



association of family  
health teams of ontario

# Integrating Primary Care

## A Family Health Team Perspective

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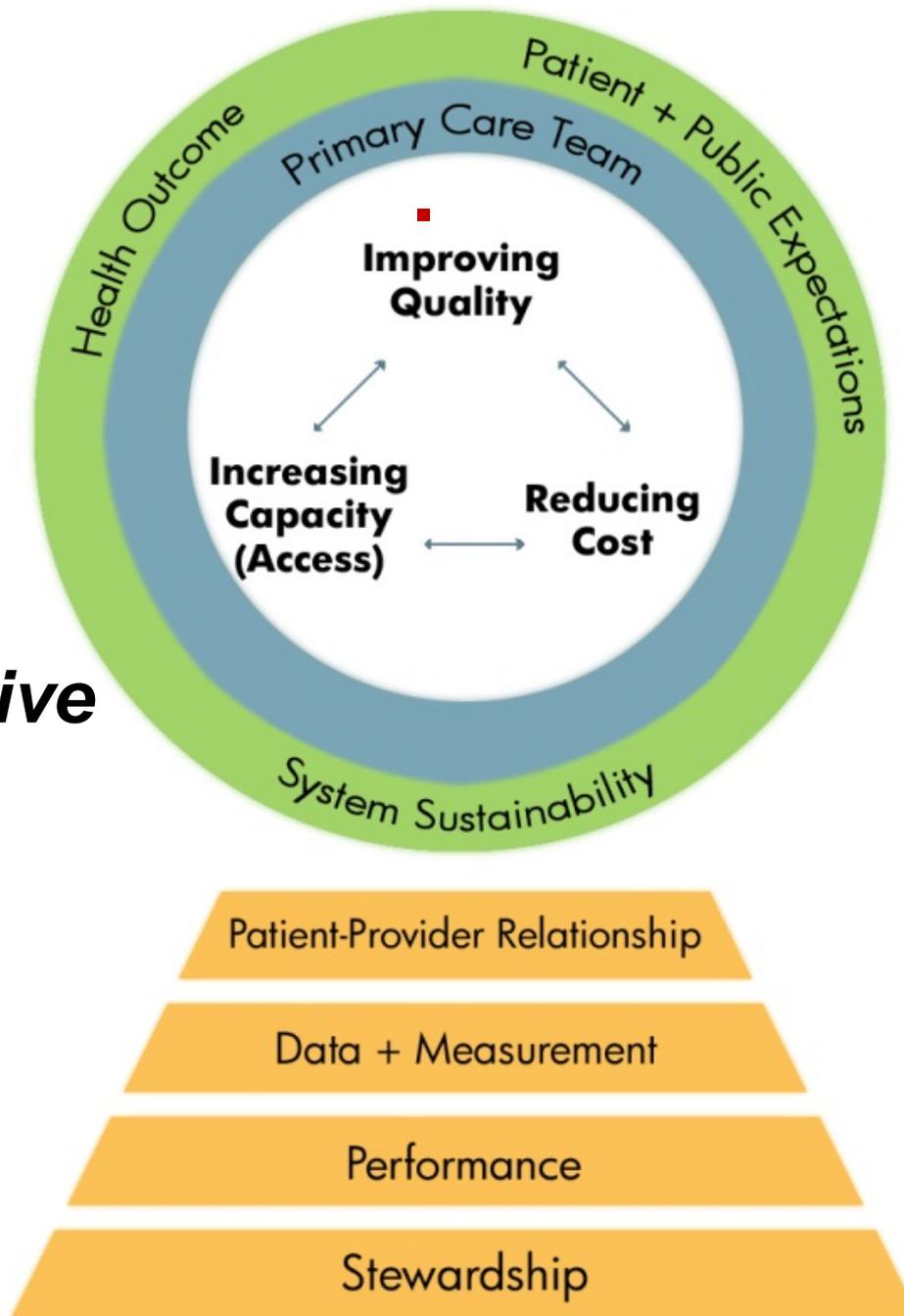
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# *Public Services For Ontarians:* **A Path To Sustainability And Excellence**

- “Make primary health care a focal point in a new, integrated health model.” (#5-56)



# ***Comprehensive*** primary care



# Drummond Commission:

- “Make FHTs the norm for primary care.” (#5-62)



# The Team within the FHT

*Access to the **right** service by  
the **right** provider  
at the **right** time*

- Case Worker
- Family Doctor
- Health Promoter
- Manager/administration
- Mental Health/Addictions Counsellor
- Nurse Practitioner
- Occupational Therapist
- Pharmacist

- Physician Assistant
- Registered Dietitian
- Registered Nurse
- Social Worker
- Specialist Physician





# Critical enablers

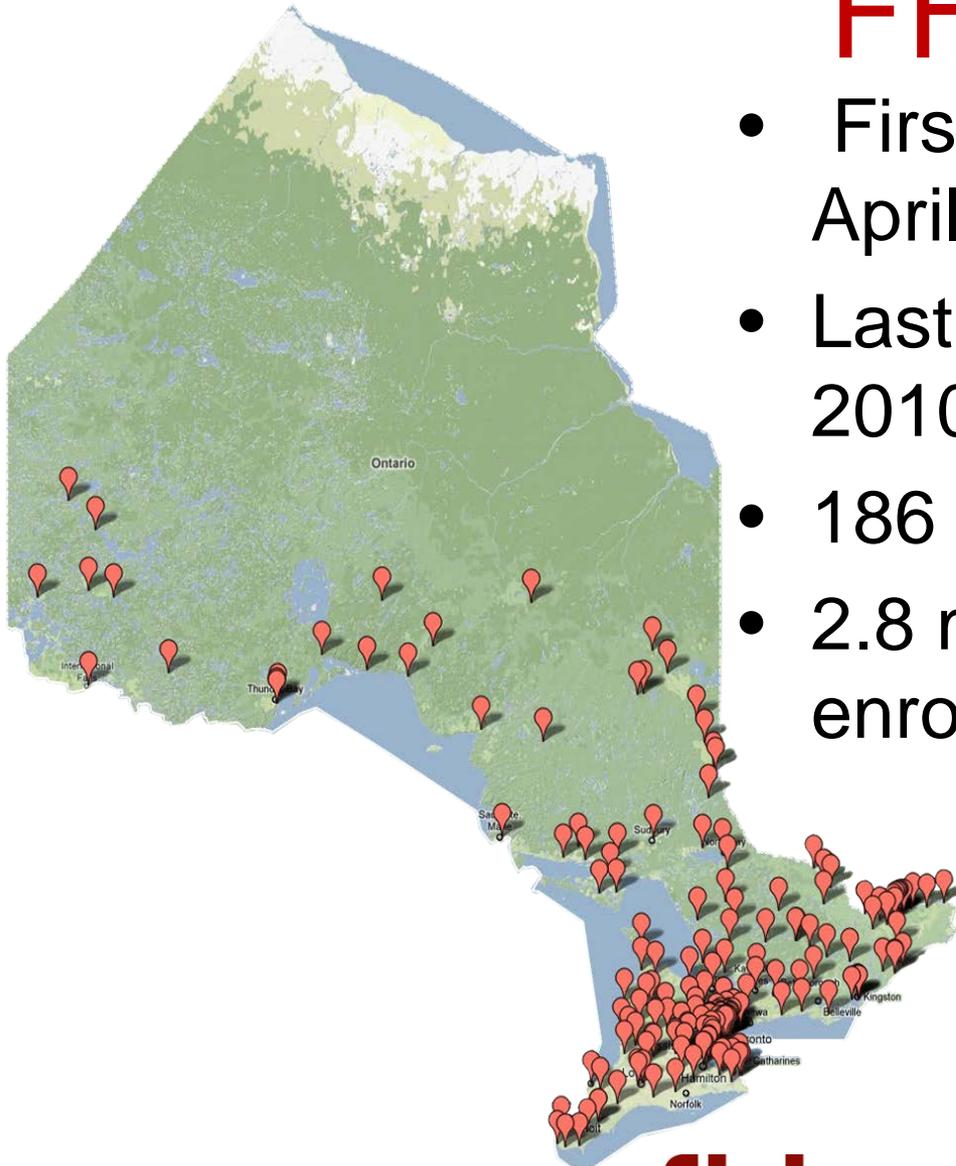
- Patient-centred / population-focused
- Interprofessional team
- Physician/clinician engagement
- Organizational infrastructure
- Informational infrastructure

## Leading to:

- Ability to develop comprehensive community-based programs in health promotion & CDPM
- Capacity to use data to improve planning, performance and outcomes
- Links with other health care organizations at the community level

# FHT Facts

- First 70 FHTs announced April 2005
- Last 30 announced Aug. 2010, opened late 2011
- 186 FHTs, 633 sites
- 2.8 million Ontarians enrolled (1 in 5)
  - ~ 2,400 physicians
  - ~ 1,700 interprof'l health providers



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# Ontario's primary care models

## Traditional

- Physician in fee-for-service in solo or group practice

## Physician patient enrolment model

- CCM
- FHG
- FHN
- FHO
- RNPG

## Interprofessional team

- CHC (73 serve 0.4M )
- AHAC (10 serve Aboriginal populations)
- FHT (186 serve 2.8M)
- NPLC (26 are getting going)

# Building the team beyond the FHT

- “Attaching the unattached”:
  - At the ED
  - Post partum
  - Referral on discharge



- Enhanced support post-discharge:
  - Transition from hospital to community
  - The Virtual Ward

# Building the team beyond the FHT (2)

- Specialized assessments in the community:
  - Memory Clinic
  - Dermatology consults
  - Mental health case conferencing
- Wound assessment and care
- Linking information systems



# Conclusions

1. Sustainability requires strategies / measurement to optimize:

- Capacity for timely access to primary care for every Ontarian
- Quality to the expectations of Ontarians
- Control of cost within team and across system

2. Integration and improvement requires capacity:

- Interprofessional team
- Physician/clinician engagement
- Organizational infrastructure
- Informational infrastructure

3. FHTs possess these critical enablers.

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