

# Family Health Teams

## *Advancing Primary Care*

### **Instructions:**

This Information Request Form is part of the Family Health Team InfoKit, which contains the following documents:

- ✍ Introduction to Family Health Teams
- ✍ Guide for Establishing a Family Health Team
- ✍ Information Request Form (Appendices A, B and C)

*Please review the accompanying documents prior to completing this form.*

**To Ensure Consideration for this Fiscal Year Please Submit a Completed Information Request Form No Later Than February 15, 2005 to:**

Primary Health Care Team  
Ministry of Health and Long-Term Care  
1075 Bay Street, 9<sup>th</sup> Floor  
Toronto, ON  
M5S 2B1

### **Attn: Family Health Team Proposals**

The ministry is in the early stages of FHT implementation and there are still some elements of the program that require refinement. As such, this form and other accompanying documents could evolve as the program is further developed and we receive feedback from you.

Please send your email address to [FHTinquiry@moh.gov.on.ca](mailto:FHTinquiry@moh.gov.on.ca) and we will ensure that you receive any new documents.

1. Contact information

Name of proposed FHT group

Name:

Address:

Phone:

Fax:

E-Mail:

2. This proposed FHT is from a:

Community-based Group

Provider-led Group

Mixed Provider/Community Group

*Please click in the appropriate box.*

*Please refer to the InfoKit Guide for Establishing a Family Health Team for additional information on the above FHT types.*

3. Please describe the population that your proposed FHT intends to serve (*including number of people to be served, size of the geographic area and general characteristics of the population*).

4. What other primary health care and health care services are available locally to this population (such as community hospitals, CCACs, other primary care groups, etc.)?

5. Will the proposed FHT provide all of the identified comprehensive care services (as outlined in Appendix A)?

Yes       No  (if no, please explain)

6. If applicable, please describe any additional services that you may wish to provide (*please see Appendix A for examples*).

Yes  (*if yes, please complete table in Appendix A*) No

7. Are you proposing to offer special programs or services that address the particular needs of any target populations to be served by the proposed FHT?

Yes  (*if yes, please describe in the box below*) No

8. Please identify the type and number of health care providers that are envisioned to provide services in the proposed FHT. *Please provide additional details in Appendix B.*

Provider Type	Proposed Number of Providers
Family Physician	_____
Nurse Practitioner	_____
Registered Nurse	_____
Registered Practical Nurse	_____
Other ( <i>please describe</i> ) _____	_____
Other ( <i>please describe</i> ) _____	_____
Other ( <i>please describe</i> ) _____	_____
Other ( <i>please describe</i> ) _____	_____

9. Is this proposed FHT to replace (or partially replace) an existing non-fee-for-service primary health care group (i.e., Community Health Centre, Family Health Network, Health Service Organization, Primary Care Network, Community Sponsored Contract, Northern Group Funding Plan)?

Yes  (if yes, please provide detail in the box below) No

10. Have you identified a location(s) to provide FHT services?

Yes  (if yes, please provide detail in the box below) No

11. In the space below please briefly identify any potential funding partners (*e.g., municipality, community agency, etc.*) who may contribute toward either (or both):

⌘ **infrastructure and capital** for this FHT

⌘ **on-going operating costs** (*including in-kind support*) for this FHT

*Please attach a letter describing the nature of proposed support for each identified partner.*

12. If applicable, please describe the FHT's affiliation with one or more of the six Academic Health Science Centres (AHSC), located in Toronto, London, Ottawa, Hamilton, Kingston or Sudbury/Thunder Bay.

13. Describe the proposed relationships between any local hospital(s) and the FHT primary care providers (i.e., availability of admitting privileges, on-call duties, etc.).

14. Were other organizations involved in the development of this FHT proposal (i.e., *Community Care Access Centre, Public Health Unit, etc.*)?

Yes  (If yes, please complete **Appendix C** for each applicable organization)

No

15. Approximately how much time would your FHT require to be fully operational following approval? Please identify the key factors that will ensure your readiness to get started (e.g. physical and human resources).

## Appendix A

### Comprehensive Care and Optional Additional Services

*Please refer to Questions 6 and 7*

The following is a list of services that will be provided, coordinated or overseen by FHTs.

*This list is provided for information purposes only.*

- ☒ Health assessments (physical examinations)
- ☒ Diagnosis and treatment
- ☒ Primary reproductive care (e.g., counseling on birth control and family planning)
- ☒ Primary mental health care (early identification and treatment of emotional and psychiatric illnesses and where appropriate collaborate with psychiatrists or the FHT mental health workers)
- ☒ Primary palliative care (provide palliative care or provide support to the team responsible for providing palliative care)
- ☒ Support for hospital, home, public health and long-term care facilities (through formalized linkages, assist with discharge, planning, rehabilitation services, out-patient follow-up and home care services)
- ☒ Service coordination and referral (coordination of services among the FHT and, where appropriate, referrals to other health care providers and agencies)
- ☒ Patient education and preventative care (e.g., development of self care tools and supports)
- ☒ Access to pre-natal, obstetrical, post-natal and in-hospital newborn care
- ☒ Arrangements for around-the-clock care (through extended office hours and the Telephone Health Advisory Service)
- ☒ Chronic disease management programs
- ☒ Organized health promotion and disease prevention programs

Depending on community needs and size, FHTs may wish to provide a number of optional additional services. In the table below, please indicate which optional services might be provided by this FHT.

Optional Service	May Potentially Provide	
	Yes	No
X-ray, ultrasound, sleep studies, pulmonary function studies, nuclear medicine (IHF-licensed services)	<input type="checkbox"/>	<input type="checkbox"/>
Laboratory services	<input type="checkbox"/>	<input type="checkbox"/>
Some minor day surgery	<input type="checkbox"/>	<input type="checkbox"/>
Some specialist services (e.g., internal medicine, pediatrics and cardiology)	<input type="checkbox"/>	<input type="checkbox"/>
Other ( <i>please describe</i> ) _____	<input type="checkbox"/>	<input type="checkbox"/>
Other ( <i>please describe</i> ) _____	<input type="checkbox"/>	<input type="checkbox"/>

# Appendix B

## Providers' Commitment to FHT *Please refer to Question 9*

Please complete the table below for **each** proposed health care provider. Include the names of health care providers who have indicated a preliminary commitment to participate in the proposed FHT.

Provider Type	Name and Full Contact Information

## Appendix C

### Potential Partnerships with External Organizations

*Please refer to Question 15*

For each organization that contributed to the development of this proposal, or with whom the FHT anticipates collaborating with to deliver services, please provide the name and contact information of the organization and the way in which collaboration is envisioned.

If available, please feel free to attach letters of support from these organizations that provide additional details.

Name & Contact Information of Participating Organization	Describe Involvement in Proposal Development	Describe Potential Role or Participation in FHT (optional)