



association of family
health teams of ontario

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February 6, 2017

Feedback on the Family Health Team Contracts

Dear Nadia and Fernando,

Thank you for meeting with AFHTO and providing us with the changes that the Ministry is contemplating in the upcoming new FHT contract. On February 1st we provided you with the feedback from the ED contract working group – below are those comments as well as some feedback from a few physicians to the proposed changes (listed by each change that is being proposed):

1. Require **FHT boards to be skill-based** in their composition; transition from three agreements, currently defined by board composition, into one agreement for all FHTs.

Generally, all are fine with this requirement but in the technical briefings, it will need to be made clear that the boards need to be skills based NOT mixed governance. AFHTO also has examples of skills matrices if you are looking for examples to include in the contract.

2. **Strengthen conflict of interest provisions** to ensure conflict at the governance level is managed appropriately and incorporated into Board by-laws.

All fine with this requirement.

3. **Require all FHTs to incorporate** as non-profits consistent with the Ontario Not-for-Profit Corporations Act 2010, unless otherwise exempted by the ministry.

All fine with this requirement with the following comments:

- Ensure that there is enough time as going through incorporation can take 6 to 9 months – please make sure one time funding is provided to FHTs who will need to hire lawyers familiar with incorporation filings.
- In the technical briefings, the Ministry will need to be clear that any FHTs looking for an exception will need a well laid out plan as to why incorporation is not in the best interest of the FHT (i.e. ones affiliated with hospitals and/or academic institutions).

4. Require all FHTs to have a formal mechanism to include **patient and community input into FHT planning and priorities**, including input from the Local Health Integration Network(s) within which the FHT is situated.

More on this later in the document with regards to relationship with the LHIN but for the technical briefings, please ensure that FHTs are aware of a few options that they can employ, including the

patient satisfaction surveys which all FHTs do for their QIPs. This does not mean having to create Patient Advisory Councils or patient focus groups.

5. Require the FHT Board to secure a **commitment from its affiliated physician group to participate in the development and implementation of the FHT's Quality Improvement Plan**, consistent with the 2012 commitment with the Ministry and the OMA.

This requirement had the most feedback from the EDs and the physicians and the most concerns – how do you hold FHT Boards to account for commitment when physicians are not accountable to the FHTs.

Some feedback:

- Without board authority over physicians most don't see how this can be achieved with any certainty. The present climate is a definite obstacle but even if this gets addressed in the coming year through negotiations between the OMA and Ministry, there will be challenges beyond the control of FHT boards. Any alignment between FHT QIPs and physicians will likely be based on culture rather than obligation.
- Currently EDs are struggling with physicians giving them or even the QIDSS 'permission' to access the EMR...if a physician does not participate in the QI work, it can also be a detriment to the FHT in terms of getting the shared group data (like SAR, PCR) – aggregate data for the affiliated physician groups MUST be available to the Board to improve (there are many examples of physicians blocking accessing to reports which impedes measurement). What is the recourse if they don't participate? How do you secure commitment?
- AFHTO will be collecting examples of FHT-FHO MoUs and Frameworks for those interested but that is not going to change culture – what is happening at the Ministry to ensure this can be a reality amongst all FHTs and it doesn't punish patients?

Certainly the current mood amongst the physician groups would not make them very willing dance partners and for some groups it would be impossible to accomplish.

6. Include a **statement of goals** within the FHT contract to guide Boards in their decisions and to achieve less variation in the model of care.

Statement of goals is much needed but there are some challenges the Ministry needs to be aware of:

- There currently is tremendous push back around ownership of EMR, especially giving access to people that the physician may not personally know (e.g. in larger FHTs that are multi-sited); again, what is the recourse if access to EMR is not even guaranteed? Should there be a recommendation in the contract referring to a data sharing agreement but how to manage that? And what if physicians still don't give access?
- Some FHTs are moving to become the HIC and the physicians agents but is there funding in place so that FHTs can manage the breaches that may ensue? It is collaborative care but it puts huge liabilities on the FHT and there needs to be assurances that right protocols are in place in the event of a breach and, more important, the correct insurance is in place. CMPA will still cover the physician in the event of a breach but they will not cover the FHT as a HIC.
- How do you manage if the FHT has opened its doors to other physicians in the community – who bores the liabilities? EMR accessibility? Capacity? Are they members of the corporation? Should they be signing something with the Board? While these may be organizational specific questions, people would like some answers on how to mitigate these challenges, especially as they face increasing pressure 'to open up their doors'.

- What if some physicians do not agree with the mandate as per above and no longer want to be part of the FHT? How to manage if they remain as part of the FHO? Removing FHT services only penalizes the patients.

7. Require FHTs to deliver programs based on a **community needs assessment**, in consultation with the Local Health Integration Network(s) where the FHT is situated

Some comments on this requirement:

- What is meant by a community needs assessment? For their patient population? For the community? Who will fund this? Is this not the responsibility of the planners (i.e. the LHIN?)
- How will smaller FHTs deal with this? If other stakeholders (hospitals, etc.?) are leveraged for this, what assurances are in place that bias will not be introduced? The "needs" will have to be determined by primary care in consultation with the LHIN and not be influenced by "special interests" that may have a longer-term relationship with LHINs.
- How do you we support FHTs who are in multiple LHINs with multiple priorities – FHTs do not have a catchment area and this is going to be leading to a lot of duplication in administration.

8. In supporting schedules to the contract, incorporate standardized **measures/indicators related to outcomes** and establish associated reporting requirements.

Please use measures already being used like D2D – do not add new ones!

9. Include requirement for FHT to submit **Quality Improvement Plan** annually to Health Quality Ontario and Ministry of Health and Long Term Care

All in agreement

10. The FHT is required to **participate in Sub-LHIN region** initiatives including Health Human Resource planning

The LHIN needs to do the outreach as well – who is holding them accountable? Most LHINs have decided to work with the solo or unorganized primary care and have not engaged FHTs yet. This statement is very vague and is the most contentious with physicians – will the LHIN hold the FHT accountable if the physicians do not want to participate?

11. Enhance existing enforcement provisions in the agreement to improve monitoring and disciplining of teams.

All in agreement that this is very much needed with a recommendation that a dispute resolution mechanism needs to be entrenched into the contract even with the "graded responses" to poor performance proposed. What about rewards for high performers?

12. The FHT must ensure **stable and fixed hours of operation** to allow for patient access and predictability.

Fine if in agreement that this just the FHT hours.

13. The FHT must ensure patients with urgent health conditions have the ability to **receive service within 48 hours** of contacting the FHT

Need a definition of urgent – everything is urgent to someone who is sick. And receiving services needs to be better defined as that could be everything from a home or clinic visit to a phone call or email. This statement needs more clarity.

14. The FHT is encouraged to address the **linguistic and cultural needs** of the population being served, where possible, and to address health equity through efforts to reduce health disparities through primary care programs, services and partnerships

Opportunity through the technical briefings to encourage FHTs to start working with their LHINs. Part of the LHIN health equity framework is ensuring services are culturally and linguistically accessible and they should be responsible for planning with resourcing – finding things like translation services should not be a burden on the FHTs' already tight budgets.

15. The FHT must ensure that patients are made **aware of hours of operation** through clearly visible clinic signage, voicemail, patient pamphlets, practice website and other means

Mention of website and email in this proposed change which can carry huge medical/legal liability for the FHT. Either in the contract or in the technical briefings please make sure there is mention of cyber insurance and FHTs should move to encrypted email (even if emails are not for medical inquiries, patients will often use it as a convenient tool of communication).

16. The **FHT must have an email address** that patients can contact for inquiries and complaints

As per above regarding email but also ensure in the technical briefings that there is a complaint policy for the FHT (as an agent) and the FHO (as the HIC). Unless the FHT is the HIC or handles complaints for both the FHT and the FHO.

Other Considerations:

1. The biggest concern for the FHTs (shared by the EDs and the physicians) is all the mention in the contract about working with the LHIN – the uncertainty around the lack of a physician services agreement and the current environment between the OMA and the Ministry means that there is zero goodwill by most physicians, even those leaders that are working with the FHTs. The biggest risk right now is having physician-led or mixed governance Boards NOT sign the contract, putting the FHTs and their Boards in a very difficult position.
2. Roll out of the contract should be 6 months with an extension of another 6 months to any of the FHTs who need it – there are FHTs out there that could use these changes as building blocks for planning in the next few months (tighter timelines bring a sense of urgency).
3. Most are not interested in Evergreen Contracts – prefer 3 years at most given the changing environment we are currently in (with the intention of revising the contract **early** in year 2).
4. Although mention was made that most schedules are going to remain the same (with changes to Schedule E to reflect the new indicators), please consider putting in schedules for FHTs that have

added funding and/or expectations provided to them making them unique in their composition. For example:

- (a) Academic FHTs – roster size requirements
- (b) Francophone FHTs – requirements on percentage of service that needs to be provided in French
- (c) Aboriginal FHTs
- (d) Host QIDSS FHTs – accountability to the rest of the FHTs that the QIDSS is a shared resource (this currently is presenting to be a problem and will impact the way these resources are being utilized if not better managed)
- (e) DEPs within FHTs
- (f) Blended Salary Model expectations (of course with input by the OMA)
- (g) Other

The 18 EDs that volunteered to be part of the Contract Working Group has expertise in all the areas above and can be a valuable asset in co-designing expectations or accountability schedules that are also very much needed in the new FHT contracts, especially as we move to a one contract framework.

5. There is still a lot of confusion around what a 'HSP' means and even LHINs telling FHTs that they soon will be managing them. Given we know that the annual funding contracts will remain with the Ministry for some time, please ensure you provide that message to all FHTs either in the cover letter with the new contracts or in the technical briefings.

In addition, it is becoming increasingly apparent that LHINs themselves need some education about FHTs – AFHTO would be pleased to work with the Ministry on a FAQ or principles document about FHTs/NPLCs that can go to all LHINs to get them more familiar with these models.

If you have any questions about these comments please do not hesitate to contact us – as always, we have a willing group of people who want to assist so if you need them to be convened to support the contract work please let us know.

Thanks,
Kavita