply for Wave 4 Family Health Teams?

The Ministry of Health and Long-Term Care (the ministry) undertook a needs assessment considering a range of key population and health indicators to determine which Local Health Integration Networks (LHINs) have the greatest need for additional resources. These LHINs are: *North West, North East, Erie St. Clair, North Simcoe Muskoka, Central West, Central East, Champlain, and South East.*

Key indicators for assessing need included:

- Proportion of unattached patients, excluding Health Care Connect program;
- Prevalence of one or more of nine chronic diseases, including diabetes;
- Number of full-time equivalent (FTE) general practitioners/family physicians in a LHIN per 10,000 population; and
- Number of existing Family Health Teams/Community Health Centres.

In addition, the ministry is extending an invitation for the establishment of Family Health Teams to existing Shared Care Pilots¹ and to applicants interested in expanding Family Medicine Training capacity in an interdisciplinary family health care setting within any LHIN.

Applicants interested in the expansion of Family Medicine Training capacity should note that the expansion is relative to the Family Medicine Training Units that are developed solely in conjunction with the University Departments of Family Medicine.

The Call for Applications for Wave 4 begins **Monday, June 22, 2009**, with the deadline for submission of all application by 5:00 p.m. **Thursday, July 30, 2009**. It is expected that successful applicants will be announced in *Fall 2009*.

¹ The Shared Care Pilot project was announced in 2006 to bring together physicians and interdisciplinary healthcare providers (IHP) to foster a shared care delivery model of comprehensive primary health care services with particular emphasis on chronic disease management, health promotion and disease prevention. There are six Shared Care Pilots in Ontario: Organisation de Sante Familiale Hawkesbury; Brampton East Medical Group FHG – Shared Care Pilot Site; Cochrane FHG – Shared Care Pilot Site; Downsview Family Health Group – Shared Care Pilot Site; London Doctors Relief Services FHG – Shared Care Pilot Site; and Plantagenet FHG – Shared Care Pilot Site.

A subsequent Call for Applications for Wave 5 will follow the awarding of Wave 4, with the date and details to be made available through the ministry's public website:

www.health.gov.on.ca/familyhealthteams

Family Health Care for All

The implementation of Family Health Teams is part of the government's Family Care for All Strategy, which will improve access to comprehensive family health care for all Ontarians.

Family Health Teams are providing care to over 1.9 million Ontarians, including more than 270,000 who previously did not have a family physician. The government continues to move forward on creating another 50 new Family Health Teams across Ontario.

Family Health Teams are locally driven family health care delivery organizations that include family physicians, nurse practitioners, nurses and a range of other interdisciplinary healthcare providers who are committed to working together collaboratively to provide comprehensive, accessible, coordinated family health care to a defined population, including patients who do not currently have a family health care provider (*e.g.* unattached patients).

Through Family Health Teams, patients are able to establish a continuous relationship with health care providers for comprehensive, family health care close to home. As a collaborative team practice, Family Health Teams emphasize health promotion and improved management of chronic disease through both treatment and monitoring, as well as support their patients in improving self-management skills. Keeping patients healthier and chronic disease better managed are key to reducing Emergency Room visits.

This vision allows physicians, nurse practitioners and other members of the team to practice together in a positive working environment, sharing and benefiting from the complementary knowledge and skills of their colleagues, with a focus on keeping patients healthy.

New Family Health Teams will support other ministry initiatives including: continuing to enrol unattached patients; improving chronic disease prevention and management with an initial focus on diabetes to support the Ontario Diabetes Strategy, the expansion of Family Medicine Training capacity, and integrated cancer screening. New teams should be prepared to participate in implementing the Ontario Diabetes Strategy; through approaches such as the development of diabetes programs and services that would be delivered through a registered nurse and dietician or health educator.

The Role of Family Health Teams

1. Provide increased access to family health care for patients without a family health care provider;
2. Provide comprehensive family health care services through an interdisciplinary team of family physicians, nurse practitioners, registered nurses and a range of other interdisciplinary healthcare providers, each working within their scopes of practice;
3. Provide system navigation and care coordination – linking patients to other parts of the health care system such as acute care, long-term care, public health, mental health, addictions, and community programs and services;
4. Emphasize health promotion, illness prevention, early detection/diagnosis;
5. Serve as a central catalyst for the development of new comprehensive community based chronic disease management and self-care programs;
6. Provide patient-centred care where the patient is a key member of the team and uses information and support to make informed decisions on how to manage his/her self-care needs;
7. Be linked with other health care organizations at the community level and, in general, be adapted to the needs of the specific community; and
8. Use information technology as the backbone of system integration, linking patient records across different health care settings giving providers timely access to test results and other important data.

Key Criteria for Assessing Readiness to Implement a Family Health Team

When establishing a Family Health Team, these are five key factors that serve as the foundational building blocks to support an enhanced state of readiness.

The more advance planning you are able to do towards addressing these key factors, the greater your state of readiness will be to enable an efficient, effective and accelerated path through implementation to being a fully operational Family Health Team.

You will need to consider the following factors and address them in the Application section. These factors will also inform the evaluation of applications in Wave 4:

1. **Governance:** All Family Health Teams must incorporate as non-profit corporations. The following three governance models are available:
 - i. Physician-Led – non-profit corporations governed by a Board of Directors with physician representation;
 - ii. Community-Led – community-based non-profit corporations governed by a Board of Directors including local community representation; or
 - iii. Mixed governance model – a mix of community and provider-based groups coming together through a non-profit corporation with a Board of Directors.
2. **Human Resources:** Family Health Teams are interdisciplinary teams of providers including family physicians and a range of other interdisciplinary healthcare providers each working collaboratively within their scopes of practice. The make-up of these teams will be tailored to the size of the population served and their health care needs. Team composition must include family physicians, and other interdisciplinary healthcare providers such as nurse practitioners, registered nurses and others who are committed to working together collaboratively to provide comprehensive, accessible, coordinated family health care service to a defined population, including patients who do not currently have a family health care provider (e.g. unattached patients).

Groups should also have a commitment from physicians who are presently in or willing to move to a Family Health Team-eligible physician compensation model², and to enrol unattached patients.

² Family Health Team eligible physician compensation models include: blended complement (Rural and Northern Physician Grant Agreement), blended capitation (Family Health Network or Family Health Organization), or blended salary model.

3. **Accommodations:** To promote collaboration, health care providers are expected to co-locate at one or more sites that include physicians, interdisciplinary healthcare providers and administrative staff at each site. Applicants who have identified space that can accommodate the proposed team, which requires little or no remodelling/renovations, will be ready to accommodate the proposed Family Health Team more quickly.
4. **Knowledge and Integration of Family Health Care Services in the Community:** Demonstrate knowledge of the number of unattached patient population in the catchment area of your proposed team, community population health (prevalence of chronic diseases); and of existing or planned integration/coordination of family health care services within the community (i.e. no duplication of services with hospitals, Community Health Centres, Nurse Practitioner-Led Clinics, Community Care Access Centres, Long-Term Care Homes, etc.).
5. **Information Technology:** An implemented Clinical Management System with Electronic Medical Records for patients is an asset.

Support for new Family Health Teams

Once awarded, the new Family Health Teams will have resources to help guide them through development and implementation. The materials being offered are based on the lessons learned and the experience garnered in getting the first 150 Family Health Teams up and running. These support tools are designed to help new Family Health Teams navigate the start-up phase more easily and more efficiently to reach operational status in a shorter period of time. Resources will include:

- Start-up manual: *Roadmap to Family Health Team Implementation*
- Development grant to hire a consultant to assist the Family Health Team through to the operational stage;
- Guides that will assist you in the development of your plans;
- A list of consultants with experience working with Family Health Teams and mentorship opportunities through the Quality Improvement and Innovation Partnership (QIIP), which assists Family Health Teams as they move to a new model of family health care. [for additional information about QIIP, please see <http://www.qiip.ca>]; and
- Team of trained implementation specialists at the Ministry of Health and Long-Term Care.

All guides can be found at: www.health.gov.on.ca/familyhealthteams