Community-governed Family Health Teams

Looking Back: Looking Forward

Evaluating the First Three Waves
Improvements in the Next Wave

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Looking Back

A. Background Information

The Association of Ontario Health Centres (AOHC) commissioned SMB Consulting to design and carry out a Research Project with the Community-governed Family Health Teams (CFHTs). Of the 150 Family Health Teams (FHTs) announced and in various stages of programme and team development and service delivery, 26 are community-governed and 20 of those are members of the Association. (See List of CFHTs, Appendix B.) Claudia Mior-Eckel was the consultant and Lee McKenna, Manager, Policy and Government Relations was the key contact person representing the AOHC and the final author of the report.

This project began in mid-June 2008 with a consultation at the annual Conference of the Association of Ontario Health Centres and the development of a survey for use with participating CFHTs. The Survey (see Appendix B) was sent to all Community-governed Family Health Teams, including both members and non-members of the Association.

Thirteen Community-governed FHTs participated in the research by completing the survey and participating in an interview with a SMB consultant. Surveys were completed by the end of August. Data were compiled and documented. Based on these data, a report was prepared. In the following months, further research and interviews were conducted by AOHC staff.

As the next wave of Family Health Teams prepares to come on stream, this report will support strengthened and clearer government policy and implementation as well as community groups preparing to bring a new Community-governed Family Health Team to town.

Project Objectives
1. To strengthen AOHC’s understanding of the issues, concerns, and obstacles facing Community-governed Family Health Teams.

2. To document the issues facing Community-governed FHTs with examples and recommendations.
3. To make recommendations to the Ministry of Health and Long-Term Care with respect to the CFHT experience of the first three waves of FHT development with a view to making improvements in the process - from community engagement to Business and Operational Plan submission through capital approvals, start-up and operations.

4. To make recommendations to the Ministry of Health and Long-Term Care proposing solutions to CFHT-specific concerns as well as recommendations that touch on broader issues applicable to Family Health Teams in general.

**Methodology**

A questionnaire was drafted with the input of several Community-governed FHT representatives with the objective to capture data that were relevant to the sector. The survey was distributed by e-mail to all Community-governed FHTs in the province. Given that each Community-governed FHT is unique and has followed its own path of development with changing Board members, Executive Directors, administrators, business leads, Ministry Site Co-ordinators, and sometimes changing models, the survey was developed to capture as much information as possible so that all the nuances of the sector could be collected. In addition, comprehensive phone interviews were conducted with 12 of the 13 participants who submitted a completed survey.

The Survey is divided into two sections. The first is a table where each Community-governed FHT documented information that is similar for all Family Health Teams. This included information on the following items:

- The development status of the CFHT with relevant dates such as when the Business and Operational Plan was submitted and when the Community-governed FHT received their first Interim Funding Agreement;
- The name of the sponsoring organisation;
- Whether or not there were a prior CHC application;
- Identification of Aboriginal FHTs as distinctive;
- Names of all Site Co-ordinators;
- Type of Governance structure;
- Legal Services accessed;
- Numbers of enrolled clients;
- Budgets;
- Consultants and one-time cost approvals;
- Human Resource allocation;
- Recruitment status;
- Facility and capital approvals process;
- Information Technologies;
- Marketing/Media and Public Relations.

By formatting this section into a table, the development of the Community-governed FHT sector can be benchmarked.

The second section contained questions that required more detailed and subjective information from the participants. This included information on the following items:
Participants
The AOHC provided a contact list with information for 26 FHT organisations. At the time this survey was conducted:

- Eleven were identified as Emerging Groups;
- Nine were identified as full members;
- Of the 20 members, 13 CFHTs completed written surveys and participated in phone interviews varying in length from one to three hours (65% participation).
B. INTRODUCTION AND SUMMARY OF RECOMMENDATIONS

Each Community-governed FHT is unique and no two have the same development story, history or circumstances. Given that there was no template for development, it is a challenge to identify consistent issues across all Community FHTs. Having said that, there are many issues that are shared across Community-governed FHTs, as well as some issues that apply to Family Health Teams in general, regardless of their governance or compensation model.

The following is a compilation of the results of the survey, supplemental research and interviews, analysis of the data collected, and recommendations for action. The findings and recommendations are categorised by topics that were identified as relevant to the understanding of the model as well as the ongoing development of these Community-governed FHTs and future CFHTs that will be named as part of the Ministry of Health and Long-Term Care’s intended roll-out of an additional 50 Family Health Teams. Five of the 13 participating CFHTs had previously applied to become a Community Health Centre but were not successful and were encouraged to apply to become a Family Health Team. One of the participating CFHTs is a First Nations Community Family Health Team.

Having been given the opportunity to choose a governance model that involved the community directly in the development and direction of the Family Health Team, CFHTs across the province are forging partnerships with other community groups and agencies to deliver high quality primary health care. These partnerships are creating new synergies, filling gaps amongst services, fostering collaboration and co-operation to the benefit of the entire community. Efficiencies in terms of both programme and service delivery and cost are moving CFHTs to the forefront of primary health care in their communities. Providers are reporting new enthusiasm for their work in a model that allows them a kind of autonomy and scope for creativity and collaboration that was mostly absent in other models. Physicians, relieved of responsibilities for running a business, are adjusting to and welcoming the changes inherent in collaborative practice within an inter-disciplinary team of providers and administrators.

The essential thrust of the report is this: the Community-governed Family Health Team is a model that is working, despite many obstacles, and one that is worth supporting and expanding in the next wave of Family Health Team development across this province.

We would also like to take the opportunity afforded by this report to offer our thanks to those Ministry of Health and Long-Term Care dreamers and facilitators - without whom we would not have been able to accomplish what we have done thus far. We look forward to continuing and enriching our partnership and work together and to welcoming new CFHTs into the fold.

But perhaps the highest praise belongs to the volunteer members of boards who have put in thousands upon thousands of hours into making the dream of community-based and -governed primary health care in 26 communities across this province a reality. You have stuck with your vision despite the difficulties; it was worth it!
A Rocky Start
From the outset of the FHT roll-out, from the first announcement of the model, through
the period of application (through an Information Request Form or IRF), and the drafting
of Business and Operational Plans, community-governed Family Health Teams have
encountered a vast array of obstacles in the path to development and operations. Some
of these barriers were common to all Family Health Teams, regardless of their form of
governance. Many are particular to this model.

From the announcement onward, it was clear that there was no plan, no strategy, no
clear roadmap for the development of the model. Consistent with the Ministry’s own
recent evaluation of 15 Family Health Teams, the result for CFHTs was confusion,
misinformation, frustration, and a significant wastage of resources, both human and
financial.

The FHT Guides were of limited use or value, were released in an untimely way and often
contained information contrary to what was provided by Ministry staff; some of the
Guides were revised several times. The lack of clear and consistent identification by a
dating or version numbering sequence added to the confusion.

After spending weeks or months on the preparation of a comprehensive Business and
Operational Plan in consultation with AOHC-Med-Emerg, community groups were advised
after the submission of the Plan that there were certain constraints and ratios and
requirements that applied. With no clear roadmap - expectations, parameters,
benchmarks, timelines - and few, if any templates on staffing, space/functional/facilities
planning, capital, operations or programmes guidelines to assist them or their
consultants, and often little substantive assistance or support from MOH staff, CFHTs
often found themselves at a loss as to how to move forward.

Neglect of the Community-governance Model
CFHTs felt and continue to feel invisible or second-class Family Health Teams. Although
community-governance was listed from the outset as one of the acceptable models of
governance for a Family Health Team, it has never enjoyed substantive support by the
Ministry of Health and Long-Term Care. Those communities and groups that submitted
successful IRFs, many of which had begun as CHC applicant groups, were all told at some
time in their early development to abandon the community governance model. Ministry
staff at various levels, site coordinators, consultants, Primary Care Team, repeatedly
advised CFHT steering committee and boards to get physicians on their boards, contract
with a FHN or FHO and forget community governance. In some cases, physicians who
were already employees of CFHTs on the Blended Salary Model were encouraged by Site
Co-ordinators to form FHOs.

Having advised CFHTs to abandon their preferred model of governance, MOHLTC had little
to offer in the way of support for CFHTs when they opted to stick with community-
governance. No funding for a transparent and effective creation of a representative
community governance structure was offered.
OMA and MOHLTC staff and consultants who were deployed to assist Family Health Teams in their development were completely unprepared to support the model and had no idea as to how the Blended Salary Model would work. Community boards’ questions were funnelled through a revolving door series of local coordinators and consultants and answers were invariably slow in coming, confusing, contradictory and/or incorrect. Various staff provided various and contradictory answers to the same questions. Some questions simply went unanswered.

While the physician-led FHTs benefitted richly from the support of the Primary Care Team, the Ontario Medical Association and other resources not available to kitchen-table volunteers, CFHTs provided thousands of volunteer hours and were asked to search out municipal grants and subsidies that, as far as we can discern, was something not required of physician-led FHTs.

**Delays, Delays, Delays**

Of the participating CFHTs, the majority took approximately 12 to 24 months to move from Business Plan submission to an Interim Funding Agreement (IFA). In two cases, money was flowed through a Development Grant Application (DGA) in order to begin operations while the IFA was still being negotiated. In one additional case, the CFHT received funds under the terms of an IFA for over 12 months but at the time of the survey had not yet been given a hard copy of the Agreement. The pre-operations phase was drawn out over months and years as new groups waited for approvals from over-worked and ill-equipped MOHLTC staff.

From the time of the Business Plan submissions to the date of the survey the CFHTs had worked with an average of 3.5 Ministry Site Co-ordinators with two Site Co-ordinators being the lowest number and seven being the highest. Several CFHTs found the frequent turnover of MOHLTC co-ordinators negatively impacted the development of their CFHT. With each change, CFHTs had to re-educate the new coordinator on the distinctives of CFHT. All site coordinators arrived on the job with little or no understanding of the community-governed model and the peculiar complexities of the model.

**The Role of the Association of Ontario Health Centres**

Several community boards reported that they had been advised by the MOHLTC to not hire the Association of Ontario Health Centres (that AOHC was not on their ‘list’), which was working with Med-Emerg to produce Business and Operational Plans for several CFHTs. Although the Primary Care Team would occasionally refer to CHCs as the model for Family Health Teams and, despite having benefitted from relatively recent experience of new CHCs going through the process of development and decades-long experience as community-based, extended-hours, primary health-care delivery through inter-professional teams working in collaborative practice, the sector’s advice or expertise was rarely sought or valued by the Ministry. CFHTs’ advantage of being a part of an Association that regularly provided opportunities to meet together and with members of the Primary Care Team went unrecognised and unsupported.
Physician Focus
Ministry- and OMA-funded Family Health Team events were experienced by CFHT board members and staff as ‘Are we at the right meeting?’ - with plenaries and workshops that were almost entirely physician-focussed with collaborating practitioners relegated to the category of ‘allied’ or ‘other’. CFHTs heard presentations on issues such as interdisciplinary teams that failed to acknowledge the fact that CHCs have been developing expertise in collaborative practice (‘Building Better Teams’ research and training manual, 2005) for over three decades.

General Population?
While FHTs were initially announced as the model of primary health care that would focus on general populations, the MOHLTC awarded FHTs to four First-Nations reserves and a number of homeless men’s shelters and urban core street-focussed entities. With a remuneration model dependent on rostering high numbers of patients, a model that does not take into account the dignity of aboriginal non-citizenship as defined by the dominant culture or the non-insured, high-risk, street-involved, addictions-debilitated, or the complexities of care needed for sexual minorities, all of these nascent FHTs faced insuperable barriers to both rostering and recruitment.

The Ministry’s initial decision, for example, to hire consultants to visit reserves to talk them into enrollment was unacceptable and ineffective. A second initiative that involved the hiring of a consultant lawyer, who visited each of the reserves, has yet to issue in a report or recommendations that addressed their issues. It was only after a great deal of advocacy, supported by the AOHC, that these anomalous FHTs were granted special status (as in the case of Sherbourne) or were able to benefit from rule changes with respect to multiple-affiliation, part-time physicians, and group enrollment.

QMC-QIIP
The Quality Management Collaborative, replaced by Quality Improvement and Innovation Partnership, has been a great boon to Family Health Teams. High CFHT participation is an indication of the value seen in the collaborative by the community-governed PHC sector and we look forward to participating in any evaluative processes.
SUMMARY OF RECOMMENDATIONS

I. FUNDING

I.1 Human Resources

I.1.1 Physician Compensation
1. That the Ministry of Health and Long-Term Care address the recruitment disadvantages of the CFHT model by adequately and competitively funding a new/newcomer (i.e., without an OHIP billing history) physician’s first year when there is a heightened need to build a roster of sufficient numbers to warrant full base salary.

2. That the Ministry consider lowering the first year enrollment goals so that IS physicians could move to the BSM sooner, with enrollment goals set to be achieved after two years of service.

I.1.2 Other Health-care Providers’ Compensation
3. That the Ministry of Health and Long-Term Care conduct an immediate review of those salaries paid to all members of the inter-disciplinary team order to determine a level of compensation and benefits that will ensure that CFHTs are able to compete on a level playing field with other primary health-care providers.

I.1.3 Executive Directors’ Salaries
4. That the MOHLTC conduct an immediate review of the CFHT Executive Director’s compensation, taking into account the size and complexity of the organisation, the number of staff and the complexities related to hiring, administering and compensating physicians on the Blended Salary Model (see Section III below).

I.2 Overhead
5. That the Ministry of Health and Long-Term Care conduct an immediate review of the funding formula for Overhead with a view to providing funding adequate to ensure high quality, well-supported primary health care delivery and sufficient to fund the smallest CFHTs.

I.3 Information Technology
6. That the MOHLTC conduct a survey of Clinical Management Systems in operation amongst Family Health Teams to determine the obstacles in terms of equitable funding across governance models as well as issues related to inter-operability.

7. That the MOHLTC recognise and adequately fund the following as IT/CMS-related line items: consulting, service, licensing, staff training, updating, infrastructural and hardware replacement.

II. FACILITIES, EQUIPMENT AND CAPITAL SUPPORT

8. That the MOHLTC fund CFHT facilities with a view to emerging needs, new recruiting, programme expansion and integration opportunities and partnerships.

9. That the MOHLTC review capital approvals in order to ensure a more streamlined process.
10. That the MOHLTC abandon the practice of funding CFHT facilities based on the numbers of physicians hired.

### III. BLENDED SALARY MODEL

11. That those Ministry staff working with CFHTs be fully-educated on the challenges and problems associated with the BSM of compensation and the workings of OHIP as it applies to the model.

12. That the Ministry work to improve and streamline the process of BSM registration and implementation.

13. That the Ministry provide training and resources for CFHT staff on the Blended Salary Model and the intricacies of OHIP reporting.

14. That the Ministry take the initiative to resolve BSM compensation issues with the OMA and HealthForce Ontario with respect to Shadow Billing, Premiums and Bonuses and Locum compensation.

15. That the Ministry provide adequate funding for CFHTs to hire staff with the skills of a Finance Manager/Billing Clerk who would be better able to navigate the OHIP system.

16. That the Ministry provide support and relevant assistance to CFHTs that want to remain community-governed but have contracted services from a physician group.

17. That the Ministry work with the OMA to reduce the complexity of hiring requirements in a way that acknowledges the employer-employee relationship of CFHTs to their physicians.

### IV. HEALTH-CARE PROVIDER RECRUITMENT

#### IV.1 Physician Recruitment

18. That the Ministry facilitate and support CFHT physician recruitment efforts with a commitment to full familiarity with the BSM and a ‘sales pitch’ on a par with other physician compensation models. The absence of the BSM information on the OMA Primary Care Comparison Chart must be rectified.

19. That the Ministry strengthen its support of CFHT recruitment with the regular and fulsome provision to the sector of resource lists/information on physician recruitment.

20. That the Ministry provide recruitment dollars for CFHTs to attract physicians, taking into account those challenges peculiar to the community-governed model.

21. That the Ministry, in collaboration with the OMA, undertake an immediate review of inequities in physician compensation models, with a view to early resolution.
IV.1 Team Recruitment
22. That the MOHLTC set aside both a ‘physician first’ policy and a quota régime as a guide for determining and funding staffing complements in favour of more flexible funding that reflects the needs of the population.

V. GROUP ENROLLMENT

23. That the MOHLTC immediately communicate the principles contained in Marsha Barnes’ 25 April 2007 memo (which made clear the benefits of group rostering, including as a check against physicians who depart after building a roster, taking that roster with them and thereby stripping the Family Health Team of its clients), put the appropriate forms into the hands of interested FHTs and work to redress situations such as the example provided above.

VI. PROVISION OF TELEPHONE HEALTH ADVISORY SERVICES (THAS)

24. That the MOHLTC meet with the small Family Health Teams in order to negotiate alternate arrangements for after-hours and THAS coverage that takes into account the challenges inherent in a small complement of clinicians.

25. That, once in place, on-call services be adequately supported by the Ministry of Health and Long-Term Care with timely disbursement of on-call compensation.

VII. SPONSORING ORGANISATIONS

26. That the Ministry of Health and Long-Term Care prepare clear guidelines on the following aspects of Sponsoring Organisations: their role on an initial board, their transfer of authority to an independent board, expectations around the SO’s financial contributions, and other long-term involvement.

VIII. COMMUNITY BOARD GOVERNANCE

27. That the MOHLTC provide funds adequate to support the unique needs of Community-governed Family Health Teams, sufficient to provide training in the model of governance that is at the heart of and distinctive to CFHTs.

IX. THE ROLE OF THE MINISTRY OF HEALTH AND LONG-TERM CARE

28. That the MOHLTC ensure adequate training and support for new Executive Directors.

29. That the MOHLTC ensure, as far as it is feasible to do so, that CFHTs are supported with well-informed Site Co-ordinators who provide a long-term and constant presence to guide CFHTs through the steps towards full operations.

30. That the MOHLTC provide funds to a budget line that will allow CFHTs to pool funds to provide a full-time CFHT Co-ordinator who could assist with the co-ordination of information and networking sessions, training, governance, and other services.
C. KEY FINDINGS AND RECOMMENDATIONS

I. FUNDING

All of the CFHTs surveyed reported inadequate Ministry funding to some degree across categories, i.e.,

- Human Resources, including physicians, other health-care providers and Executive Directors,
- Overhead,
- Information Technology,
- Facilities and equipment.

I.1 HUMAN RESOURCES

I.1.1 Physician Compensation and Recruitment

Of the CFHTs surveyed, nine have physicians employed on the Blended Salary Model (BSM). Three have a contracted services agreement with Family Health Networks or Organisations (FHNs or FHOs) and one does not yet have a physician.

Physician compensation, while identified as part of the Funding Agreement, is not included in the monthly Ministry fund transfer. Rather, it is a separate payment that is flowed to the Family Health Team from the Ontario Hospital Insurance Plan (OHIP). The majority of Community-governed FHTs employ physicians on the Blended Salary Model of compensation. The BSM is comprised of several revenue streams of which only one is salary. The remainder of their compensation is flowed without legislatively-required deduction and in its entirety.

Income Stabilisation

Income Stabilisation (IS) is insufficient to recruit and retain new doctors. The IS is not close to being competitive or aligned with other models of primary health-care delivery. The IS is only applicable for the Blended Salary Model, providing insufficient remuneration for a year when the physician is building a roster.

The vast majority of physician-led Family Health Teams are conversions from other models (and thus resulting in only modest gains in actual access). This means that, right from the beginning, they have doctors who already have an enrolled clientele and an OHIP history as well as a capacity to top up salaries to make them more competitive. These are unfair advantages accorded to the physician-led FHTs that need to be addressed. The Ministry’s support for community-governance within the FHT model rings hollow when CFHTs are left to cope with a long list of disadvantages with little apparent interest on the part of the Ministry to address the uneven playing field.
Income Stabilisation clearly serves a useful purpose, but it needs to be funded at a more appropriate and competitive level and the enrollment goals lowered in order to facilitate new physicians’ movement more quickly to the Blended Salary Model. Achievement of enrollment goals after two years’ of service is more reasonable and attainable.

Recommendation
1. That the Ministry of Health and Long-Term Care address the recruitment disadvantages of the CFHT model by adequately and competitively funding a new/newcomer (i.e., without an OHIP billing history) physician’s first year when there is a heightened need to build a roster of sufficient numbers to warrant full base salary.

2. That the Ministry consider lowering the first year enrollment goals so that IS physicians could move to the BSM sooner. The eventual goals would not have to be achieved until after 2 years of service.

I.1.2 Other Health-care Providers’ Compensation

Across those CFHTs interviewed, there was a concern expressed that the salaries for many positions, in particular the Registered Nurse, Nurse Practitioner, Clinical Manager and Registered Dietitian, were not competitive in the market place. This salary gap between what CFHTs are funded to pay their staff and what these professionals can get in other health-care settings including physician-led FHTs - has negatively impacted the CFHTs’ ability to recruit and retain staff.

Recommendation
3. That the Ministry of Health and Long-Term Care conduct an immediate review of those salaries paid to all members of the inter-disciplinary team in order to determine a level of compensation and benefits that will ensure that CFHTs are able to compete on a level playing field with other primary health-care providers.

I.1.3 Executive Director Salaries

Of the CFHTs surveyed, all indicated that the salary for the Executive Director was inadequate for the services and skills that are required of the position. While there is an understanding that the size of a CFHT will play into the equation of salary, they feel the Ministry is not comparing apples to apples.

In a provider-led FHT with 20 physicians and 20 support and clinical staff, the Executive Director manages the administrative and clinical support staff only. The physicians and their immediate staff are not employed by the FHT. In many of these cases, the physician group employs their own administrator. Given the complexities of employing physicians, an argument can be made that the Executive Director of Community-governed FHT with 20 employees, including BSM physicians, should receive at least the same compensation as the Executive Director of the provider-led FHT.
While most physician-led FHTs were permitted to hire Executive Directors at an appropriate point in pre-operations, CFHTs were permitted, late in development, to hire ‘Administrative Leads’ who were offered salaries below $70,000. This was the case despite the fact that CFHT Executive Directors are much less likely to have middle managers and are required to manage an entire team, including physicians, their rostering, scheduling and billing, requiring a broad range of skills. Physician-led Family Health Teams have advertised for Executive Directors for salaries $20,000 to $100,000 above those of CFHTs.

Although the Ministry uses the number of physicians as a benchmark for determining ED salaries, this is not useful in a CFHT. A better indicator would be the total number of staff employed. In addition, all CFHTs surveyed indicated that, regardless of size of staff, the workload is the same for a small FHT as a large FHT. They both need to implement policies, hire staff, secure space, etc.

**Recommendations**

4. That the MOHLTC conduct an immediate review of the CFHT Executive Director’s compensation, taking into account the size and complexity of the organisation, the number of staff and the complexities related to hiring, administering, compensating, physicians on the Blended Salary Model (see Section III below).

### 1.2 Overhead

The ‘General Overhead’ budget line is severely under-funded with a completely unrealistic list of items that it is meant to cover:

- telephone and facsimile services,
- licences, dues and fees, including professional association fees;
- consultants,
- conventions and courses including travel;
- bank charges,
- payroll service fees,
- office supplies, postage and courier;
- utilities

- taxes
- medical supplies, including sharps and medical laundry;
- lab fees,
- educational and health promotion resources,
- cleaning supplies,
- computer supplies, including software upgrades and licences;
- board expenses,
- support and security systems.

With overhead funding set at 4% of the budget (excluding physician salaries), CFHTs, which tend to be smaller, end up with insufficient dollars to provide support and services that are non-negotiable elements in day-to-day operations. The current percentage is grossly inadequate and results in a severe debilitation of a CFHT’s capacity to deliver primary health care services to its clients. CFHTs, most of which are small, are unable to take advantage of the economies of scale enjoyed by larger Teams. What is needed is a level of operating funding necessary to meet the basic operating needs of the smallest CFHT.
**Recommendation:**

5. *That the Ministry of Health and Long-Term Care conduct an immediate review of the funding formula for Overhead with a view to providing funding adequate to ensure high quality, well-supported primary health care delivery and sufficient to fund the smallest CFHTs.*

**I.3 INFORMATION TECHNOLOGY**

**I.3.1 Electronic Clinical Records**

Of the FHTs surveyed, seven said they did not have adequate funding to support their information technologies. Three have some or all funding supplemented or supplied by a partner or sponsoring agency and three are in the process of negotiating for funding. Seven FHTs have implemented electronic clinical records (ECRs). Two have had positive experiences with OntarioMD as they implemented an ECR. Three indicated that the process was not positive and they did not receive the support they needed. Two CFHTs qualified their experience as neither positive nor negative. Five CFHTs are in the process of applying for OntarioMD funds.

Any CFHT that applied for Information Technology (IT) funding and CMS implementation funding before March 2008 found the process frustrating and difficult. Whereas at the beginning, the physician-led FHTs were able to apply to Ontario MD for IT funding, the BSM was not recognised. Once OntarioMD and the Ministry determined that the former would fund BS model CFHTs, the process became easier. However, funding does not take into account the IT/CMS-related costs of consulting, service, licensing, staff training, as well as updating and infrastructural and hardware replacement.

**Recommendation**

6. *That the MOHLTC recognise and adequately fund the following as IT/CMS-related line items: consulting, service, licensing, staff training, updating, infrastructural and hardware replacement.*

**II. FACILITIES, EQUIPMENT AND CAPITAL SUPPORT**

Of the CFHTs surveyed, five reported a positive experience and/or outcome with respect to Ministry negotiations for facility. Four reported a negative experience and four are currently in the process of negotiations.

Several reported that, although the space was adequate for start-up and short-term needs, it did not provide for expansion, i.e., recruitment of additional staff, integration opportunities and partnerships with other health-care agencies, emerging needs, growing populations, or on-site consultation for other disciplines such as mental health programmes.
With budgets determined on the basis of physician numbers, they are invariably inadequate to fully fund a facility able to accommodate newly-recruited staff and programme expansion. This form of budgeting pre-determines the staffing complement, form determining function rather than the reverse, ensuring a privileging of physician hires over those of other collaborating professionals whose skills and training may be more appropriate for planned programming designed to respond to the needs of the community.

As well, a Community-governed FHT does not typically have a provider group that can contribute to the infrastructure costs. A physician-led FHT enjoys a greater capacity for financial contribution from the physicians.

CFHTs with a sponsoring organisation may also benefit from contributions from the organisation but there are no clear guidelines on what that might be and if it is in the best interest of the CFHT.

Finally, many CFHTs have community boards that are not linked to a sponsoring organisation with financial capacity to contribute funding support in the course of the pre-operational phases.

Many of the CFHTs reported the process to be confusing and riddled with delays. CFHTs are encountering in the course of their pre-operational phases delays and obstacles in capital submissions and approvals, including:

- long wait-times for funds to flow; long wait-times for approvals of submissions for all stages of capital;
- inadequate communication from Ministry of Health and Long-Term Care staff;
- delays and inconsistencies in response to concerns and questions from new Boards;
- inadequate staffing at the MOHLTC, both in terms of numbers and in terms of expertise on CFHT development and capital approvals;
- cost of capital planning phase over-runs due to new standards, delays in approvals, leasing of empty buildings, storage of equipment, etc.
- approvals for moving into a new site, furniture, equipment, office expenses, but no approval for the rent that is being paid every month.

**Recommendations:**

7. **That the MOHLTC fund CFHT facilities with a view to emerging needs, new recruiting, programme expansion and integration opportunities and partnerships.**

8. **That the MOHLTC review capital approvals in order to ensure a more streamlined process.**
III. BLENDED SALARY MODEL

Registration Process
Registration for and implementation of the Blended Salary Model is complicated, difficult and processed without adequate information and support.

All Blended Salary Model CFHTs expressed frustration with their interaction with OHIP. All indicated that the registration process for their physicians was not communicated well by the Ministry and four indicated that it took up to six weeks to receive appropriate information so that they could pay their physicians.

Need for Training
The OHIP reports were difficult to interpret by staff who had received little or no training or support from the MOHLTC. Management of physician compensation is complicated and requires more than a funded bookkeeper position to administer. Navigation through the OHIP system is required and it is a steep learning curve. The Financial Manager and/or billing expert is required to read, understand and reconcile OHIP reports to ensure that all physicians are compensated accurately and billing codes are precise. This is particularly true for Preventative Care codes, Access Bonuses and Shadow Billing.

Multiple Billing Systems within a single CFHT
In addition, some CFHTs may be employing several physicians each having arrived with their own billing software. It is not always possible for OHIP to send information back through the billing software because they are supplied by different vendors, may or may not be compatible with a ‘group billing number’ and the CFHT may not have the IT infrastructure to support group Remittance Advice (RA) reports.

Shadow Billing and Access Bonuses
CFHTs reported a need for more information and orientation with respect to Shadow Billing. There has been little or no direction from OHIP or the Ministry. CFHTs are sent to the OMA legal department and the OMA sends them back to the MOHLTC, neither able to provide adequate answers to perplexing questions and frustrations.

In addition, CFHT physicians are confronted with a basket of services list that far exceeds that required of either FHNs or FHOs. The result is that if the CFHT is not able to provide all of the services listed, physicians face negation under Outside Use provisions. The result is that CFHT physicians are often negated to the full extent of their 8.9% Access Bonus. Family physicians working in community-governed Family Health Teams are being deducted for failing to provide services such as chemotherapy, pain management, abortions, C-Sections, colorectal treatment (both screening and colonoscopies), weight loss, and knee replacements. Guidelines do not make it clear that any outside use (either by referral or self-referral by the client) results in negation of the fee.

When FHNs were first put in place, FHT physicians were likewise burdened with an impossible basket of services that included many procedures for which family physicians are not trained and which are typically referred to the relevant specialist. The physicians protested and the list was reduced substantially. A review of the basket of services for
Blended Salary Model physicians is overdue. The FHO and FHN respective baskets of services provide more realistic benchmarks.

**Locum Support**

Some of the CFHTs qualified for HealthForce Ontario’s locum program, depending on their RIO (Rurality Index) score. They were assigned to the Fee-for-service category for locum support. This category compensates locum physicians at $600.00 per day plus 50% of fee-for-service billings - which tends to yield somewhere between $950 and $1,000.00 per day. CFHTs cannot offer half of FFS billings, as most are on BSM, leaving them $600.00 to attract locum physicians. On the other hand, FHTs whose physicians are on FHN, FHO or RNPGA compensation qualify for the HFO daily rate of $700-$800 per day plus 50% of FFS billings for non-rostered patients. In addition to the problem this presents with respect to recruitment of locum physicians, it is not clear to CFHT Executive Directors whether or not locum physicians can sign up for the 5% shadow billing premium and, if they do so, whether or not they would be negated at the same rate and for the same ‘outside use’ services for which CFHT physicians are negated.

In the case of CFHTs which do not have a high enough RIO score or have part-time physicians, monthly locum dollars/allowances are provided for their physicians at a rate of 5% of the physician’s salary. This amount is inadequate to cover the physician’s four weeks of vacation (taking into account the going rate for locum support at $1,000 a day) and for small FHTs with few physicians there is an impact on the CFHT’s ability to care for their patients, as most have to close the clinic due to little or no locum coverage, resulting in a decrease in access to local primary health care. Five per cent is inadequate even for new doctors who start at four weeks vacation (or 8% of the year), not to mention senior physicians who have negotiated longer vacations.

**Lack of Support by MOHLTC**

The Blended Salary Model of compensation is neither well-understood nor well-supported by the Ministry of Health and Long-Term Care.

Community-governed CFHTs that wish to remain community-governed but have had to contract services with a physician group have encountered very little understanding of the unique challenges and benefits of their chosen governance model within the MOHLTC and have had to fight to retain the model. CFHTs are left with the impression that the implications of the offer of community-governance and the BSM as an alternative to physician-led was little understood and the support necessary for the model to flourish was not foreseen or intended.

**Complexity of hiring requirements**

The logistics of hiring a physician is complicated, involving three separate agreements or approvals. Hiring a physician requires that the CFHT secure:

- the written approval of the OMA,
- registration with OHIP, and
- an employment agreement with the Family Health Team.
The process is needlessly complex and could be made simpler through the creation of provincial standards on issues such as data-sharing and streamlining communications going through the Ministry of Health and Long-term Care. CFHTs, as employers of physicians, should not have to seek the permission of the OMA.

**Recommendations:**

9. That those Ministry staff working with CFHTs be fully-educated on the challenges and problems associated with the BSM of compensation and the workings of OHIP as it applies to the model.

10. That the Ministry work to improve and streamline the process of BSM registration and implementation.

11. That the Ministry provide training and resources for CFHT staff on the Blended Salary Model and the intricacies of OHIP reporting.

12. That the Ministry take the initiative to resolve BSM compensation issues with the OMA and HealthForce Ontario with respect to Shadow Billing, Premiums and Bonuses and Locum compensation.

13. That the Ministry provide adequate funding for CFHTs to hire staff with the skills of a Finance Manager or Billing Clerk who would be better able to navigate the OHIP system.

14. That the Ministry provide support and relevant assistance to CFHTs that want to remain community-governed but have had to contract services from a physician group.

15. That the Ministry work with the OMA to reduce the complexity of hiring requirements in a way that acknowledges the employer-employee relationship of CFHTs to their physicians.

**IV. HEALTH-CARE PROVIDER RECRUITMENT**

**IV.1 Physician Recruitment**

The challenges and still-unresolved problems of the BSM exacerbate CFHTs’ capacity to recruit and retain physicians. When they are being penalised with the loss of their Access Bonus, as well, it makes recruitment and retention even more difficult.

Physician recruitment is challenging everywhere in this province and more so in a Community-governed FHT. There is very little support for the BS Model of compensation and consequently very little information available as compared to other physician compensation models. The OMA’s Primary Care Comparison Chart includes several different models of physician compensation including Fee-for-service, Comprehensive
Care, Family Health Groups, Family Health Networks, and Family Health Organisations. The document does not include the Blended Salary Model.

Many Community-governed FHTs have encountered a lot of misinformation about the BSM as they have tried to recruit new physicians. There is also an impression that the Ministry does not support this model on a par with the provider-led models. In addition, the funding for recruitment needs to be increased since Community-governed FHTs recruit for all positions including physicians.

In a MOHLTC memo dated 30 March 2009, the Ministry indicated that physicians on IS working in a rural environment would be eligible for a $17,000 rurality premium. In response to enquiries from CFHTs with BSM physicians, the MOHLTC replied that this premium was never intended for those on BSM; the letter did not apply to them. It is not clear if this is another example of inequitable treatment or an unanticipated oversight.

**Recommendations to the Ministry of Health and Long-Term Care:**

16. That the Ministry facilitate and support CFHT physician recruitment efforts with a commitment to full familiarity with the BSM and a ‘sales pitch’ on a par with other physician compensation models. The absence of the BSM information on the OMA Primary Care Comparison Chart must be rectified.

17. That the Ministry strengthen its support of CFHT recruitment with the regular and fulsome provision to the sector of resource lists/information on physician recruitment.

18. That the Ministry provide recruitment dollars for CFHTs to attract physicians, taking into account those challenges peculiar to the community-governed model.

19. That the Ministry, in collaboration with the OMA, undertake an immediate review of inequities in physician compensation models, with a view to early resolution.

**Team Recruitment: ‘Physician First’ Policy and Hidden Ratios**

All CFHTs surveyed indicated that the relationship between physician and other health professionals was positive and productive. In particular, nurse practitioners and physicians reported a strong collaborative approach to clinical care.

Though the evidence is anecdotal at this point and it was not covered by the survey attached to this report, CFHTs tend to roster unattached clients with greater complexity of care needs. CFHT staffing complements appear to reflect that, with CFHTs more likely to have a greater diversity of practitioners in a staff team (compared to a provincial ratio of 1614 recruited physicians to 1122 total collaborating practitioners, or a ratio of 1.4:1 doctors to all other staff, excluding administration). In some CFHTs, the staffing complement hired to reflect the needs of the community results in a low physician-to-collaborating health-care providers ratio. For example, one south-western Ontario CFHT has a staff of 23, including three physicians, two nurse practitioners, three registered nurses (one of whom is dedicated to health promotion), two RPNs, a pharmacist, a social
worker, one dietitian, a clinical programme coordinator, a chiropodist and a volunteer programme coordinator.

With a full inter-professional team in place, clinical teams of nurses, nurse practitioners, dietitians, social workers, health promoters and physicians are able to roster more than the required numbers, with some physician rosters reaching 5,000 clients and those of Nurse Practitioners exceeding 1200 clients.

Since the majority of Community-governed FHTs

- employ physicians paid on the Blended Salary Model;
- are located in under-serviced areas;
- don’t qualify for funding for other healthcare providers and administrative support until they have physicians in place -

the result is delay in the development of the CFHT and a negative impact on physician recruitment.

CFHTs that participated in the survey indicated that the Ministry needs to reconsider or abandon their rigid formulae for collaborating health-care providers and administrative support funding to take into account the challenges of hiring physicians and the needs of the community.

Small CFHTs with fewer physicians receive very small allocations for collaborating practitioners and administrative support. All CFHTs surveyed indicated a need to ‘re-think’ the allocation formula. Given that most of the areas in which CFHTs are located are designated as under-serviced with large numbers of formerly orphaned patients, these Family Health Teams require greater numbers of collaborating practitioners and administrative support staff.

To require of CFHTs that they first ‘roster-up’ before they can be provided with additional staffing to address the needs of those newly-rostered ensures that providers approach burn-out before they get the help they need.

Some CFHTs report anecdotal evidence of other primary health care groups recommending that patients with complex care needs go to the CFHT where their needs will be better addressed. Those CFHTs surveyed, given these realities - orphaned and complex-care patients in under-serviced areas combined with the concomitant difficulty of recruiting and retaining physicians - indicated that a better solution than rigid allocation formulae would be to provide flexible funding for a staffing complement that reflects the needs of the population and the reality with respect to physician recruitment. That kind of population health needs approach would also ensure increased capacity for access to Ontarians in need of primary health care.
Recommendation:
20. That the MOHLTC set aside both a ‘physician first’ policy and a quota régime as a guide for determining and funding staffing complements in favour of more flexible funding that reflects the needs of the population.

V. GROUP ENROLLMENT

There continues to be confusion around patient enrollment to the CFHT group vs enrollment to the physician. Many CFHTs expressed their concern that if a patient is not enrolled to the group CFHT and a physician leaves, the CFHT is obliged to re-enroll all of the former employee’s clients, the well-being of clients is better served through group enrollment. In many CFHTs, it is the CFHT that has done the enrolling, not the physicians.

Various CFHTs have received very different messages about the group enrollment option, some being informed that it was not an option at all, while others had received a group enrollment form and rostered their patients accordingly. As of Marsha Barnes’ memo of the 25th of April 2007, the Ministry had made it clear that there were benefits to group rostering, ensuring that physicians do not build a roster and then depart with their patient roster, stripping the Family Health Team of its clientele. However, the import of this memo has yet to be fully recognised and supported by the MOHLTC staff working with new CFHTs.

In one CFHT, a physician left to join a FHT in a neighbouring community, but not before she had transferred, with the Ministry’s aid, all of her clients to the new location 20 kilometres away. At a point when the CFHT was close to reaching sufficient numbers of enrolled patients to add providers to the staff, this physician stripped the FHT of more than 1500 of their clientele. Another physician in another CFHT is preparing to do the same thing.

In some CFHTs, the physicians have arrived with a full roster and that fact should be taken into account when and if that physician leaves, but stays in the area.

The MOHLTC, over a period of almost two years, has neglected to put all necessary supports in place to ensure that the principles articulated in the 25 April 2007 memo are adhered to.

Recommendation:
21. That the Ministry of Health and Long-Term Care immediately re-affirm its commitment to group rostering and the principles contained in Marsha Barnes’ 25 April 2007 memo (which made clear the benefits of group rostering, including its function as a check against physicians that depart after building a roster, taking that roster with them and thereby stripping the Family Health Team of its clientele), put the appropriate forms into the hands of interested Family Health Teams and work to redress situations such as the example provided above.
VI. PROVISION OF TELEPHONE HEALTH ADVISORY SERVICES (THAS)

Most Community-governed Family Health Teams are small with five or fewer physicians. Some have found it difficult to reasonably provide Telephone Health Advisory Services (THAS) coverage for the entire week as well as their after-hours care. Consequently, their patients may have to resort to accessing care in a hospital emergency room or walk-in clinic. This, in turn, compromises their Access Bonus. If CFHTs are to provide this service, the full $2,000 maximum should be available, regardless of the numbers of physicians on staff, to be pooled across neighbouring Family Health Teams who will share responsibility for coverage of THAS. In other situations, CFHTs reported that, while on-call services had been provided for many months, they were having to badger the Ministry for payment.

**Recommendations**

22. That the MOHLTC meet with the small Community Family Health Teams in order to negotiate alternate arrangements for after-hours and THAS coverage that takes into account the challenges inherent in a small complement of clinicians.

23. That, once in place, on-call services be adequately supported by the Ministry of Health and Long-Term Care with timely disbursement of on-call compensation.

VII. SPONSORING ORGANISATIONS

Of the participating CFHTs, four had Sponsoring Organisations (SO), five had steering committees that included politicians, First Nations Chiefs and Council and/or municipalities and five had committees that were not identified in either category. The last group would have been comprised of local citizens and community leaders.

The changing role of sponsoring organisations has been an issue with some CFHTs. Some Sponsoring Organisations find themselves in or create a conflict of interest that results in irregular benefits for the organisation. The MOHLTC need to provide clear guidelines for Sponsoring Organisations and their role in CFHT development.

The role of a Sponsoring Organisation needs to be more clearly defined. Over time their role may change but vigilance must be maintained to ensure that no conflict of interest arises due to changes in the role of the Sponsoring Organisation. While some Sponsoring Organisations fulfilled their responsibility to bring a new organisation on stream and then to step aside, handing responsibilities to a fully independent board, the lack of clarity on SO roles has meant that others have not been as clear and transparent in their relationship with the new organisation. Some SOs assumed that, because they had contributed money to assist the CFHT in getting up and running, that they had or were owed an ongoing pecuniary interest and governance role in the new organisation. The results have included hurt feelings, threatened lawsuits, community conflict, the loss of staff and delays in the healthy development of the Family Health Team.
Though Sponsoring Organisations have played critical roles in the development of some CFHTs, future roll-outs of CFHTs would benefit from a set of guidelines so that all parties to the development are clear about their respective roles and responsibilities. SOs can play extremely beneficial roles in the ongoing development and work of the CFHT through an advisory capacity or as a partner in the delivery of programmes and services.

**Recommendation**

24. That the Ministry of Health and Long-Term Care prepare clear guidelines on the following aspects of Sponsoring Organisations: their role on an initial board, their transfer of authority to an independent board, expectations around the SO’s financial contributions, and other long-term involvement.

**VIII. COMMUNITY BOARD GOVERNANCE**

**Board Transition Challenges**

Of the participating CFHTs, all had a Community Governance structure. Seven had partner organisations as board members either on initial steering committees or existing boards. In addition, ten CFHTs surveyed described the role of the current Board of Directors to be positive and supportive.

Two describe their current Board as inexperienced and/or sometimes in conflict. Of the ten that are currently having positive experiences, several have gone through planned turnovers in membership from their original Board of Directors or Steering Committees.

Several CFHTs have experienced some degree of challenge with their Board of Directors. Steering Committees/Boards of Directors that have been involved since the earliest stages of development are familiar with an operational role as is appropriate in those stages. However, such Boards and their members are often in need of additional support as they transition into the oversight role of a Governing Board.

**Recommendation:**

25. That the MOHLTC provide funds adequate to support the unique needs of community-governed Family Health Teams, sufficient to provide training in the model of governance that is at the heart of and distinctive to CFHTs.

**IX. THE ROLE OF THE MINISTRY OF HEALTH AND LONG-TERM CARE**

Many CFHTs indicated that although the Community-governed Family Health Team was a model presented by the Ministry, it was not well understood or supported in the first two years of FHT development. That led to many misunderstandings and difficulties in negotiations which ultimately led to stalled development for some CFHTs. In addition, some CFHTs indicated that the Ministry has made suggestions or given them direction to consider changing their model to a provider-led FHT.
To varying degrees, the CFHTs surveyed felt that the Ministry was not forthright in sharing information with respect to an apparent schedule of required ratios of physicians to collaborating practitioners or formulae used to determine such items as overhead allocations. Many CFHTs indicated that they heard updates or received information from colleagues before the Ministry informed them. Also, there is confusion as to why some CFHTs have seemingly been more successful than others in receiving funding for items such as facility or staffing.

The result is that the CFHT and its preferred method of remuneration for physicians (BSM) is invisibilised by MOHLTC staff who are either unaware of and/or unprepared to speak to the model. With revolving-door site coordinators, CFHTs were constantly have to start over with new people with little or no experience with FHTs, never mind, CFHTs.

From the first announcement of Family Health Teams, the community-governance model was listed as an option available to communities. However, it is an impoverished option when it is, in many ways, as detailed above, at a significant disadvantage in comparison to the physician-led FHTs. No guidelines or roadmaps specific to the needs of CFHTs were in place for those new teams that were starting from scratch, with a new steering committee, no physicians, no rosters, no physical plant. To undertake the development of a new Ministry-funded corporation without such guidelines or roadmaps adds a level of challenge for community groups that can be avoided in the future.

While the physician-led FHTs have benefitted hugely from FHT conferences (whose themes are almost entirely focussed on the needs and concerns of physicians) as well as the well-funded Quality Management Collaborative and its offspring (in whose initiatives some CFHTs and CHCs are participating), the particular needs and concerns of the CFHTs are going largely unmet. Earlier conversations with former staff led the CFHTs to believe that support would be forthcoming, but this has not materialised. Without that support, CFHTs do not have equitable opportunities for information-sharing, networking and professional development on common issues. Having to draw on poorly-funded Overhead budget lines ensures that these opportunities become expendable.

A CFHT Co-ordinator could fulfill many functions that would benefit and facilitate high quality development of Community-governed Family Health Teams, from the organising of sessions for information-sharing and networking to providing training opportunities for staff and boards. A Co-ordinator could work with MOHLTC Site Co-ordinators to ensure that all CFHTs get the same messages and to act as a clearing house for learnings from CFHTs across the sector in order to benefit from those teams already up and running.

At this stage in their development and despite the difficulties enumerated in this report, many CFHTs report high levels of satisfaction with the model. Physicians are glad to be free of the ‘rat-race’ of fee-for-service, high volume, low-satisfaction work, glad to be free of responsibility for leasing, equipping and running the physical plant, and pleased with rich inter-disciplinary relationships within a high functioning team of professionals. It is a model worth supporting.
Recommendations

26. That the MOHLTC ensure adequate training and support for new Executive Directors.

27. That the MOHLTC ensure, as far as it is feasible to do so, that CFHTs are supported with well-informed Site Co-ordinators who provide a long-term and constant presence to guide CFHTs through the steps towards full operations.

28. That the MOHLTC provide funds to a budget line that will allow CFHTs to pool funds to provide a full-time CFHT Co-ordinator who could assist with the co-ordination of information and networking sessions, training, governance, and other services.

X. THE ROLE OF THE ASSOCIATION OF ONTARIO HEALTH CENTRES

Of the CFHTs surveyed, the vast majority indicated that the AOHC has had or could have a positive role to play for their organisation. Five are members of the Association of Family Health Teams of Ontario (AFHTO).

The CFHTs once more repeated earlier recommendations that a CFHT Co-ordinator be hired as part of the AOHC staff team - having been led to believe at a January 2007 constituency meeting with lead members of the Primary Care Team that they would support some kind of arrangement that would fund this position. This arrangement would ensure that CFHTs are able to benefit from the AOHC’s resources and expertise in areas such as board development and training, inter-professional teams, job descriptions, etc.
D. CONCLUSIONS

CFHTs work! Despite the difficulties encountered, communities and dedicated volunteers have collaborated unflaggingly to put in place a model that is ideal for creating an environment that fosters collaborative health-care delivery under the strategic direction of vested and invested community members. Those CFHTs surveyed felt strongly about the model and its potential for success.

In retrospect, it seems clear that many of the obstacles encountered were partly, if not largely, due to a culture of communications that values brevity over detail, that pays insufficient heed to institutional memory, the need to take the time to ensure that a vision is understood and its implementation thoughtfully and carefully planned out and that plan carefully imparted across the breach between vision bearers and implementers, between political staff and the bureaucracy, between the Ministry of Health and Long-Term Care and community groups.

There is a higher degree of adoption of the collaborative practice model by all providers and, of particular note, by physicians who have chosen this model as an employee. This is especially important in rural and under-serviced areas - where the majority of CFHTs are located. Unlike physician-led FHTs, the vast majority of which were conversions from other models of primary health care, including private practice, CFHTs begin from scratch, with the majority of their rosters composed of previously unattached patients. A model of care that advances access to new clients merits support at least equal to that provided to the physician-led FHTs.

At this point, the ability to strategically implement this model successfully is dependent on:

- a tenuous balance of committed, knowledgeable Board members and/or Sponsoring organisations who do not have a conflict of interest;
- a good understanding of the model and BSM physician compensation by the community, Board and Executive Director;
- Ministry support for the Community-governed FHT model and BSM compensation;
- a skilled and experienced business Executive Director with appropriate administrative support;
- appropriate financial management resources; and
- access to relevant information, strong and well-informed support and resources.

With this report, we would urge the Ministry of Health and Long-Term Care to implement the recommendations of this report - not only in preparation for an anticipated roll-out of an additional 50 Family Health Teams, of which we expect a significant percentage to be Community-governed - but for the benefit of those CFHTs in various stages of development through to full implementation.
LOOKING FORWARD

A. WHERE TO NEXT?

This report has enjoyed the broad input and support of CFHT staff and boards. The process began almost a year ago and, as time has passed, our analysis and understanding of both those things that might have been done differently in the past and how we can improve and enhance the success of Community Family Health Teams - has grown enormously. At this point, CFHTs represent sixteen percent of the Family Health Teams, a modest, but mighty, subsection of the model. While CFHTs have had difficulties specific to their chosen model of governance, they have clearly also experienced successes that are specific to the model and grounded in that choice.

The new round of FHT expansion is targeting those areas that are rural, remote, under-serviced. This is where CFHTs have tended to emerge: of the 26 CFHTs, 18 are located in small towns or villages, or First Nations Reserves. They are areas where recruiting physicians has been traditionally challenging. The CFHT model, fully supported, is an attractive model for physicians looking to return to their rural or remote hometowns or with a desire to focus on those specific populations. The model is well-suited to serve those Ontarians who have been long orphaned and in need of getting back to the primary health care they need to prosper.

It is our hope that the issues and difficulties identified in this report are not used as a rationale to avoid the model in the future. Rather than dismissing the model as not worth the effort, we would encourage exactly the opposite: once the obstacles identified in this report are addressed, CFHTs will flourish, attracting both the health-care providers they need and the clients who will fill their rosters.

As we look forward, our respectful expectations and requests are these:

1. That the Family Health Team Action Group receive this report.

2. That the FHT/AG endorse a process that involves the MOHLTC, representatives from the CFHT Executive Director Network and the Association of Ontario Health Centres to review the recommendations in this report as well as an ongoing commitment to resolve issues and report back to the Action Group in six months on progress achieved.

3. That the new expansion support a
   • policy that CFHTs remain recognised as an ongoing FHT model for expansion;
   • fair process whose application and decision-making mechanisms are transparent and equitable for all FHT governance models.