

LHIN Family Medicine Advisory Committees (LHIN FMACs) Terms of Reference

The LHIN FMACs are intended to facilitate and enable family physicians to meet the highest possible standards of care in family medicine in each region and liaise with their regional LHIN and with other LHIN FMACs. This will be accomplished through the creation of an advisory committee with broad representation from key family practice organizations and community stakeholders which ensures 2-way communication between the family physicians, the family physician organizations, other primary care disciplines, consumers and community representatives, as well as between family physicians and the LHIN Boards, and between the fourteen provincial LHIN FMACs.

The family medicine special interest groups will link with the LHIN FMACs to ensure that comprehensive care family medicine (e.g., office practice, chronic care, mental health, prevention, home care, hospital care, palliative care, Long Term Care, obstetrics, emergency care, rural family medicine) is addressed.

Set up of LHIN FMAC

Each region will establish its own LHIN FMAC based on local needs. Each LHIN FMAC will have a lead family physician (elected or appointed) responsible for liaising with the LHIN and the Provincial LHIN FMAC.

Organizational structure

LHIN FMAC

Each LHIN FMAC will consist of voting representatives from the following organizations, numbers and terms to be determined by each LHIN FMAC:

- Chiefs of Family Medicine

- Academic Family Medicine Representative
- OCFP representative
- OMA, SGFP representative
- COFP representative
- Section of Rural Family Medicine
- Urban family physicians
- Rural family physicians
- PCR Representative

In addition, each LHIN FMAC will have the following members at large:

- Representatives from the Interdisciplinary Committee
- Representatives from the special interest groups Subcommittees
- LHIN CEO
- MOHLTC representative
- MPP
- Mayors and city councillors
- Consumers
- Community agencies (ie CCAC)
- Public Health MOHs

Interdisciplinary Committee

An Interdisciplinary Committee will be established to advise the LHIN FMAC about interdisciplinary issues and will consist of members (not limited) from the following disciplines:

- Nursing
- Nurse practitioners
- Registered practical nurses
- Social workers
- Dietitians
- Psychologists
- Chiropractors
- Physiotherapists
- Occupational therapists
- Pharmacists
- Optometrists
- Chaplains

Special Interest Groups Subcommittees

Each LHIN FMAC will establish mechanisms to liaise with family practices regarding the provision of comprehensive family practice care in the following areas (not limited):

- Office practice
- Chronic care
- Mental health

- Palliative care
- Long-Term Care
- Obstetrics
- Hospital care
- Home care
- Emergency care

Administrative structure/operations

Each LHIN FMAC will be responsible for the following administrative functions/operations to ensure the best quality of care:

- Professional development
- Credentialling
- Continuing quality improvement
- Communications/information management/ linkage with specialists
- CHC/HSO/FHT/FHN/FHG/PCN (PCR Initiatives)
- Research and evaluation
- Physician recruitment/retention/shortages
- Continuing professional development
- Database management

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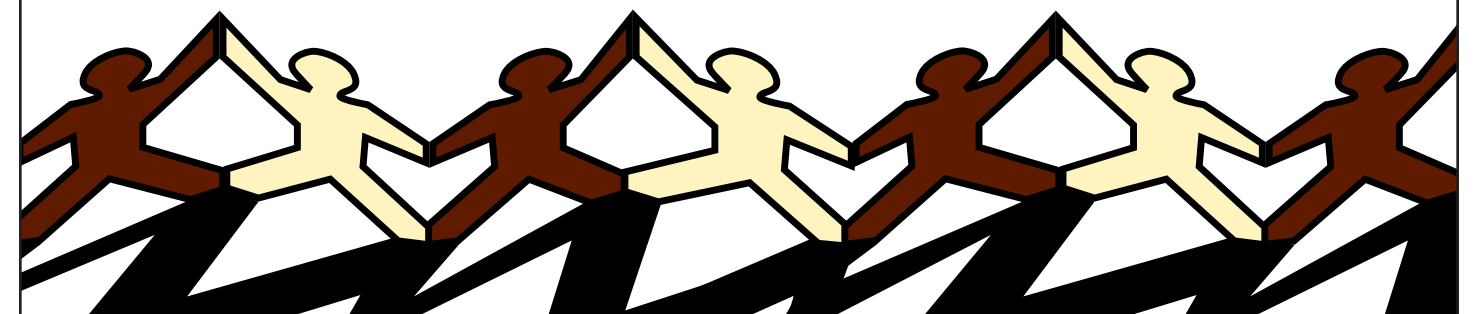
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Linking Family Physicians with Local Health Integration Networks (LHINs)

Final Report December 2005

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Linking Family Physicians with Local Health Integration Networks in Ontario: Project Description

Purpose

To recommend how family physicians in Ontario can best link with the newly formed Local Health Integration Networks (LHINs).

Methodology

An international literature review and environmental scan, interviews with key national and international stakeholders, focus groups with family physicians and a strategic planning meeting with key stakeholders, to identify recommendations on how to link family doctors with the new LHINs.

Family Physicians and Health Care Policy

Health policy should be directed toward strengthening the primary care orientation of health systems (Starfield & Shi, 2002).

International comparisons, and studies within countries, document the beneficial impact of primary care physicians on the effectiveness (i.e., health outcomes), efficiency (i.e., lower costs), and equity of health outcomes (i.e., reducing disparities across population subgroups) (Starfield & Shi, 2002).

The supply of primary care physicians and the receipt of care from them, have been shown to have a beneficial impact on hospitalization rates and subsequent morbidity, mortality and health care costs (Shi et al., 2005).

Health System Regionalization

Health system regionalization has a relatively long history in Canada and abroad.

The jury is still out regarding the effectiveness of health system regionalization (Lewis & Kouri, 2004).

Loose coupling and new power relationships impact on the effectiveness of regionalization (Hinings et al., 2003)

Bibliography

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- Shi, L. et al. 2005. "Primary Care, Social Inequalities, and All-Cause, Heart Disease, and Cancer Mortality in US Counties, 1990." *American Journal of Public Health*, April: 674-680.
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Linking Family Physicians with Local Health Integration Networks (LHINs): Major Recommendations

1. Establish Family Medicine as a priority area for each of the Local Health Integration Networks (LHINs) in Ontario.
2. Establish LHIN Family Medicine Advisory Committees (LHIN FMACs) in the 14 regions, comprised of key family physician representatives from: the Hospital Chiefs of Family Medicine, urban family physicians, OMA/Section of General Family Practice, OCFP, COFP, Academic Family Medicine Representative, Society of Rural Physicians, PAIRO Representative, PCR Representative.
3. Include, on the LHIN FMACs, consumer and government members from: LHIN CEO's, Medical Officers of Health, consumers, local politicians, MPP's, and the MOHLTC.
4. Appoint one representative Family Physician Lead from each of the 14 LHIN FMACs to each LHIN Board.
5. Set up an organizational structure (i.e., subcommittees) for LHIN FMACs that allows family physicians to address comprehensive care in family practice within the LHINs: office practice, chronic care, mental health, prevention, home care, hospital care, palliative care, Long Term Care, obstetrics, emergency care, rural family medicine, etc.
6. Establish an interdisciplinary Primary Care Committee representing nursing, nurse practitioners, dietitians, pharmacists, social workers, and other health professionals that work in family practices with a representative on the LHIN FMACs.
7. Set up LHIN FMAC administrative structures that allow the LHIN FMACs to address operational issues across the regions such as: primary care reform, physician recruitment/retention/shortages, credentialing, continuing professional development, CQI, research/evaluation and information/communications management.
8. Establish a Provincial Family Medicine Advisory Committee comprised of one representative from each of the 14 LHIN FMACs. The committee will elect a chair. The Chair of this committee will also sit on the provincial FMAC Committee.
9. Fund the LHIN FMAC organizational structure through the LHINs/MOHLTC.
10. Remunerate family physicians for any time they spend formally participating in the LHIN structure.

