



## **AFHTO Leadership Report:**

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

From membership input at October 17<sup>th</sup>, 2016 Leadership Session

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## Report Overview

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. While focused on the FHT contract, AFHTO is mindful of the implications for AFHTO's NPLC members and others.

This report documents the positions AFHTO will adopt and actions to be taken following from the direction that emerged from the Oct.17 AFHTO Leadership Session. The topics covered in the session resulted from 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.

Two key themes that ran through all the discussions were:

- **Recognize the three-way relationship:** Ministry-FHT, Ministry-FHO, FHT-FHO – each of these relationships impacts the others.
- **Culture has more impact than structure:** Must be aware of culture and support evolution of that culture. Contracts can't mandate cultural change, and could impede it.

AFHTO's next steps are presented in table format, over the next few pages. The table summarizes:

- Position to be taken by AFHTO with respect to the Ministry-FHT contract.
- Why this direction is being taken.
- Additional action for AFHTO and membership (subject to resource availability/priorities).

Following the table, the appendices present:

- Objective and process for AFHTO's consultation with members regarding FHT contract development.
- Detail on each of the issues that surfaced through the consultation process. Background is presented from the discussion document, followed by results from the Leadership Session.

## AFHTO action resulting from member direction

Issue	Position to be taken by AFHTO with respect to the Ministry-FHT contract	Why	Additional action for AFHTO+membership (subject to resource availability/priorities)
Move to one contract template regardless of governance model	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.	<p>To recognize the role of governance under the Corporations Act, including the ability to determine appropriate board composition.</p> <p>To give flexibility so organizations can evolve their governance.</p> <p>Results from Leadership Session:</p> <ul style="list-style-type: none"> <li>• 74% support</li> <li>• 8% disagree</li> <li>• 18% don't know</li> </ul>	<p>Set up working groups to work through the schedules. For example:</p> <ul style="list-style-type: none"> <li>• For FHTs with physicians paid under Blended Salary Model (e.g. how they are to be paid, expectations/clarifications re: role)</li> <li>• For FHTs with associated FHO/FHN/etc. – whatever expectations/clarifications as to role of each (e.g. who pays for what)</li> <li>• Any other special situations where expectations need to be clarified/defined (e.g. Aboriginal, Academic, Francophone, FHT is department of larger organization)</li> </ul>
Fostering teamwork	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.	<p>Culture is a key factor in teamwork, and it's difficult to mandate.</p> <p>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.</p>	<p><b><u>Regarding leadership + culture:</u></b></p> <p>Governance training is crucial, including need to set common vision and to establish skills-based board.</p> <p>Continue to foster participation in <a href="#">Data to Decisions (D2D)</a>, <a href="#">Schedule A planning + measurement</a>, and <a href="#">Quality Improvement Plans</a> to strengthen common purpose.</p>

Issue	Position to be taken by AFHTO with respect to the Ministry-FHT contract	Why	Additional action for AFHTO+membership (subject to resource availability/priorities)
		<p>To support the necessary evolution of culture and working relationships, boards will need to assess and decide whether an MOU or formal contract is most appropriate for their team.</p> <p>Results from Leadership Session:</p> <ul style="list-style-type: none"> <li>• 67% support mandatory MOU (31%) or contract (36%)</li> <li>• 14% said keep it voluntary</li> <li>• 19% not sure</li> </ul> <p>38% already have MOU or contract.</p>	<p><b><u>Regarding MOU and/or Framework:</u></b> AFHTO will need to engage more broadly with members/FHT physicians to:</p> <ul style="list-style-type: none"> <li>• Collect existing MOU and contract templates from members and review to develop guidance for membership.</li> <li>• Reach out to educate on what is a MOU, benefits of having one and how to develop/work with one for teams that are interested.</li> </ul> <p>Develop a case study highlighting FHTs and physician groups that have successfully implemented a MOU or framework document that is mutually beneficial.</p>
Defining the “team”	Given that FHT boards have no authority over physician groups, contract should not hold FHT boards accountable for physician performance.	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 <i>Patients First Act</i> held by the OMA and other physician groups.	While AFHTO’s position is that FHT <b>contracts</b> should not hold boards accountable for physician performance, performance is a critical ingredient to the success of the team. If the interprofessional model is to continue and spread, the value of the model must continue to be demonstrated. <p>For this reason, AFHTO will continue its work with members to strengthen leadership, governance, measurement and quality improvement.</p>

Issue	Position to be taken by AFHTO with respect to the Ministry-FHT contract	Why	Additional action for AFHTO+membership (subject to resource availability/priorities)
		Results from Leadership Session: <ul style="list-style-type: none"> <li>• 60% said FHT boards should NOT be accountable for physician performance</li> <li>• 29% felt FHT board should be accountable for performance of whole team, including physicians</li> <li>• 19% not sure</li> </ul>	In addition, AFHTO will monitor and advocate to both the Ministry and the OMA on issues that would bring greater alignment in this three-way relationship, especially in the agreements between Ministry-FHT, Ministry-physicians, FHT-physicians.
Defining the population	<p>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.</p> <p>Where the FHT is willing and able to be accountable for the sub Region population, this could be articulated in the contract.</p>	<p>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.</p> <p>Results from Leadership Session:</p> <ul style="list-style-type: none"> <li>• 30% said FHTs should be accountable for the sub Region population</li> <li>• 61% felt FHTs should participate in sub Region planning but accountability should remain for rostered patients</li> </ul>	<p>Continue to advocate for “spreading” not “stretching” access (i.e. waits and quality of care can’t be allowed to deteriorate). The AFHTO position paper – <a href="#">Optimizing value of and access to team-based care</a>) continues to be the guide</p> <p><a href="#">D2D</a> measurement is critical to be able to track the relationship between HR capacity, quality and total cost of care, and therefore have evidence for resource needs.</p> <ul style="list-style-type: none"> <li>• How do FHT leaders and AFHTO get all teams, including their physicians, to participate?</li> </ul> <p>Seek advice for members on liabilities, and how to mitigate those liabilities, if FHT opens doors to patients of other doctors.</p>

<b>Issue</b>	<b>Position to be taken by AFHTO with respect to the Ministry-FHT contract</b>	<b>Why</b>	<b>Additional action for AFHTO+membership</b> (subject to resource availability/priorities)
Defining minimum standards of governance	To foster greater consistency across all FHTs, contract should include the items listed in the Governance and Compliance Attestation as minimum standards for governance.	Consistently sound governance across all FHTs and NPLCs is important to the credibility and further development of this sector. Teams with weak governance bring the whole sector into disrepute.	<p>Based on the most consistent themes identified by many tables, develop ways in which to support need for:</p> <ul style="list-style-type: none"> <li>• Board/ED <b>training</b> in governance, role of board, and handling conflict – especially for struggling boards</li> <li>• <b>Skills-based boards</b> – this does not necessarily mean a move to a mixed governed Board but need to ensure a community perspective (and expertise) is readily available</li> <li>• Clarity in defining <b>conflict of interest</b> &amp; put in place processes to manage it</li> </ul> <p>Continue with targeted outreach to teams that could benefit from governance and/or leadership training as identified by the Ministry (through governance and compliance attestation requirements).</p>
Accountability	<p>Reporting must be meaningful, manageable and avoid duplication:</p> <ul style="list-style-type: none"> <li>• Articulate process to evolve reporting requirements</li> <li>• Board accountability must be aligned with their authority</li> <li>• Contract must also acknowledge accountability of Ministry +</li> </ul>	<p>Much of this follows from <a href="#">accountability principles</a> that members had agreed on at the 2014 Leadership Session. Members re-iterated the points about reporting once again in consultations to prepare <a href="#">AFHTO's response to the Dec. 2015 Patients First proposal</a>.</p>	<p>Member input and progress in <a href="#">D2D</a> will continue to provide direction for AFHTO's vigorous advocacy on what is meaningful and manageable to report.</p>

Issue	Position to be taken by AFHTO with respect to the Ministry-FHT contract	Why	Additional action for AFHTO+membership (subject to resource availability/priorities)
	<p>LHINs to align policy and funding with performance expectations</p> <ul style="list-style-type: none"> <li>• Revise out-of-date sections that tie funding to patient enrollment commitments (sec.3.9 in physician-sponsored and mixed contracts)</li> </ul>		
Dispute resolution	Advocate for a dispute resolution mechanism to be spelled out in the contract, as is currently in place for hospital accountability agreements.	To guard against unreasonable unilateral action by funder.	None at this time
AFHTO role with/for members	n/a	<p>Questions were asked at Leadership Session to ensure AFHTO continues to do what members most value. Should AFHTO “push” teams to improve where needed?</p> <ul style="list-style-type: none"> <li>• <i>61% want balance between “coach” and “cheerleader” roles</i></li> <li>• <i>30% - “coach”</i></li> <li>• <i>7% said remain in cheerleader mode.</i></li> </ul>	<p>Based on the most consistent themes identified at Leadership Session, <b>advocacy</b> continues to be what members value most, specifically for:</p> <ul style="list-style-type: none"> <li>• Resources</li> <li>• Primary care leadership</li> <li>• Aligned contracts</li> </ul> <p>AFHTO to take a more direct approach to “push” teams to improve where needed.</p>

## APPENDIX 1. AFHTO objective and consultation process

### 1.1 AFHTO objective re Ministry-FHT contract renewal:

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 outcomes<sup>1</sup>
- Is acceptable to all parties to the contract.

### 1.2 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.
- **Oct 17 – Leadership Session** before AFHTO conference -- *Tackling the big issues: relationship and accountability questions in Ministry contract templates.*

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<sup>1</sup> These bullets are from AFHTO's vision statement.

## APPENDIX 2. Top five issues for AFHTO members and Leadership Session results

### ***Background on the Leadership Session***

AFHTO's annual Leadership Session took place October 17, 2016, 10:00 AM – 12:00 noon, Westin Harbour Castle, Toronto. Entitled "*Tackling the big issues: relationship and accountability questions in Ministry contract templates*", the meeting's objective was:

- 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.

Board members, EDs and MD/NP Leads from all AFHTO-member FHTs and NPLCs were invited. They also received a discussion document, with the questions to be explored in the meeting. The discussion document focused on the FHT contract, with an eye on the content and implications for AFHTO's NPLC members and other primary care contracts.

The topics in the discussion document emerged from earlier meetings 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. The key topics that surfaced were:

- 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***

Roughly 200 leaders from AFHTO-member organizations attended. Sitting in tables of 10 people, participants discussed and recorded responses to open-ended questions using networked laptops. All participants had a voting keypad to record their responses to closed-ended questions. All questions had been pre-distributed in the discussion document.

This report gives details on each of the five issues that surfaced through the consultation process. Background is presented from the discussion document, followed by results from the Leadership Session.

## 2.1 Top Five Issues for AFHTO Members

### *2.1.1 One standard FHT contract, regardless of board makeup*

#### *2.1.1.1 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).

#### 2.1.1.2 *Outcome of Oct.17 Leadership Session*

- Poll results found that three-quarters agree with doing away with the three different forms of contract based on governance model and adopting a **single contract template** for all FHTs, with schedules to deal with unique situations (e.g. blended salary model physicians, academic mandate, etc). This would give greater flexibility for governance to evolve.

#### 2.1.1.3 *AFHTO position to be taken / Additional action for AFHTO and members:*

- 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.
- 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 regarding 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 department 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.

### 2.1.2 *Fostering “teamwork” and defining the “team”*

#### 2.1.2.1 *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.

#### 2.1.2.2 *Emerging agreement from EDAC-PLC meeting (Sept.16, 2016):*

- By definition, a team implies accountability of each member to the others. Have to find a way to support this.
- What is clear from members is that both FHT and physician contracts must be addressed simultaneously – high level of interdependence.
- 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 to pay careful attention to physician leadership and incentives. Physicians are used to being autonomous; this is a significant cultural shift.
- 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.
- Need further exploration with membership to determine extent to which this could be expressed in a Ministry – FHT contract.
- 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.

#### 2.1.2.3 *Outcome of Oct.17 Leadership Session*

This topic was first discussed at each table, then followed with electronic polling on 4 questions.

#### **Table discussion**

- **Question:** 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).

#### **Summary of responses:**

*NOTE: there were 22 tables at the session and the following speaks to how many mentions there were for each issue brought forward*

## Boards need:

- 9 mentions - Governance and board training crucial...regular webinars
- 8 mentions - Clarity comes with a contract: a three way agreement (FHT, FHO, Ministry). It can't be too prescriptive or punitive to doctors.
- 7 mentions - Skills-based mixed board: A good mix of skills on board: including clinical, legal, quality, admin, HR, finance type backgrounds.
- 7 mentions - MOU probably makes sense initially to set high level expectations, define roles and responsibilities (depending on model, between FHO/FHN and FHT or individual physicians and FHT).
- 5 mentions - Common vision and rules of engagement up front -> clear direction and expectations
- 4 mentions - Clear policy and procedures with Job descriptions, responsibilities.
- 4 mentions - Templates (accountability agreements etc.) are very helpful.
- 3 mentions - Culture is a struggle: difficult to mandate / force team building. Recognition that strong culture is imperative for FHT success.
- 2 mentions - Standardized measurements... A mechanism to audit compliance against expectations.
- 2 mentions - A mentor / coach to help Boards and facilitate physician buy-in.
- 2 mentions - Database/info sharing mechanism that allows boards to share experiences.
- 2 mentions - Some direction from Ministry on relationship expectations.
- 2 mentions - Financial support re: liabilities.

## Challenges:

- A lot of noise in the system right now that we need to try to filter and make understandable without causing fear and push back.
- Risks of losing docs in a rural environment.
- Culture is critical ... mandating may not be the appropriate route.
- FHO is an association not a corporation...

## Some of the representative comments:

- This is like a marriage. Our FHT and MD group are the 2 partners and as much as we like each other, we can fight about money and it can damage the relationship. We need clarity in terms of the shared costs between the MD group and FHT. IN terms of contracting service is a separate issue. For example, a service would be a shared room - who has control? Or FHT is supporting one clinic more than another within the same MD group.
- We need a new FHT/FHO contract that is not too prescriptive or appears punitive to physicians, but not allow physicians to opt out of FHT culture.
- Memorandum of Understanding make sense as a next step to help delineate responsibilities and allow Board to meet governance obligations. MOU should not relate to physician compensation.
- Has to be a written agreement between the Physician group and the FHT on how they will work together for delivery of Primary Care Services. There should be common language in both agreements that speaks to sharing data and participation in Quality Improvement Measure, as set out by the Board of Directors.
- Not sure that one size fits all: that one MOH contract would work; perhaps MOH could provide template to be used by FHTs/FHOs.
- Possible memorandum of understanding between the FHO-FHT, need some kind of legal structure but believe we should wait until physician contracts are finalized. This is a very

involved conversation that needs more time and possible webinar. Request Ministry funding for legal support for these negotiations.

**Quick polls following debrief:**

- While all acknowledge that physicians are key contributors to team performance, 29% of participants indicated that FHT governors should be accountable for team performance that includes physicians; whereas the majority (60%) believe FHT governors should NOT be accountable for team performance that includes physicians.
- Two-thirds indicated some form of agreement between FHT and physicians should be mandatory, in the form of either:
  - A contract (36%) – be it between FHT and
    - FHT + each physician (14%)
    - FHT + FHO (9%)
    - FHT + FHO plus FHT + each physician (13%)
  - Or an MOU (31%)
- Of the remaining one-third, 14% prefer to keep this voluntary – FHT boards and physicians can develop agreements if they want to, and 19% are not sure.
- The key theme from table discussion is that the value of such agreements is to develop clarity around expectations – roles, responsibilities, finances, etc.
- Just over one-third currently have a contract or MOU with physicians already.
- When it comes to what should be included in a FHT-physician agreement, over 140 of the 180-people using voting clickers in the room said yes to each of the four items presented, i.e.:
  - Use of and access to EMR
  - Participation in developing/implementing team-based programs and services
  - Participation in TEAM level accountability reporting
  - Participation in measurement and improvement activities

*2.1.2.4 AFHTO position to be taken / Additional action for AFHTO and members:*

- 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.
  - Reach out to educate on what is a MOU, benefits of having one and how to develop/work with one for teams that are interested.
  - Develop a case study highlighting FHTs and physician groups that have successfully implemented a MOU or framework document that is mutually beneficial.
- Through AFHTO – explore, evaluate and spread tools + techniques that ***promote team culture***
  - Governance training is crucial, including need to set common vision and to establish skills-based board.
  - Key is to develop common purpose + measure progress toward it.
    - Continue to foster participation in [Data to Decisions \(D2D\)](#), [Schedule A planning + measurement](#), and [Quality Improvement Plans](#) to strengthen common purpose.
    - 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?

While AFHTO's position is that FHT **contracts** should not hold boards accountable for physician performance, performance is a critical ingredient to the success of the team. If the interprofessional model is to continue and spread, the value of the model must continue to be demonstrated.

For this reason, AFHTO will continue its work with members to strengthen leadership, governance, measurement and quality improvement.

- Given government's commitment to achieve its Primary Care Guarantee, we can anticipate Ministry/LHIN pressure for contracts to include targets for same day/next day access. We can anticipate similar pressure on measures such as follow-up post-hospitalization, cancer screening, diabetes care, etc.
- AFHTO would need to agree on mandatory reporting for these indicators and do QIPs where needed to improve on these indicators, but stop well short of "accountability". Will need further discussion with AFHTO members and board as Ministry develops contract template.

In addition, AFHTO will monitor and advocate on issues that would bring greater alignment in this three-way relationship, especially in the agreements between Ministry-FHT, Ministry-physicians, FHT-physicians. Issues may include:

- Support for physician work in critical non-clinical tasks such as QIPs, Health Link development, etc.
- Incentives/consequences in FHO contract to give FHO colleagues a mechanism to deal with problems.
- 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).

### *2.1.3 Defining the "population" for which governors are accountable*

#### *2.1.3.1 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 sub Regions?
  - 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.

#### *2.1.3.2 Emerging agreement from EDAC-PLC meeting:*

- Definition of population is important if interprofessional primary care teams want to lead in sub Region 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. Aboriginal, 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”.

#### *2.1.3.3 Outcome of Oct.17 Leadership Session*

- When it comes to defining the population for which FHT governors should be accountable,
  - 30% said FHTs should be accountable for the sub-LHIN population.
  - 61% felt FHTs should participate in sub Region planning but accountability should remain for rostered patients.

#### *2.1.3.4 AFHTO position to be taken / Additional action for AFHTO and members:*

- 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.
- 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?
- 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 for “spreading” not “stretching” access – i.e. waits and quality of care can’t be allowed to deteriorate – 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)

#### 2.1.4 *Defining minimum standards of governance / addressing conflict of interest*

##### 2.1.4.1 *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 the 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.

#### 2.1.4.2 *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)

#### 2.1.4.3 *Outcome of Oct.17 Leadership Session*

Discussion question at each table:

- 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?
- The most consistent themes identified by many tables in their discussions were:
  - The need for board and ED **training** in governance, role of board, and handling conflict – especially for struggling boards.
  - The need for **skills-based mixed boards**.
  - Need to be very clear in defining **conflict of interest** and put in place processes to manage it (including many further comments about need to move to mixed boards).

*NOTE: there were 22 tables at the session and the following speaks to how many mentions there were for each issue brought forward*

- it is recognized that not all of these are mutually exclusive.

#### Themes:

- 8 mentions - Board composition: mixed skills-based boards recommended
- 7 mentions - Need clear bylaws, procedures with mechanism to address and resolve conflict
- 6 mentions - Focused help and training for struggling boards (HR expertise, ombudsman etc.)
- 6 mentions - Many culture related comments (how to create it, what it looks like) ... Focus should be on leadership, relationship and culture (not on accountability measures)
- 5 mentions - Clear Definition of “conflict of interest” (so everyone understands what it is/is not)
- 5 mentions - Specific training for EDs and boards on how to handle difficult conflict, role of board
- 4 mentions - In meeting suggestions: COI declaration at every meeting, reminder on agenda etc
- 2 mentions - Coherent vision and objectives
- 2 mentions - Need a clear FHT-FHO agreement

#### 2.1.4.4 *AFHTO position to be taken / Additional action for AFHTO and members:*

- To foster greater consistency across all FHTs, contract should include the items listed in the Governance and Compliance Attestation as minimum standards for governance.
- Based on the most consistent themes identified by many tables, develop ways in which to support need for:
  - Board/ED **training** in governance, role of board, and handling conflict – especially for struggling boards
  - **Skills-based mixed boards**
  - Clarity in defining **conflict of interest** & put in place processes to manage it
  - For physician-led boards, engage with FHT physicians on the benefits/concerns of moving to skills-based boards.

- 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

## 2.1.5 Accountability and dispute resolution

### 2.1.5.1 Current state:

#### 2.1.5.1.1 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.

#### 2.1.5.1.2 Two-way accountability

- While government 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.”

#### 2.1.5.1.3 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.

### 2.1.5.2 *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)

### 2.1.5.3 *AFHTO position to be taken / Additional action for AFHTO and members*

- 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 expectation.
- Revise out-of-date sections that tie funding to patient enrollment commitments (sec.3.9 in physician-sponsored and mixed contracts).
- Advocate for dispute resolution mechanism.
  - Use the language in the LHIN-Hospital SAA as a starting point (see section 3.3)
- Member input and progress in [D2D](#) will continue to provide direction for AFHTO's vigorous advocacy on what is meaningful and manageable to report.
  - Points to critical importance of QIDS Specialists + QIDS Program, and indicators that capture role of team. Continue to promote to MDs.

## 2.2 AFHTO role with and for members

### 2.2.1 *Outcome of Oct.17 Leadership Session*

- Discussion at tables: What is the one most important thing that we, collectively through AFHTO, need to do?
  - Advocate for resources/primary care leadership (responses from 8/22 tables were in this category)
  - Advocate for aligned contracts (8/22 table responses in this category)
  - Advance measurement/simplify reporting (2/22 tables)
  - Recognize differences and ensure flexibility (2/22 tables)
  - Provide sufficient time for review - we need time to share with FHO members and gain support to content, particularly if there are any accountabilities for physicians and promote a full understanding of the content. (1 table)
  - Give high priority to impact on physicians. If physicians are not happy there is a risk that the FHO could choose to leave the FHT. AFHTO needs to flag to the Ministry that physician responsibilities/compensation need to be managed as part of the next FHT contract negotiations to avoid this outcome (1 table)
- Quick poll: 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
- 61% want balance between “coach” and “cheerleader” roles; 30% - “coach”; 7% said remain in cheerleader mode.

### 2.3 Next Steps

This leadership session highlighted that there is a real need to start working with the Ministry on a contract that is, like our performance work, meaningful for our members. There are a lot of challenges ahead of us with the implementation of the Patients First Act but there are a lot of opportunities as well given that primary care is the foundation of the Act. The Ministry has indicated that they would like to go ahead with a new contract for the upcoming fiscal year and AFHTO will be at that table to lead the way, ensuring that the members’ comments are reflected in any changes being proposed.

Thank you to the leadership of AFHTO’s member organizations who participated in the October 17<sup>th</sup> Leadership Session and participated in a lively discussion about what changes they would like to see. We will provide ongoing updates and further consultations with the leadership as the contract renewal work process unfolds.

In the meantime, if you have any further comments or questions please feel to contact any of the following at any time:

- Regarding advocacy work, to CEO Kavita Mehta ([kavita.mehta@afhto.ca](mailto:kavita.mehta@afhto.ca))
- Regarding the governance and leadership of FHTs/NPLCs, to the Provincial Lead for the Governance and Leadership Program, Bryn Hamilton ([bryn.hamilton@afhto.ca](mailto:bryn.hamilton@afhto.ca))
- Regarding AFHTO’s work to advance measurement capacity, to the Provincial Lead for the Quality Improvement Decision Support Program, Carol Mulder ([carol.mulder@afhto.ca](mailto:carol.mulder@afhto.ca))