MODERNIZING THE CONTRACTUAL FRAMEWORK FOR FAMILY HEALTH TEAMS

A RECOMMENDATION REPORT FROM
THE ASSOCIATION OF FAMILY HEALTH TEAMS OF ONTARIO
AUGUST 2026

afhto ASSOCIATION OF FAMILY HEALTH TEAMS OF ONTARIO

Executive Summary

In June, OH notified the Association of Family Health Teams of Ontario (AFHTO) that updates are being made to the Family Health Team (FHT) Transfer Payment Agreement (TPA), last issued April 1, 2018, and currently set to expire March 31, 2027. OH requested that AFHTO engage members for feedback.

AFHTO appreciates the opportunity to inform this process and the sincerity with which OH has sought and engaged with our feedback to date.

With the support of a member working group—consisting of approximately 20 FHTs from across the province—AFHTO provided preliminary feedback to OH in July, with a wide range of specific requests and recommendations. Now, AFHTO and the working group have developed this broader, strategic report, defining core principles and priority recommendations for an updated contractual framework—inclusive of both the TPA and the broader policy regime. These recommendations are designed to not only better enable FHT operations, but in doing so, better position FHTs to help the Ministry of Health (MOH) achieve its Primary Care Action Plan (PCAP) attachment goals by 2029.

Principles

Through the development of the working group's recommendations, three core principles emerged. Overall, an updated contractual framework needs to:

1) Shift from an approval-based approach to an accountability-based approach;
2) Encourage local collaborations that best leverage resources;
3) Offer sufficient clarity to allow FHTs to operate freely, without being overly prescriptive.

Through the PCAP, FHTs are being tasked with significant, rapid growth and expansion; PCAP's success and the long-term sustainability of primary care as the foundation of Ontario's health system depends on it. But the current contractual framework doesn't support this ambition. Now 20 years into their maturation journey, FHT executives need to have the autonomy and responsibility afforded to other healthcare leaders, to freely manage their organizations and budgets through a broader, more strategic lens.

Recommendations

Specifically, the broad range of suggestions and ideas for improving the contractual framework ladder up to three core recommendations. The revised contractual framework should:

1) Institute global budgets, to empower FHTs to strategically deploy their resources in response to community needs;
2) Reduce and streamline planning and reporting requirements to focus on performance in relation to the delivery of programs and services;
3) Better position FHTs to collaborate locally and drive attachment.

We urge OH and MOH to consider, support, and adopt these recommendations. While doing so would not replace the need for increased funding to stabilize FHT operations related to health human resources and infrastructure, they would allow FHTs to leverage the resources they do have in the most efficient and effective way possible.

Introduction

In June, OH notified AFHTO that updates are being made to the FHT TPA, last issued April 1, 2018, and currently set to expire March 31, 2027. OH requested that AFHTO engage members to provide feedback on potential changes that could be reflected in the updated agreement.

AFHTO appreciates the opportunity to inform this process and the sincerity with which OH has sought and engaged with our feedback to date.

Following a brief member survey, AFHTO formed a working group to capture and consolidate feedback. This working group includes representatives of 20 FHTs from across Ontario: two from Central region; five from East region; four from North East region; two from North West region; three from Toronto region; and four from West region.

This group also includes at least two FHTs representing each of the following primary care patient enrolment models: Family Health Organizations (FHO), Family Health Networks (FHN), Blended Salary Models (BSM), Rural Northern Physician Group Agreement (RNPGA).

In some cases, AFHTO and working group members have also solicited ad hoc feedback from additional FHTs, to further broaden the perspectives captured in this report.

Principles

This report reflects the most prominent pieces of feedback brought forward by working group members, related to how the TPA and supporting policies—namely, the Community Financial Policy—and processes can be modernized to increase operating efficiency and effectiveness.

Through the development of the working group's recommendations, three core principles emerged. Overall, the updated contractual framework needs to:

1) Shift from an approval-based approach to an accountability-based approach;
2) Encourage local collaborations that best leverage resources;
3) Offer sufficient clarity to allow FHTs to operate freely, without being overly prescriptive.

There is clear a throughline: the contractual and administrative framework should focus on agreed-upon commitments and corresponding agreed-upon targets—and then provide FHTs with the flexibility to operate responsibly, strategically, and effectively to fulfill those commitments and reach those targets. Not only will this improve FHT operations, but it will greatly reduce administrative burden related to oversight and approval processes for OH and MOH, as well.

Through the PCAP, FHTs are being tasked with significant, rapid growth and expansion; PCAP's success and the long-term sustainability of primary care as the foundation of Ontario's health system depends on it. But the current contractual framework doesn't support this ambition; rather, FHTs are highly stifled by rigid budgets and operational limitations. Now 20 years into their maturation journey, FHT executives need to have the autonomy and responsibility afforded to other healthcare leaders, to freely manage their organizations and budgets through a broader, more strategic lens.

Recommendations

Recommendation #1: Institute global budgets, to empower FHTs to strategically deploy their resources in response to community needs

Currently, FHTs are not able to independently reallocate funds in their budget between lines unless the amount is below $10,000. Any need to reallocate $10,000 or more requires OH approval. Based on the experiences of working group members, many submit 1-3 requests a year, with variable response timelines, ranging from weeks to months; some choose not to submit any, based on frustration with the process and timelines. While there was some variability, most working group members indicated that almost all their requests were ultimately approved. This highlights the fact that this administrative step simply slows operating decisions that impact services and attachment—by weeks or months—rather than actually mitigating any risk in practice.

Particularly in the context of the PCAP's ambitious attachment targets and timelines, FHTs need the operational autonomy required to most effectively marshal their resources and meet community need. Sufficient operational autonomy includes being able to staff their organizations at the levels, in the configurations, and with the compensation required to recruit and retain top quality administrative and clinical staff. It also includes having the flexibility required to make strategic and risk-based operational investments (e.g., increased spending on digital infrastructure and cybersecurity and modifications to physical space to accommodate expansion).

Right now, strict budgets and reallocation approval processes undermine FHTs' ability to act swiftly to deploy their resources in the most effective and responsible way. These limitations and processes often result in FHTs losing top performers, leading to vacancies and costly recruitment and retraining efforts, all of which ultimately reduce capacity.

Arguably, the operationalization of interprofessional primary care team (IPCT) expansion has led to greater funding disparities within some regions—with some but not all primary care organizations in a given community receiving an influx of funding—which further highlights the need for FHTs to have the flexibility to use their resources as needed to remain competitive in recruiting and retaining staff.

As such, the contractual framework should be amended to allow FHTs to operate with global budgets. This would enable FHTs to move human resources (HR) and operational dollars as needed, based on the evolving requirements within a year. At the same time, the Community Financial Policy should be amended to properly align with this shift, and formally ensure adequate flexibility (e.g., a modernized approach to procurement and asset disposition, termination and severance negotiation, non-insured services to ensure equity with family physician practices etc.).

Such a shift—supported by commensurate adjustments to the Community Financial Policy—would directly lead to:

- Fewer budget reallocation requests to submit for FHTs and to process for OH, allowing for swifter decision-making on time-sensitive matters related to programs and services
- Reduced time spent on reporting and tracking of funding envelopes
- Faster response to staffing and patient-care needs

- Improved recruitment and retention through wage flexibility (and opportunities for performance-based incentives)
- Ability to fund overtime, locums, contractors, and temporary services
- Better planning for technology, equipment, training, and capital improvements
- Reduced year-end spending pressure—and more strategic spending as a result

It is important to emphasize that global budgets won't directly address the need for increased funding to fully address health human resource recruitment and retention issues, and growing infrastructure challenges. But global budgets would allow FHTs to best leverage the resources they do have, based on their local needs and realities.

If such a shift is not made, then reallocation thresholds should be significantly increased from the current $10K limit (either based on percentage of overall budget or a greatly raised dollar value), and definitions of budget categories broadened, to reduce the need for reallocation requests and approvals.

Recommendation #2: Reduce and streamline planning and reporting requirements to focus on performance in relation to the delivery of programs and services

The current FHT planning and reporting regime is very laborious and time-consuming, sometimes duplicative, not consistently clear—and is focused on the minutia of operations rather than the objectives we are trying to achieve.

Between the Annual Operating Plan (AOP), including the service plan ("Schedule A"), the Quality Improvement Plan (QIP), HR Report, program-specific reports (e.g., Diabetes Education Program Quarterly Activity Report), financial reports (e.g., Audited Statements of Revenues and Expenditures Report)—and for those who have received IPCT funding, two new monthly reports—working group members report spending an average of 10-40 (and much more in some cases) staff hours per month just on reporting to OH. This is on top of the time and effort devoted to developing the various plans in the first place.

FHTs consistently report that the overall approach suffers from:

- Repeated HR and staffing submissions
- The same or similar metrics across AOP, QIP, quarterly reports, and IPCT reporting
- Financial information submitted multiple times
- Similar data entered into different systems/forms
- Frequent ad hoc requests for previously submitted information

Further, FHTs are rarely provided with feedback or an explanation of how all this data meaningfully contributes to quality improvement or provincial and regional planning.

Notably, these issues have been exacerbated since the implementation of the PCAP, particularly through the IPCT expansion process. This is challenging for all FHTs, but perhaps to an even greater degree for small FHTs with minimal administrative staff, leading the ED to spend a significant proportion of their time just on trying to fulfill reporting requirements, rather than focusing on organizational strategy and operations.

There are various drivers for these issues, but perhaps the most significant is that FHTs are being forced to submit plans at a level of detail that does not reflect how FHTs operate or the natural flow of business. As

an example, service plans (and IPCT plans) require FHTs to parse how funding and staff are being deployed to core operations, expansion efforts, and specific services within each—which is incredibly difficult and painstaking to do in an accurate and meaningful way. As a result, FHTs are then held to these very specific plans, and must regularly report on them—with approvals required for changes in many cases.

Fundamentally, service plans should focus on commitments and targets related to services offered and delivered (that are reasonably within the control of the FHT); decisions with respect to how these commitments will be fulfilled should be left to the FHT to determine on an ongoing basis.

However, there is considerable variability across OH regions in terms of the extent to which approval for relatively minor changes are required. For example, some FHTs report that approval is required for cost-neutral staffing substitutions, minor FTE changes, discipline mix changes based on workforce availability, changes to staff-to-service allocations, etc.

The TPA should prescribe service plan requirements that limit the need for approvals, while focusing on performance, with respect to the fulfilment of commitments and achievement of targets.

As examples, service plans could focus on agreed-upon commitments to offering and delivering funded programs and services, with agreed-upon targets related to:

- Patient attachment
- Access and wait-times
- Patient encounters and service volumes (including with respect to chronic disease management and preventive care services)
- Quality improvement indicators
- Patient experience and satisfaction

Importantly, any such commitments must be defined in a way that reflects what is within the control of the FHT, and not contingent on the practice of collaborating physicians (e.g., in a FHO), who the FHT does not have control over.

If FHTs commit to targets in relation to such measures, and can demonstrate achievement of these targets, it's not clear that there is sufficient additional value in providing plans and reports at a more granular level given the time it takes away from strategy and operations. However, where it is required, it is helpful for FHTs to understand how OH and MOH use the data to supports its analytical and planning purposes.

Recommendation #3: Better position FHTs to collaborate locally and drive attachment

With greater budgetary flexibility offered by global budgets and streamlined planning and reporting focused on performance, FHTs would be better enabled to operate efficiently. Still, there's an additional need to better structure funding arrangements and policies to enable collaboration that allows full communities to operate more efficiently. Within this recommendation, there are several specific recommendations.

<u>A) Allow Greater Freedom to Keep Remaining Dollars in the Community</u>

The introduction of global budgets would lead to a reduction in year-end surpluses (and deficits)—as well as a reduction in late-year spending urgency—by providing teams with the ability to use resources as needed.

Having said that, there may be cases where year-end approaches and there are dollars remaining that could be used within the organization—but could be even more effectively deployed through collaborations with other FHTs or primary care organizations (or other healthcare organizations) in the community. Particularly within the context of MOH's PCAP, and in the spirit of collaborating to attach all patients and meet community need, we recommend that FHTs should be permitted to (without approval) direct funds to another community organization in such cases.

Ideally, FHT would be allowed reasonable year-end operating surpluses to be carried over for contingencies, retained for reinvestment, and support time-bound, Board-approved operating reserves (with the appropriate parameters in place). But recognizing that such a change would face significant approval hurdles, at a minimum, FHTs should be allowed to engage in self-directed reallocation to another community organization (potentially in coordination with the local Ontario Health Team).

B) Allow FHTs to Formally Collaborate with Family Physicians Under Multiple Models

FHT TPAs should allow for simultaneously collaborating with family physicians operating under multiple types of primary care patient enrolment models (e.g., a FHT with BSM physicians and an affiliated FHO, or a FHT formally working both with physicians in a FHO and physicians operating under the RNPGA). This would offer flexible practice management that supports work-life balance, phased retirement or shared practices—thereby making recruitment more competitive.

Overall, we project that such a change would:

- Increase the number of physicians who can join a FHT
- Improve patient attachment
- Improve continuity of care
- Increase access to FHTs for a broader population and region
- Reduce wait times
- Support recruitment of physicians in underserved communities
- Support recruitment of physicians with specialized interests
- Maximize human resources
- Improve efficiency in back-office integration

Especially given the push to attach all Ontarians to a primary care physician (or nurse practitioner), with a focus on those working with team-based models (like FHTs)—and the well-established physician recruitment challenges in Ontario (particularly in some parts of the province)—the model requires flexibility.

The distribution of family physicians across the province is not even. And family physicians have varying preferences for the type of model they are interested or willing to practice in. Even if the value proposition of working with a FHT is clear to a given family physician—being able to practice to their optimal scope and serve a greater number of patients in virtue of having a supporting clinical team to refer patients to—it might not be a practical option for them; if the only way to do so is to be part of a local FHO and either the FHO is not willing to accept new physicians or a physician doesn't want to be part of the FHO, then they just won't have the opportunity to work with the FHT. Anecdotally, as an example, we are increasingly hearing of family physicians who would join a FHT if they could operate in a BSM.

As such, at least in some parts of the province, the reality might be that the only way to collaborate with the number of family physicians sufficient for attaching all patients in the community to team-based care will be to work with physicians in multiple types of models. Consistent with the core theme throughout this document, FHTs need the discretion to build these relationships and form these collaborations.

C) Clarify Roles, Responsibilities, and Accountabilities

FHT models vary with respect to the primary care patient enrolment model their collaborating physicians operate under. Particularly for FHTs working with family physicians in independent organizations (e.g., FHOs), it is critical that the TPAs are written to reflect that FHTs are not accountable for physician practice (including whether family physicians choose to encourage or refer their patients to the FHT for services), nor their targets. In this spirit, the TPA should clearly define what the FHT is, the FHT's purpose and role, what the FHT is expected to provide, and who FHT programs and services are available to (i.e., all patients of collaborating physicians)—all of which are distinct from (though often dependent on) a collaborating physician group.

Relatedly, consideration should be given to how to manage capacity when there is organic expansion. For example, if a FHT's affiliated FHO is expanding, and the FHT is expected to support all new patients rostered to that FHO, the FHT's capacity to do so is compromised without additional resourcing.

Finally, given the reality of the governing boards of many FHTs, there should be clearer accountabilities and expectations with respect to the steps FHT boards of directors must follow to identify and manage conflicts—so that this isn't left to each team to determine. Direction from OH and MOH on this is especially important here, to the extent that a FHT which currently finds itself in a conflict may not be able to appropriately identify and address it—precisely because they are in a conflict.

Next Steps

In order to meet the ambitious goals of the PCAP by 2029, FHTs need to be empowered and enabled to operate as responsible, strategic businesses that are capable of assessing community needs, organizational strengths and weaknesses, opportunities and risks, and making decisions accordingly.

Specifically, the revised contractual framework should:

1) Institute global budgets, to empower FHTs to strategically deploy their resources in response to community needs;
2) Reduce and streamline planning and reporting requirements to focus on performance in relation to the delivery of programs and services;
3) Better position FHTs to collaborate locally, to drive attachment.

With a clearer understanding of OH's and MOH's vision for the direction of future agreements, we can also further consider and refine these recommendations.

In the meantime, we urge OH and MOH to consider, support, and adopt these recommendations. While doing so would not replace the need for increased funding to stabilize FHT operations related to health human resources and infrastructure, they would allow FHTs to leverage the resources they do have in the most efficient and effective way possible.

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- Sam Marzouk, Executive Director, Bridgepoint FHT
- Maria Spadaro, Executive Director, Central Brampton FHT
- Danielle VanGennip, Manager of Operations, City of Kawartha Lakes FHT
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- Angela Campbell, Finance Manager, Kingston FHT
- Jan Powell, Executive Director, Lakelands FHT
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- Theo Barker, Executive Director, Northumberland FHT
- Anna Gibson-Olajos, Executive Director, Powassan and Area FHT
- Connie Gray, Director of Finance and Operations, South East Toronto FHT
- Stephanie Evenden, Finance Manager, Sunset Country FHT
- Cheryl Dobinson, Executive Director, Taddle Creek FHT
- Jill Strong, Executive Director of People and Performance, Thames Valley FHT
- Tabatha Berriault, Director of Finance and Human Resources, Timmins Academic FHT
- Margo Reilly, Executive Director, Windsor FHT

Staff Contact

Chris Langlois, Director, Strategy, Policy and System Transformation; *Working Group Co-Chair*
Email: chris.langlois@afhto.ca
Phone: 1-647-933-0503