Schedule A
“One size does not fit all”

October 2017

Primary Health Care Branch

Ontario

Family Health Teams

- Family Health Teams (FHTs) were created throughout Ontario to improve and expand access to comprehensive family health care through an interdisciplinary team of health professionals.

- The Ministry and FHT program funding recipients share the goals of building and expanding a high-quality primary health care system that is: centered on the person, ensures patients receive timely access together with proactive, integrated, and coordinated community-based comprehensive care within the respective regions of recipients.

- As of March 2017, FHTs are serving over 3.4 million Ontarians in over 200 communities through teams that include more than 2,100 interdisciplinary health professionals such as Nurse Practitioners, Social Workers, Dietitians, Pharmacists and over 2,900 affiliated physicians.

Schedule A – Program and Service Reporting Tool

- Quarterly performance and financial reporting are a ministry-FHT agreement accountability requirement.

- FHT reporting on Programs and Services in Schedule A over the years has had noticeable improvements, due in no small part to all the work done by AFHTO in this area, with ministry support.

- In 2017-18 FHTs on their Schedule As reported they deliver on average approximately 10 Programs.

How does the ministry use Schedule A information?

- Schedule A reporting demonstrates value for money – the information details how FHTs are allocating ministry funded Interdisciplinary Health Provider FTEs to deliver on programs and services to FHT target populations.

- The ministry regularly accesses Schedule A information to:

  - Justify investments in the program to government and decision makers.
  - Respond to information requests from Minister, ADM office, other Ministry of Health Branches, other government branches, LHINs and others.
  - Assess new FHT IHP FTE requests in FHT Annual Operating Plan submissions.
  - Populate the FHT Annual scorecards.

Schedule A : Early years

PATIENT ENROLMENT TARGETS												
	Enrolled Patients as of March 31, 2011				Target Enrolment for March 31, 2012				Target Enrolment for March 31, 2013			
	PROGRAMS AND SERVICES											
	# Eligible Patients	Nurse Practitioners	Registered Nurses	Registered Practical Nurses	Registered Dietitians	Pharmacists	Social Workers	Psychological Associates	Chiropodists	Other IHPs[2]:	Other IHPs[2]:	Other IHPs[2]:
Col 1	**Col 2**	**Col 3**	**Col 4**	**Col 5**	**Col 6**	**Col 7**	**Col 8**	**Col 9**	**Col 10**	**Col 11**	**Col 12**	**Col 13**
Acute & Episodic Care Services												
Core primary care services provided in response to an acute or episodic illness or during a general health assessment (e.g. treatment, consultation, etc.)												
PLANNED CARE												
Chronic Disease Management Programs												
Asthma												
COPD												
Cardiovascular Disease												
Congestive Heart Failure												
Hypertension												
Diabetes												
Mental Health												
Other (please specify):												
Health Promotion/Disease Prevention Programs												
Cancer Screening												
Immunization (childhood/adult)												
Smoking Cessation												
Nutritional counselling												
Other (please specify):												
INDIRECT PATIENT CARE												
System Navigation (only record if >25% of workload)												
Service coordination & referral to link patients with the appropriate provider / organization in the community, including rehabilitation, outpatient & homecare services	N/A											
Assistance with hospital discharge planning	N/A											
Assistance with issues related to determinants of health (i.e. housing, social assistance, etc.)	N/A											
Training, Development & Team Collaboration												
Activities that support interdisciplinary learning, interprofessional consultation, team-building and collaborative practice	N/A											

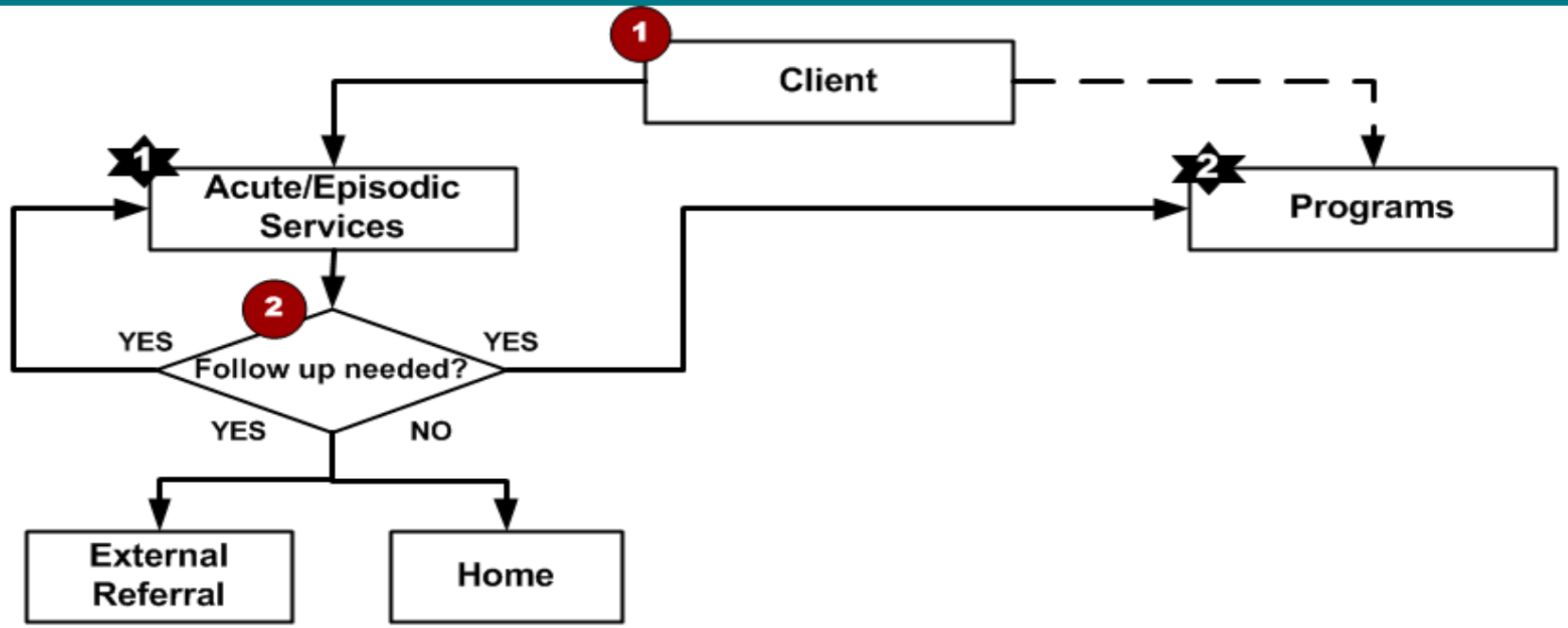
Current Schedule A

Programs/Services

Program Name	Type	Priority	Staff	Program Description	Goal	Target Population	Target # of Patients	Objectives	Program Activities	Performance Measures	Performance Targets
	Acute/ Episodic Chronic Disease Management Health Promotion Prevention	Seniors' Care Diabetes Obesity/ Nutrition Smoking/ Addictions Mental Health Lung Health Heart Health Other									

Services	Type	Priority	Staff	Program Description	Goal	Target Population	Target # of Patients	Objectives	Program Activities	Performance Measures	Performance Targets

Schedule A : Decision Flowchart



Program Category Examples

- Disease Specific
- Population Group
- Discipline Specific
- Health Promotion/ Prevention

Processes

1 **Initial encounter is for acute/episodic/immediate primary care need, unless self-refer or triage (- - -) directly to programs**

2 **After assessment by MD/NP/RN/RPN/PA, determination made to:**

- refer to programs based on established referral/program admission criteria
- follow up with another acute appointment,
- external referral, or
- "home", i.e. issue resolved

Additional Notes

1 **Examples of acute/episodic services performance measures:**

- Access (e.g. # of visits, same day/next day)
- System level indicators (e.g. ER diversion)

2 **Programs:**

- Program planning process is followed
- Admission/referral criteria to program are created
- Planned visit
- Targeted Intervention
- Use of clinical outcome measures expected as a performance measure. Eg. Number of patients with COPD who have had diagnosis confirmed with pulmonary function test/post-bronchodilator spirometry