



association of family  
health teams of ontario

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Nadia Surani  
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Primary Health Care Branch  
9th Flr Suite 900,  
1075 Bay St, Toronto, ON M5S 2B1

Dear Nadia,

**RE: Feedback for Renewal of the Family Health Team Contracts**

Thank you for the opportunity to provide some feedback for the renewal of the Family Health Team contracts, which are coming up for expiration on March 31<sup>st</sup>, 2017.

As you know, AFHTO has been working very hard with its members over the last year to take a closer look at the contracts and for our members to provide some advice and feedback in areas where there needs to be either more clarity or discussion before setting course for the next contract. At our October 17<sup>th</sup>, 2016 Leadership Session, before the AFHTO Conference, over 200 Executive Directors, Lead Physicians, Board Chairs and Board members participated in a workshop where they provided the key issue that needed to be addressed and what the position should be for AFHTO with respect to the contract itself.

This letter will detail some of those issues and recommendations; however, to fully understand the intent behind the recommendations I am requesting we have a meeting so further explanation can be provided and the Ministry can better understand why the various positions are being undertaken.

**1. Move to one contract template regardless of governance model**

Recommendation:

In place of three templates for Ministry-FHT contracts (for physician, community and mixed governance) move to one standard contract template, regardless of board makeup, with appropriate schedules to address specific circumstances such as blended salary model payment for physicians, hospital governance, university involvement, etc.

Why:

- To recognize the role of governance under the Corporations Act, including the ability to determine appropriate board composition.
- To give flexibility so organizations can evolve their governance.

## **2. Fostering Teamwork**

### Recommendation:

Where there is mutual willingness to do so, by both the FHT and physician group, encourage FHT Boards to work through the development of a framework or MOU.

### Why:

- Culture is a key factor in teamwork, and it's difficult to mandate.
- The option to have an MOU would, however, prompt FHT boards to have open discussions with their physician groups to clarify, agree and write down expectations regarding roles and how the FHT and its associated physician groups work together in a mutually beneficial relationship.

## **3. Defining the “team”**

### Recommendation:

Given that FHT boards have no authority over physician groups, the contract should not hold FHT boards accountable for physician performance.

### Why:

- By definition, a team implies accountability of each member to the others. Accountability in a contract, however, must be aligned with authority. FHT boards do not have any authority over physicians – individually or as groups. At present, collaboration is based on goodwill. However, that goodwill could be set back by current concerns about the *Patients First Act* held by the OMA and other physician groups (which will have huge implications on the sustainability of a number of FHTs in the province).

## **4. Defining the population**

### Recommendation:

Contract should continue to define the FHT's accountability in terms of “rostered patients”. The contract could add responsibility for the FHT to participate in sub Region planning and collaborate with partners to arrange services for patients most in need. Where the FHT is willing and able to be accountable for the sub Region population, this could be articulated in the contract.

### Why:

- Contracts should articulate the scope of the team's responsibility, in terms of population to be served. The definition must be flexible so that each contract is reasonable and suitable for each FHT.

## **5. Defining minimum standards of governance**

### Recommendation:

To foster greater consistency across all FHTs, contract should include the items listed in the Governance and Compliance Attestation as minimum standards for governance.

### Why:

- Consistently sound governance across all FHTs and NPLCs is important to the credibility and further development of this sector.

## 6. Accountability

### Recommendation:

Reporting must be meaningful, manageable and avoid duplication:

- Articulate process to evolve reporting requirements;
- Board accountability must be aligned with their authority;
- Contract must also acknowledge accountability of Ministry + LHINs to align policy and funding with performance expectations (this is leading to much confusion in the field currently);
- Revise out-of-date sections that tie funding to patient enrollment commitments (sec.3.9 in physician-sponsored and mixed contracts).

### Why:

- Much of this follows from [accountability principles](#) that members had agreed on at the 2014 Leadership Session. Members re-iterated the points about reporting once again in consultations to prepare AFHTO's response to the [Dec. 2015 Patients First proposal](#).

## 7. Dispute Resolution

### Recommendation:

Advocate for a dispute resolution mechanism to be spelled out in the contract, as is currently in place for hospital accountability agreements.

### Why:

- To guard against unreasonable unilateral action by funder.

These are just quick summaries of recommendations our members have suggested be looked at with the next FHT contract – each issue and recommendation has an action that AFHTO and its members will be taking in the upcoming year that is not outlined in this letter. We would be happy to talk to you further about how AFHTO and its members can co-design a new FHT contract with the Ministry that better equips our teams as they move forward in the health system redesign that is currently underway.

Any questions please do not hesitate to contact me – looking forward to speaking with you and your team soon.

Sincerely,



Kavita Mehta  
Chief Executive Officer