

2016 Leadership Session:

Tackling the big issues: relationship and accountability questions in Ministry contract templates

October 17, 2016, 10:00 AM – 12:00 noon, Westin Harbour Castle, Toronto

CONTENTS:

October 17 Leadership Session: what to expect.....	2
Meeting objective:	2
Summary of this discussion document	2
Meeting process:.....	2
1 Overall objective re MOHLTC-FHT contract templates.....	3
2 Contract renewal process	3
2.1 Parties to the Ministry consultation process	3
2.2 Out of scope topics (to be confirmed by MOHLTC):.....	3
2.3 AFHTO consultation process:.....	4
3 Considerations in developing MOHLTC-FHT contract template.....	4
3.1 Evidence related to FHT performance	4
3.2 “Patients First” environment	5
3.3 LHIN environment.....	5
3.4 Physician environment.....	7
3.5 Questions raised by MOHLTC regarding FHT contract renewal:	7
3.6 AFHTO member guidance to date	8
3.7 Legal guidance on shared liabilities between FHT and FHO (physician group)	10
4 Top five issues for AFHTO members (so far).....	11
4.1 One standard FHT contract, regardless of board makeup.....	11
4.2 Defining the “team” and fostering “teamwork”	12
4.3 Defining the “population” for which governors are accountable	15
4.4 Defining minimum standards of governance / addressing conflict of interest	17
4.5 Accountability and dispute resolution	19
5 Next steps	20

October 17 Leadership Session: what to expect

“Patients First is turning the health system on its head...and it is complicated! It’s important for primary care to drive the bus. For this we need strong leadership, and to find the right balance in our approach – deep rooted culture changes and structural fixes. Accountability is critical, and that requires authority over the critical ingredients to foster performance. Measurement is important – it’s what we do now. We have to keep innovating. We have to evolve our governance, focus on skills based boards and focus on corporate responsibility. And finally, we need to nurture the leadership we have.”

– Sean Blaine MD, AFHTO President and Clinical Lead, STAR Family Health Team in Stratford

Meeting objective:

To find common ground and guide AFHTO’s position on particularly challenging issues related to the FHT contract, with the view to its potential impact on NPLC and other primary care contracts.

Summary of this discussion document

Contracts between Ministry and FHT must be re-negotiated before they expire on March 31, 2017. Indications are that all primary care contracts, including NPLCs, CHCs, AHACs as well as FHTs, could be standardized not long thereafter. This discussion document is focused on the FHT contract, with an eye on the content and implications for AFHTO’s NPLC members and others.

The document is the result of discussions over the past few months with the AFHTO board, Physician Leadership Council and ED Advisory Council, as well as very preliminary discussion with MOHLTC and other parties to the process, namely AOHC and OMA.

A critical theme throughout these discussions has been the further evolution of “team culture” and the relationship between physicians and the FHT; and how that relationship is influenced by the Ministry-FHT and Ministry-FHO contract, as well as the formal or “unwritten contract” between FHT and FHO.

The key topics that have emerged so far are:

- One standard Ministry-FHT contract, regardless of board makeup
- Defining the “team” and fostering “teamwork”
- Defining the “population” for which governors are accountable
- Define minimum standards of governance and address conflict of interest
- Accountability and dispute resolution

Meeting process:

Board members, EDs and Physician Leads from all AFHTO-member FHTs and NPLCs have been invited, and will receive this discussion document. Just over 200 are expected at the meeting. In tables of 10 people, participants will discuss and record responses to open-ended questions using networked laptops. All participants will have a voting keypad to record their responses to closed-ended questions.

To help inform members, this document presents an environmental scan (section 3). Each of the 5 topics is presented in section 5, followed by one or more questions at the end of each topic.

1 Overall objective re MOHLTC-FHT contract templates

To develop templates for the next round of FHT Agreements, the content of which:

- Supports the movement toward timely access to high-quality, comprehensive interprofessional primary care:
 - Informed by the social determinants of health – the conditions in which people are born, grow, live, work and age
 - Delivered by the right mix of health professionals, working in collaborative teams in partnership with patients, caregivers and the community
 - Anchored in an integrated and equitable health system, promoting good health and seamless care for all patients
 - Sustainable – efficiently delivered and appropriately resourced to achieve expected outcomes¹
- Is acceptable to all parties to the contract.

2 Contract renewal process

2.1 Parties to the Ministry consultation process

- MOHLTC:
 - Have committed to undertake a full consultation process; details yet to be finalized. (See early draft below.) While dates have been delayed, staff indicate MOHLTC is still committed to having new contracts in place by March 31, 2017.
- LHINs:
 - MOHLTC has stated it will work closely with LHINs in developing next template. Passage of Patients First Act would eventually lead to contracts being transferred to the LHINs.
- AFHTO:
 - Full partner in the process
- OMA:
 - Has representation rights on matters within the scope of the Physician Services Agreement, and the right to be consulted on template for “Physician Sponsored” FHTs.
- AOHC and OCFP:
 - Would most likely be invited by MOHLTC to provide input

2.2 Out of scope topics (to be confirmed by MOHLTC):

The following topics are outside the scope of the Ministry-FHT contract. While these issues may be raised, comments/concerns will be forwarded to the appropriate tables.

- Matters within the scope of the Physician Services Agreement
- Formulas or other mechanisms used to determine funding level for each FHT (note point above, however, about need to review section 3.9 on patient enrollment requirements)

¹ These bullets are from AFHTO’s vision statement.

2.3 AFHTO consultation process:

- Aug. 10 – AFHTO Physician Leadership Council (PLC) meeting for initial discussion.
- Sept.16 – Combined meeting of PLC + Executive Director Advisory Council (EDAC) to report back on findings to date, test out their thoughts on what has emerged, and begin to factor in the more administrative aspects of the contract.
- Sept.20 – AFHTO board meeting to review input to date and provide further direction on consultation content and process.
- Late Sept – option to test some ideas with broader membership via survey/web meeting
- **Oct 17 – Leadership Session** before AFHTO conference – opportunity to build consensus and/or ratify positions on key issues with roughly 250 leaders of AFHTO-member organizations in attendance
- Dates TBD -- AFHTO staff to meet with other key stakeholders (OMA, AOHC, OCFP) to exchange issues/perspectives/emerging positions at this point.

3 Considerations in developing MOHLTC-FHT contract template

3.1 Evidence related to FHT performance

- The Conference Board of Canada (2014) conducted a formal five-year evaluation of FHTs with the following key findings:
 - Positive findings re patient satisfaction, but significant variation across key indicators.
 - Key markers of operational maturity (governance, full scope of practice, etc.) strong in some but absent in others.
- The Ontario College of Family Physicians (2013) examined how the FHT model supports team-based care and found the following:
 - The dual governance structure (in which FHTs and affiliated physician groups are governed separately) leads to conflicts of direction and interest.
 - More needs to be done to encourage FHTs to operate as integrated care teams (e.g. co-location, common vision/mission, comparable pay scales).
- [Data to Decisions \(D2D\)](#), AFHTO members' work to advance manageable and meaningful measurement, has generated data that reveals [higher primary care quality is associated with lower total health system cost, and AFHTO members are delivering higher quality than average for Ontario primary care.](#)
 - D2D is gradually freeing primary care from the serious limitations of relying solely on administrative data, and beginning to capture the impact of the team, not just physician billings.
 - This is made possible by the network of [Quality Improvement Decision Support \(QIDS\) Partnerships](#), available to most (but not all) primary care teams.

3.2 “Patients First” environment

- *Patients First* is aiming to achieve:
 - Effective integration of services and greater equity through subLHIN regions
 - Timely access to and better integration of primary care
 - More consistent and accessible home + community care
 - Stronger links to population + public health.
- Contract language needs to consider scenarios that may likely develop, including:
 - expanding access to teams for people who are most in need, and therefore engaging with patients of FPs outside the team
 - partnerships and collaborative relationships across subLHIN, e.g.:
 - “Host” for QIDS Partnership, particularly if they expand beyond teams
 - HealthLinks coordinator
 - Other shared programs
 - “embedded” staff, e.g. from CCAC (LHIN)
 - evolving relationship with LHIN

3.3 LHIN environment

Given the province’s move to have LHINs assume responsibility for FHT, NPLC and AHAC contracts at some point in the future, and MOHLTC’s commitment to consult with LHINs on the next contract template, the content of LHIN contracts with CHCs could be instructive.

The LHIN-CHC contract is called a “Multi-Sector Service Accountability Agreement” (MSAA). Much like the FHTs contracts, the contract language is fairly standard, with additional schedules that require, among other things, a Service Plan with budget, performance indicators and targets.

MSAAs are put in place for 3 year terms; all of the current ones terminate on March 31, 2017 – same day as the FHT contract – however, the LHINs have just decided at the advice of the MSAA Advisory Committee to extend their MSAA for one year to March 2018. This will give 2017-18 to make changes as per Patients First implications. There is talk of a possible “PCSAA” for all CHCs, AHACs NPLC and FHTs.

Overall – the **activities** required of the Health Service Provider (HSP) are similar to what’s required of FHTs and NPLCs, but the **specifications** appear much more stringent.

- **Planning activity:**
 - Must also provide multi-year plans including financial forecasts and plans for achieving performance targets.
 - Requires community engagement in establishing service priorities and plans
 - Requires HSP to work with other providers to identify and coordinate services

- **Reporting requirements:**
 - MSAA sets out the Sector Specific and Core Indicators that must be reported for Accountability purposes, as well as Explanatory Indicators ²
 - Presumably this will be revised once the Ministry completes its plan to introduce a “Provincial Performance Measurement Framework” for all of primary care.
- **Performance improvement:**
 - Includes requirement to “strive to achieve on-going performance improvements”
 - To deal with “Performance Factors”— “any matter that could or will significantly affect a Party's ability to fulfill its obligations under this Agreement”; there is requirement to “notify the other Party as soon as reasonably possible after the Party becomes aware of the Performance Factor”.
- **Declaration of Compliance:**
 - Within 90 days of the HSP's fiscal year-end, the Board must issue a Compliance Declaration declaring that the HSP has complied with the terms of this Agreement.
- **Dispute resolution:**
 - Sadly, there is NOTHING about this in the MSAA nor in the FHT and NPLC contracts.
 - The HSA (for hospitals) apparently does have dispute resolution language.

There are additional requirements that do not appear in FHT nor NPLC contracts at all. These include:

- **CEO Performance Agreement:**
 - This provision is completely foreign to the FHT + NPLC contracts and in the FHT environment, would be very challenging to implement.
 - It states: “the HSP has, or will have within 60 days of the execution of this Agreement, a Performance Agreement with its CEO that ties the CEO's compensation plan to the CEO's performance” (sec. 10.3).
- **Financial reduction:**
 - MSAA sets out a series of conditions where “at the discretion of the LHIN, the HSP may be subject to a financial reduction.” These all have to do with non-compliance with planning, reporting and service delivery commitments.

² Indicators in MSAA for CHCs:

SECTOR SPECIFIC INDICATORS	CORE INDICATORS	EXPLANATORY INDICATORS
Cervical Cancer Screening Rate (PAP Tests)	Fund Type 2 Balanced Budget	Cost per Unit of Service by Functional Centre
Colorectal Cancer Screening Rate	Proportion of Budget Spent on Administration	Cost per Individual Served (By Program/Service/Functional Centre)
Inter-professional Diabetes Care Rate	Percentage Variance Forecast to Actual Expenses	Turnover Rate
Influenza Vaccination Rate	Percentage Total Margin	Repeat Unscheduled Emergency Visits within 30 days for Mental Health Conditions
Breast Cancer Screening Rate	Service Activity by Functional Centre	Repeat Unscheduled Emergency Visits within 30 days for Substance Abuse Conditions
Periodic Health Exam Rate	Variance of Forecasted to Actual Units of Service	Percentage of Acute Alternate Level of Care (ALC) days (closed cases)
Vacancy Rate (NPs and Doctors)	Number of Individuals Served	
CHC Clients Hospitalized for Ambulatory Care Sensitive Conditions (ACSC)		
Individuals Served by Functional Centre		

3.4 Physician environment

OMA members rejected the ratification Tentative Physician Services Agreement on August 14. This cancelled provisions to broaden entrance to FHOs as well as the commitment for OMA + MOHLTC to review/re-negotiate terms of family physician contracts (FHO, FHG etc.) by Nov.1.

OMA has full representation rights on all matters related to physician compensation and working conditions. [OMA's June 14 analysis of the Patients First Act](#) gives insight into positions they may take on issues related to physicians working in FHTs, e.g.:

- In reference to **Service Accountability Agreements** (Bill 210 Section 20):
The Family Health Team (FHT) Agreement expired on March 31, 2016 and the terms have been extended until March 31, 2017. It is expected that a new FHT agreement will be developed to reflect the changes proposed in Bill 210. Changes to provisions within the FHT Agreement may include accountability and performance reporting on physician-generated patient data. It is unclear how such changes will impact the collection, use, and disclosure of patients' personal health information, and what patient privacy issues may result from these potential changes. The OMA will work through 2016 to consider and identify what aspects of Bill 210 will alter the role and relationship family doctors have with FHTs and what impact they may experience as FHT services are transferred to the LHINs.
- In reference to **Reporting to the LHIN** (Bill 210 Section 37.1):
The collection of information on practice policies, profiles, wait-times and coverage is intrusive and not the LHINs role. This requirement erodes physician self-regulation, and violates the terms of the OMA's Representational Rights Agreement with the MOHLTC. In addition, this requirement seems to duplicate some existing practices, and shifts responsibility of some elements of physician agreements to the LHINs without providing LHINs with the legislative authority to administer or manage the agreements.

3.5 Questions raised by MOHLTC regarding FHT contract renewal:

- Governance
 - Are the right governance models in place?
 - Do contracts reflect the type of governance models necessary to further the success of FHTs?
 - Are governance models sufficient to enable improved integration and other goals associated with Patients First?
 - Are conflict of interest and other relation governance provisions consistent with governance best practices?
- Performance and Accountability
 - Are there opportunities through contract reform to enable improved performance?
- Physician/Provider Affiliation
 - Are there opportunities through contract reform to strengthen the relationship between affiliated physician groups and the FHT corporation?
 - Can contract reform be used to strengthen the "team" aspect of FHTs?

3.6 AFHTO member guidance to date

AFHTO's consultation process so far (see section 2.3) has greatly informed this discussion document. Each of the five topics (sections 4.1 – 4.5) include a summary of "emerging agreement" from the Sept. 16 meeting of the combined Physician Leadership and ED Advisory Councils (EDAC-PLC).

This process is building on previous direction AFHTO members had already provided on topics related to governance, accountability, team collaboration, and the FHT-physician relationship. These are summarized below:

Governance and accountability:

- Leadership Session, October 2014: The principles that emerged were articulated in the report – [Toward the next ministry contract: Principles and guidance for moving forward](#), i.e. FHTs and NPLCs are not-for-profit corporations in a health system mandated to provide appropriate, equitable, sustainable care. Their boards:
 - Are accountable to the patients, funders and members of their organization.
 - Ensure their organizations are appropriately managed and advocate for appropriate resources so that patients can access high-quality comprehensive care that is sustainably delivered and strives to meet patient and public expectations.
 - Ensure the culture of their organization supports development of high-functioning interprofessional teams.
 - Provide leadership to harmonize and optimize policies and practices for effective and efficient teamwork within the organization and with other entities contributing to the health and health care of the organization's patients and community.
 - Provide leadership and collaborate with other organizations to spread best practice and encourage growth in capacity so that all Ontarians can have access to high quality interprofessional comprehensive primary care.
 - Ensure that patients and community members are engaged in the development of programs and services.
- Leadership Session, October 2015 resulted in the report – [Leading Primary Care through the Next Stage](#).
 - Topics included "skills and competencies most in need on FHT/NPLC boards". Polling revealed that:
 - About 2/3 of the 200+ participants were in FHTs/NPLCs that had or were moving toward identifying necessary skills and competencies and nominating board members to fill these needs
 - 40% expected to see an increase in community presence on their boards.
- In December 2015 AFHTO engaged members to develop [recommended indicators to meet 2016-17 reporting requirements](#), which were submitted to the Ministry.

- In AFHTO’s member consultations to develop its response to government’s *Patients First* proposal, leaders of AFHTO member organizations expressed great concern about the implications of dual reporting to the Ministry and LHIN. AFHTO probed this further, to develop an [AFHTO position on accountability and contractual relationships, included in its response to government](#). Recommendations related to governance and accountability include:
 - Consistent performance measurement is critical:
 - Listen to field to ensure indicators are measurable, meaningful and manageable.
 - Adopt the “Starfield Principles” to track and evaluate performance, make informed investments, and deal with inequities over time
 - Streamline multi-level reporting requirements and processes, and provide feedback to teams
 - Ministry must establish minimum requirements for the LHINs’ role in planning and overseeing primary care, and hold LHINs accountable for meeting those requirements
 - Ministry and LHINs must ensure that funding and performance requirements set out in contracts with primary care organizations, individual or groups of primary care providers, and other entities are aligned to achieve desired outcomes for the population and the health system
 - As capacity and trust are developed within each LHIN over time, evaluate whether funding and contractual relationships should remain with Ministry or shift to LHIN

Team collaboration and the FHT-physician relationship:

- The call for boards to “Provide leadership to harmonize and optimize policies and practices for effective and efficient teamwork within the organization” first appeared in [Toward the next ministry contract: Principles and guidance for moving forward](#).
 - The September 2014 AFHTO leadership survey that shaped this document found that 80% of respondents agreed that “greater harmony between the physician-funded groups and the FHT-funded groups is essential to the FHTs moving forward to ensure optimal interprofessional comprehensive primary care.” PLC members agreed on the opportunity to assist FHTs in harmonizing working relationships and practices for effective and efficient teamwork
 - AFHTO’s Physician Leadership Council (PLC) has consistently supported and offered direction for promoting greater harmonization – see the [Report on the inaugural meeting of the Physician Leadership Council](#) in January 2015, and [PLC reports from March 2015](#) and [January 2016](#) .
- The need to address various funding-related impediments to team collaboration were identified in an [AFHTO letter to OMA Negotiations Committee, Nov.2013](#) . This letter was prepared with significant input from a physician consultation session held at 2013 AFHTO Conference, led by Dr. Suzanne Strasberg, an OMA Past President. These included:
 - Incentives that can lead to duplicated work and/or are not fully conducive to full scope of practice (e.g. diabetes and preventive incentives)
 - Support for physician work in non-clinical tasks such as Health Link development, Quality Improvement Plans, data collection, etc.

- Capitation fees in teams where both NPs and FPs are primary providers.
- Need for a sustainable model for funding EMR infrastructure

3.7 Legal guidance on shared liabilities between FHT and FHO (physician group)

Through discussions with members to date, the following legal questions have emerged so far:

- To what extent are FHT and FHO truly separate, or are there elements where they already share legal liabilities (e.g. for staff, health + safety, patient complaints/adverse events)?
- When it comes to patient complaints and adverse events, what are the advantages or disadvantages of maintaining completely separate FHT and FHO compared to having contractual relationship between the two?
- Any further advice on whether legal liabilities are increased or decreased when FHT and FHO are kept completely separate or have a contractual relationship?

AFHTO has engaged Kathy O'Brien, DDO Health Law, to provide advice. It will be distributed separately, as soon as available. Thanks once again to AFHTO members who made a voluntary contribution to the Legal and Consulting Fund, which has enabled this work.

4 Top five issues for AFHTO members (so far)

4.1 One standard FHT contract, regardless of board makeup

4.1.1 *Current state:*

- Contract specifies one of three forms of governance – physician-sponsored, community-sponsored or mixed governance.
- Key difference is that current “community-sponsored” (CS) template includes detailed provisions related to physicians paid through the Blended Salary Model (BSM)
 - Section 4.2 says – “As a condition of Funding, the CS must enter into and maintain a physician services contract containing the mandatory provisions set out in Schedule “1” herein.”
 - Blocks ability to contract with other physicians unless they join as BSM (barrier to broadening access to teams)

4.1.2 *Emerging agreement from EDAC-PLC meeting:*

- Greater flexibility needed to evolve governance models and physician relationships. Therefore, aim for one form of contract, with separate schedules as needed to allow for different governance/funding models.

4.1.3 *Next steps for AFHTO and members:*

- Establish working groups to determine the content needed for these schedules. Situations where schedules are needed include:
 - For FHTs with physicians paid under Blended Salary Model – e.g. how they are to be paid, expectations/clarifications re role.
 - For FHTs with associated FHO/FHN/etc. – whatever expectations/clarifications as to role of each, e.g. who pays for what.
 - Any other special situations where expectations need to be clarified/defined, e.g. Aboriginal, Academic, Francophone, FHT is dept of larger organization
- Anticipate having to deal with issues related to different governance models, i.e. perceptions/concerns about:
 - Conflict of interest on physician boards
 - Limited provider input on community boards

4.1.4 *Question for participants at Leadership Session*

- Quick poll:
 - **Q.** Do you agree with move toward one FHT-MOHLTC contract template, and establishment of working groups to determine the content of the schedules needed to deal with unique circumstances (e.g. Blended Salary Model physicians; academic, aboriginal and/or francophone status, etc.)
 - 1) Agree
 - 2) Disagree
 - 3) Don't know

4.2 Defining the “team” and fostering “teamwork”

4.2.1 *Current state:*

- [Research evidence](#) suggests that primary care is most effective when there is a long-term, continuing relationship with physician or NP, working as a full collaborator in an interprofessional team.
- Except for the 20 FHTs that have physicians in the Blended Salary Model, the other 164 FHTs work in a **“two-corporation” model**, where the FHT and one or more physician groups (FHO, FHN, RNPGA or APP) are separate entities.
- To deal with the Blended Salary Model, the community-sponsored (CS) contract states -- “4.2 As a condition of Funding, the CS must enter into and maintain a physician services contract containing the mandatory provisions set out in Schedule “1” herein. The CS must provide a draft copy of its proposed physician services contract for review and approval by the Ministry and the OMA prior to the commencement of this Agreement, or, at the option of the Ministry, a certificate addressed to the Ministry and the OMA, confirming that all mandatory provisions as set out in Schedule “1” have been included without amendment in the CS’s physician services contract.”
- Only reference to physician expectations in the physician-sponsored and mixed contracts is – “2.6 It is a condition of the Ministry’s continued funding that all patients of the physicians in an affiliated Primary Enrolment Model to the Family Health Team have equal access to the Family Health Team services including the services of the interdisciplinary health providers.”
- Any FHT could decide to put in place FHT-physician contracts, without being required to do so by MOHLTC. A few have entered into various forms of contracts already, typically dealing with financial and operational matters.

4.2.2 *Emerging agreement from EDAC-PLC meeting:*

- By definition, a team implies accountability of each member to the others. Have to find a way to support this.
- Both cultural and structural change are needed to move forward. Physicians are key members of team – need to promote culture that thinks about FHT-FHO as a whole
- Need further exploration with membership to determine extent to which this could be expressed in a Ministry – FHT contract.
- What is clear from members is that both FHT and physician contracts must be addressed simultaneously – high level of interdependence.

4.2.3 *Issues and opportunities raised in EDAC-PLC discussions*

- Need to pay careful attention to physician leadership and incentives. Physicians are used to being autonomous; this is a significant cultural shift.
- Could requirement for a contract between FHT and physicians (as a group and/or as individuals) help to harmonize relationships?
- Should FHT be allowed to contract with individual physicians, in addition to or instead of physician groups? Is it helpful to have such a mechanism to deal with “outliers”?

- Could contracts with individual physicians outside of the team help to support effective team functioning while expanding access to those most in need?
- Impact of “voluntary” vs “mandatory” approach?
- Challenge for a physician-governed board to negotiate a FHT-physician contract, particularly in a small FHT where the physicians ARE the board. Would need an alternative mechanism.
 - Could possibly be managed through development of a Ministry-approved template that specifies minimum requirements (as is currently done with BSM MDs). Ministry may want to retain right for final approval of all such contracts. OMA must have representation rights for all these contracts.
- Changes to the FHT contract and working conditions need to keep in mind what makes physicians want to work in a team environment, and what could make them leave or stay away:
 - Most attractive advantages for physicians: Getting support from other professionals, ability to take time off, confidence in ability to provide better care for patients.
 - Biggest dangers that could drive them away: Feeling that they are forced to do things that they don’t believe is important (e.g. accountability measurement, QI, team meetings); Perceived reduction in autonomy
 - Appeal to why physicians want to have access to teams – quid pro quo is to agree to collaborate, and collaboration requires accountability to the patient and the team

4.2.4 *Potential actions identified for AFHTO and its members*

- Identify the extent to which FHTs + FHOs already share legal liabilities (e.g. for staff, health + safety, etc.) -- LEGAL ADVICE WILL BE DISTRIBUTED FOR MEETING. NOTED IN SECTION 3.7.
- Through AFHTO – explore, evaluate and spread tools + techniques that promote team culture
 - Key is to develop common purpose + measure progress toward it.
 - Ways in which to get FHT + FHO to have common purpose?
 - Encourage FHO to sign on to Quality Improvement Plans (QIPs)
 - Two-thirds of AFHTO members are participating in D2D:
 - How to encourage further adoption of measurement, as a way to strengthen collaboration across physicians + teams
 - Opportunity to use D2D and Schedule A indicators to help physicians see contribution of team?
 - Find out how many FHTs have a current contract with physicians in place and how effective this approach has been
 - Refine/share templates for FHT-FHO agreements
 - If FHT-physician contracts were to be mandated:
 - Need to consider the change management principles and training that would be required to implement contractual agreements successfully
 - Advocate to MOHLTC + OMA to:
 - Determine a sustainable model for funding EMR infrastructure for the whole team. Potential enticement: EMR funding tied to requirement to deliver data to team and share access with team
 - Support physician work in critical non-clinical tasks such as QIPs, HL development, etc.

- Introduce intermediate incentives/consequences in FHO contract that would give FHO colleagues a mechanism to deal with non-compliance, short of expelling the person from the FHO
 - Need for more holistic approach to look at both the physician compensation and FHT funding models
 - Need to design and implement more balanced and evidenced-based approaches to compensating physicians (and FHTs as well) for the complexity and size of their rosters
 - Current incentives can lead to duplicated work and/or are not fully conducive to full scope of practice (e.g. diabetes and preventive incentives)

4.2.5 *Issue for discussion*

- **Discussion at tables:**

- Optimal performance in a primary care team requires physicians to play full role. This suggests MOHLTC contract should require FHT board to be accountable for performance of whole team, including physicians. It should also ensure board has the power/expectation to develop whatever form of accountability with team members that they feel is best. Following from this:

- What do boards need to help them govern the full team? Consider legal, structural, financial and cultural aspects. Distinguish between what should be mandated through the contract and what should be done voluntarily (structure versus culture).

- **Quick polls following debrief:**

- **Q.** Does your FHT currently have a contract with physicians (yes, no, not sure)
- **Q.** Should FHT-physician contracts be introduced as a mechanism to help harmonize relationships and support accountability of the TEAM?
 - 1) Yes – mandatory contracts between FHT and physician group(s)
 - 2) Yes – mandatory contracts between FHT and each physician
 - 3) Yes - Both a + b:
 - 4) Keep as is – FHT boards and physicians can develop voluntary agreements if they wish
 - 5) Not sure
- **Q.** Should FHT governors be accountable for performance of the whole team, including physicians? (yes, no, not sure)
- **Q.** What should be included in a ministry-FHT or FHT-physician agreement to support high-quality care and a quality work environment? (**select all that apply**)
 - 1) Use of and access to EMR?:
 - 2) Participation in developing/implementing team-based programs and services?:
 - 3) Participation in TEAM level accountability reporting
 - 4) Participation in measurement and improvement activities?

4.3 Defining the “population” for which governors are accountable

4.3.1 Current state:

- With the *Patients First* focus on equity, access and greater integration, MOHLTC is moving to a population approach and access to teams for those most in need.
- What role do FHTs want to play in their subLHINs?
 - Do they want to take a significant leadership role, with accountability for a population?
OR
 - Participate with others in planning for population, but accountability remains to rostered patients.
- All 3 FHT templates currently define their responsibilities in terms of the patients rostered or enrolled to physicians in the team. The NPLC contract simply ties funding “directly to the Clinic’s total number of patients ... accessing Clinic services”. The MSA for CHCs references this solely through the accountability indicator “Number of Individuals Served”.
- The community-sponsored template includes numerous specifications regarding enrollment and services for patients.
- The physician-sponsored and mixed governance templates contain these provisions:
 - “2.6 It is a condition of the Ministry’s continued funding that all patients of the physicians in an affiliated Primary Enrolment Model to the Family Health Team have equal access to the Family Health Team services including the services of the interdisciplinary health providers”
 - “3.9 The Ministry’s Funding commitment under this Agreement and the corresponding approved IHP complement, has been determined in part, by the patient enrolment commitments set out in the Recipient’s original business case.”
 - “6.1.f.i requirement to submit Annual Report that includes information on “success in reaching roster targets”
- For reasons of equity and integration, Ministry has indicated desire to expand access for patients who’d most benefit from team-based care
- Based on [research evidence](#) on the need for physicians to be an integral part of the team (i.e. not a referral model), AFHTO position paper – [Optimizing value of and access to team-based care](#) – says “Do not expand access unless family physicians are ready to commit to minimum requirements for meaningful collaboration and communication.”
 - (It also says “Do not expand access unless capacity is sufficiently developed, such that additional demand can be managed without causing unacceptable increases in waits for appointments and/or decreases in quality of care.”)
- Must clearly distinguish between:
 - FHT’s capacity to provide IHP services to patients who have a physician outside the FHT ... versus ...
 - FHT physicians agreeing to take on orphan patients

4.3.2 *Emerging agreement from EDAC-PLC meeting:*

- Definition of population is important if interprofessional primary care teams want to lead in subLHIN regions; require a flexible approach that could change over time:
 - Some FHTs are ready, willing and able to assume responsibility for whole community (especially if they're the only game in town).
 - Some FHTs are mandated to serve a specific population unrelated to geography (e.g. Inuit, Francophone, transient clients of a homeless shelter)
 - Others are not ready, are highly resource constrained, and/or are in a community where an appropriate definition of population is VERY difficult (e.g. Toronto Central LHIN)
- Do NOT sacrifice quality to expand access to teams – “spread” not “stretch”.

4.3.3 *Next steps*

- Measurement is absolutely critical to be able to track the relationship between HR capacity, quality and total cost of care. This is what D2D is all about.
 - How do FHT leaders and AFHTO get all teams, including their physicians, to participate?
 - Can we continue with this voluntary approach, or must it be mandated through contracts? (Ministry-FHT, Ministry-FHO, and/or FHT-FHO)
- FHTs must measure to be prepared for opportunity to have LHINs reallocate funding to reduce total cost and advocate for appropriate resources to meet community needs
- Continue to advocate based on AFHTO position paper – [Optimizing value of and access to team-based care](#) . As found in [research evidence](#) :
 - NOT referral model – “Do not expand access unless family physicians are ready to commit to minimum requirements for meaningful collaboration and communication.”
 - “Do not expand access unless capacity is sufficiently developed, such that additional demand can be managed without causing unacceptable increases in waits for appointments and/or decreases in quality of care.”
- AFHTO needs to seek advice for members on liabilities, and how to mitigate those liabilities, if FHT opens doors to patients of other doctors
- Continue to support members to improve their ability to do needs assessment to determine highest priority programs and evaluate their impact (Schedule A)

4.3.4 *Issue for discussion*

- Quick polls to test level of agreement:
 - **Q.** What constitutes the “population” for which FHT governors should be accountable?
 - 1) FHTs should play a leadership role, with accountability for the sub-LHIN population:
 - 2) FHTs should participate with others in planning for the sub LHIN population, but accountability should remain to rostered patients
 - 3) Not sure

4.4 Defining minimum standards of governance / addressing conflict of interest

4.4.1 Current state:

- **Self-governance:** All three forms of FHT contract and the NPLC stipulate this requirement. All forms of FHT contracts include the following statement:
 - Autonomous Family Health Team: Family Health Teams are autonomous self-governing corporations with administrations and Boards of Directors that are responsible and accountable for the management and quality of care delivered by their organization. Each Family Health Team is fully responsible for determining its own governance arrangements within the Ministry framework as described in the Ministry’s Family Health Team Guide for Governance and Accountability.” (sec.13.1 in physician-sponsored+mixed)/20.0a in community-sponsored)
- **Conflict of Interest:** Concerns around governance quality, in particular perceived and real Conflict of Interest, continues to hold back confidence in the FHT model.
 - All Ministry and LHIN primary care contracts include provisions requiring Recipient to immediately disclose to the Ministry any situation that amounts to a conflict of interest.
 - The Physician-sponsored and NPLC contracts add the stipulation – “All non-arms length transactions between the Family Health Team and its members and/or their family members must be based on the fair market value of the services and/or supplies exchanged, and must be appropriately disclosed in the financial reports and audited financial statements provided by the Family Health Team to the Ministry. (section 8,3)
- **Specified requirements for governance:** There are also concerns about the variation in the quality of governance. The community-sponsored contract says nothing more beyond the paragraph on “Autonomous Family Health Team”. The physician-sponsored + mixed contracts include the following requirements, which is similar to what is found in the NPLC contract:
 - “The Recipient shall establish and maintain a governance structure (or by-laws if incorporated) that addresses matters that include:
 - (a) the establishing of a bank account and signing officers;
 - (b) the determination of a minimum of two elected officers who will jointly be able to bind the Recipient in matters pertaining to the execution of reports, budgets, agreements, amendments and disbursement of Funds pertaining to this Agreement;
 - (c) in the event that the Recipient is comprised of more than one legal entity, the ownership of assets purchased with the Funds;
 - (d) management of the Family Health Team;
 - (e) in the event that the Recipient is comprised of more than one legal entity, a process for admission or deletion of parties to this Agreement;
 - (f) a process for the admission or deletion of Members in the Family Health Team Corporation (if applicable);
 - (g) the sharing of financial information pertaining to this Agreement.”
- **Annual Governance and Compliance Attestation requirement:** Two years ago, with input from AFHTO, the Ministry introduced this. Each year FHTs and NPLCs are required to confirm whether a number of governance fundamentals are in place. For teams that do not meet these requirements, the Ministry asks AFHTO to contact them to offer training or other support. Just over half have taken up this offer. The requirements are:

- Board practices: annual meeting, regular board meetings, strategic planning and operational review, bylaws review, insurance, public complaints and dispute resolution policy and process, conflict of interest policy and process
- Board structures: committee structures that focus on quality improvement, audit, HR, information management
- Board self-evaluation: board member roles documented, board recruitment strategy document, board performance self-evaluation tool, at least one-third of board has board experience and/or received training
- Board fiduciary functions: ED job description and performance evaluation process, performance measures monitored, financial policies and processes documented, quality improvement plan, risk management plan, board performance monitoring
- Governance policies: Board policy manual, sign agreement of each board member to Conflict of Interest and Code of Conduct policies
- Organizational maturity: staff recruitment and retention documentation
- **LHIN MSAA:** This requires the Health Service Provider to warrant that it has established and will maintain policies and procedures on code of conduct, conflict of interest, effective decision-making and management of funding (sec.10.3) . In addition, it requires board to have:
 - Policy and process for addressing complaints
 - Processes to “monitor and ensure accurate and timely fulfillment of the HSP’s obligations under this Agreement and compliance with the Act”
 - A Performance Agreement with its CEO that ties the CEO's compensation plan to the CEO's performance
- **Increasing challenge to recruit volunteers for board:**
 - For physician boards: hard to move beyond the same few people
 - For outside reps in smaller communities: smaller pools of candidates to serve on boards, who are also sought for other local organizations.

4.4.2 *Emerging agreement from EDAC-PLC meeting:*

- State minimum standards in contract to foster greater consistency. FHTs with weak governance bring whole sector into disrepute. Use items from Governance and Compliance Attestation.
- Value in moving to “skills-based” boards (Provider board could be a skills-based board)

4.4.3 *Next steps for AFHTO and members*

- Conflict of interest has to be addressed – this is a risk for future of FHTs
- Through AFHTO – explore, evaluate and spread tools + techniques that promote evolution of boards to become more skills-based and patient-centred, e.g.
 - Competency matrix and interview process for board selection
 - Use D2D results to assess relationship between performance + governance type
 - review/update bylaws as needed to be clear about membership in corporation and how board directors are chosen

4.4.4 *Issue for discussion*

- **Discussion at tables:**
 - What should be included in the contract as the minimum set of governance expectations for FHT governance? In particular, what requirements should be stated to reduce perceived or real conflict of interest?

4.5 Accountability and dispute resolution

4.5.1 *Current state:*

4.5.1.1 *Accountability reporting*

- AFHTO has lobbied intensively for more meaningful and manageable reporting requirements. This has resulted in MOHLTC agreement to change the “Schedule E” reporting requirement from activity counting to something more meaningful, to be implemented for March 2017 reporting.
 - AFHTO has submitted the [recommended indicators to meet 2016-17 reporting requirements](#). The Ministry has not yet communicated what the final requirements will be.
- AFHTO also worked closely with MOHLTC to improve the effectiveness and efficiency [“Schedule A” reporting on program and services](#). This includes development of a [Schedule A Indicator Catalogue](#) to help members select appropriate measures to report for their programs.
- *Patients First* calls for primary care performance reporting to LHINs and creation of a provincial performance measurement framework.
- AFHTO members are highly concerned that dual reporting to LHIN and MOHLTC will greatly increase the reporting burden.

4.5.1.2 *Two-way accountability*

- While govt funding, policy and the Physician Services Agreement are out-of-scope for this consultation, the MOHLTC-FHT contract should recognize the accountability of the Ministry to enable and promote efficient and integrated high-quality care through these levers.
- In particular, if Ministry/LHINs want access to teams to be expanded, capacity must sufficiently resourced and developed, such that additional demand can be managed without causing unacceptable increases in waits for appointments and/or decreases in quality of care.”

4.5.1.3 *Dispute resolution between FHT and funder:*

- Re contract administration (e.g. interpretation of policy and contractual requirements, process by which payment could be reduced or suspended or recouped by Ministry)
- Re determination of funding level and performance targets

4.5.2 *Emerging agreement from EDAC-PLC meeting:*

- Members agreed on accountability principles at 2014 Leadership Session. This led to member recommendations for indicators to replace Schedule E reports at end of 2016-17
- High need for dispute resolution mechanism
- Accountability and authority must be aligned.
- Also need to revise sections of contract that tie funding to patient enrollment commitments – out-of-date! (section 3.9 in physician-sponsored and Mixed contracts)

4.5.3 *Next steps*

- To get AFHTO recommendations implemented in contracts, and agree on process for further evolution of reporting requirements.
- Advocate for dispute resolution mechanism
 - Use the language in the LHIN-Hospital SAA as a starting point (see section 3.3)
- In that context, need to determine:
 - What the measures will be, and what (if any) targets/thresholds will be set
 - Reporting schedules and their content
 - Points to critical importance of QIDS Specialists + QIDS Program, and indicators that capture role of team. Continue to promote to MDs

5 Next steps

5.1.1 *Final questions for this meeting*

- **Discussion at tables:**
 - Having read the material and heard the comments today, when it comes to the next contract your FHT will have to sign with MOHLTC for April 1:
 - What are you most hopeful about?
 - What are you most concerned about?
 - What is the one most important thing that we, collectively through AFHTO, need to do?
- **Quick poll :**
 - Q. AFHTO is the champion for members and interprofessional primary care. To what extent should AFHTO's role be more like a:
 - "Cheerleader" that celebrates good performance and showcases it to others; Or
 - "Coach" who celebrates the good and also points out deficiencies, all with the view to encourage and push teams to improve where needed.
 - Balance of the two
 - Don't know

5.1.2 *After this meeting*

AFHTO staff will compile the results into a meeting report to share with members and the AFHTO board. AFHTO will continue to inform and consult with members to develop positions as issues emerge. These results will form the basis for what AFHTO will advocate for the next FHT contract template.