afhto association of family health teams of ontario

CASE STUDY

MOUNT FOREST FAMILY HEALTH TEAM

Summary

Mount Forest Family Health Team has successfully integrated FHT and FHO staffing, benefits, HR policies and procedures and procurement. The organizational culture has shifted so that all staff now operate as one group. The FHT has also integrated staff from a number of external organizations which has doubled the FHT budget in the past year.

Background

Mount Forest is a rural community of 4,000 residents located about 1.5 hours northwest of Toronto. Six physicians in a FHO provide all of the area's primary health care and 24-hour on-call local hospital work. There are three sites – one main site and two physicians who work out of their own offices. The local hospital is the FHT's landlord.

FHT governance is a mixed model, with the Board comprising three physicians, four community members and three hospital representatives. A recent Bylaw change requires the Board Chair to be a community member, which reduces the potential for conflict of interest.

The FHT has integrated and harmonized staff from a number of different employers external to the FHT and FHO. These include:

- Six Outreach Workers are funded by the CCAC, performing care facilitation and coordination for hard to serve populations. Three of these staff work with the Mount Forest FHT, and three work with other FHTs but are employed by the Mount Forest FHT
- CMHA health care coordinator
- CCAC coordinator
- Cancer care coordinator who is funded by a local volunteer group
- Low Back Pain Team contracted with or employed by Mount Forest FHT and working in three FHTs
- Health Links team (Mount Forest FHT is the Health Links lead)

As a result of all of these partnerships and collaborative arrangements, the FHT budget more than doubled in one year.

The Motivation for Change

When the FHT began operation, although four physicians were co-located in the same clinic, the physicians were operating independently with their own assigned staff and shared billing and reception staff and a shared EMR. One FHO physician operated his office completely independently including using a separate EMR. Workplace culture at the time was focused around the physicians' schedules and their obligations in the Emergency Department. An office manager was managing the physician staff, and the Executive Director was managing the FHT staff. The first year of operation saw a great deal of conflict between the two sets of staff. Physician staff had lower salaries, fewer policies and procedures,

Quick Facts:

- Wave 2 FHT (2006/2007)
- 6 physicians in a FHO
- Mixed governance model
- Rural setting
- 12,500 patients (9,250 rostered; a large number of patients decline rostering and pay for their health care services privately)
- 9 IHPs (FHT)
- Physicians employ 3 RNs, 2 medical secretaries, Finance Manager, billing/medical records specialist, 2 receptionists
- Multiple sources of funding

no benefits and less attractive working conditions. The management team (FHT Lead Physician, HR Manager, Executive Director, clinic Lead Physician and office manager) sat down to mediate, to try to understand the environment, and to solve the ongoing tension.

The Process

The management team made the decision to hire a consultant who began by interviewing every member of staff. The result was a report with 175 recommendations, of which 78% have now been implemented. The management team proceeded to make changes, ranging from automating the FHO payroll, to contracting the FHT to provide HR management services to the FHO.

Two agreements provided the basis for the relationship:

1. **FHT/FHO Agreement for HR Management:** This agreement outlines the terms by which the FHT provides HR management services to the FHO. It also defines the reporting structure for staff – i.e. ALL staff now report to the Family Health Team Executive Director; however FHO staff continue to be paid by the physicians. Both entities now use the same pay grid; it took four years to achieve parity. It also took several years to bring all of the nurses to the point where they now practice to their full scope.
2. **A Shared Services Agreement** defines the relationship between the physicians, expectations for sharing coverage and staffing, and a formula for establishing the sharing of expenses.

There are two policy and procedures manuals, one for each employer; however, the manuals are the same.

Mount Forest FHT – Summary of Harmonization to Date

Procurement	✔
Strategic Planning	✔
FHT/FHO Staffing	✔*
Benefits	✔
HR Policies and Procedures	✔

*Note: employment relationship has not changed for physician employees; reporting relationship has changed.

Success Factors

- Open and clear communication
- Frank conversations
- Build trust
- Trying to understand each other's worlds

In addition to these factors, the management team had an 'Aha' moment when it became clear that the two sets of staff were motivated by different drivers. Physician staff had been trained and were accomplished at protecting the physicians' time as a means of optimizing access and facilitating patient care in a fee-for-service world; FHT staff focused on patients first, and ensuring that they could access the care they needed. Achieving a shared vision and undertaking staff education helped to bridge this gap. A clear understanding of the capitation payment model allowed staff to think about quality patient care in a different light.

The integration has been highly successful internally, and sights are now set at potential integration opportunities with external partners.

Accomplishments To Date:

- Successful internal integration, and now beginning to integrate with other service providers in the community. Adding more people to the team so have to redefine roles and responsibilities again.
- All staff now on the same pay grid
- Clinic nurses working to full scope of practice
- Culture has changed now – they operate as one group. No longer seek permission to talk to people on "the other side of the fence".
- All staff feel like part of the FHT – pay cheque may come from the clinic MDs, but the organizations operate as one. The only difference is that the FHT matches staff RSP contributions up to 5%, but the MDs don't. Clinic staff preferred to have more sick days instead of an RSP contribution, so the FHT and FHO were flexible to accommodate differences.
- All staff on the same benefit plan with MDs paying the clinic staff premiums
- Have worked out cost sharing based on trust - Some invoices the clinic pays for, some invoices the FHT pays for and some they pay for jointly.

The Challenges

Not all physicians shared the same vision for the FHT and the FHO, and not all physicians were comfortable giving up some of their traditional autonomy. At the Mount Forest FHO, one physician left when it appeared that he would never be comfortable with this degree of collaboration. Two new physicians who were subsequently recruited also left after a short time. The lesson learned is to ensure that physicians support the service delivery model before they commit to the FHO and the FHT, including the sharing of services and staff, the amount of consultation inherent in the model, and consensus decision making.

Key Tools

Two legal agreements**
Shared services and privacy agreement**

*** Confidential documents. For more information contact the individual FHT for details*

Advice for Other FHTs

- Sit down with front line staff for honest conversations about what's working, what's not working, and what changes would make the system work better. Front line staff have a unique and valuable perspective that can support process improvements. Involving all staff in these discussions also builds a sense of team, and a sense of confidence.
- Use your Executive Director network (formal or informal). Four Executive Directors from similar FHTs (e.g. where physicians provide extensive hospital coverage) have been collaborating for several years. As the Ministry requires FHTs to do more and as FHTs become more sophisticated, this kind of collaboration will become a necessity.

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