Health Links

Ontario Medical Review – Collection of Articles

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Backgrounder

Health Links:

Ontario's new local patient care networks focused on improved outcomes, system efficiency

by Maggie Keresteci
OMA Public and Corporate Affairs Department

IN DECEMBER 2012, THE MINISTRY OF HEALTH AND LONG-TERM CARE LAUNCHED "HEALTH LINKS,"[1] THE LATEST INITIATIVE IN ONTARIO'S MULTIFACETED ACTION PLAN FOR HEALTH CARE.[2] HEALTH LINKS PROVIDES A UNIQUE AND IMPORTANT OPPORTUNITY TO CO-ORDINATE AND MAXIMIZE PATIENT ACCESS TO HEALTH SERVICES, WHILE INTRODUCING EFFICIENCIES IN AN OVERBURDENED HEALTH-CARE SYSTEM.

Based on work undertaken by the Institute for Clinical Evaluative Sciences (ICES), the Health Links model recognizes the essential role of primary care providers in the health transformation agenda, as well as a need to better integrate a vast array of specialties and services in order to co-ordinate the full patient journey through the health-care system, thus ensuring higher quality care and improved access to care without duplication of services.

The model identifies a need for local (sub-LHIN level) partnerships in the form of patient care networks — voluntary, self-organizing systems designed to encourage greater collaboration between existing local health-care providers, including family care providers, specialists, hospitals, long-term care, home care, and other community supports.

While the Ministry and Local Health Integration Networks (LHINs) will provide assistance to develop and implement Health Links locally, all Links will have a co-ordinating partner such as a family health team, community health centre, community care access centre (CCAC), or hospital, and will be accountable to their local LHIN.

Each Health Link will include representation from patients, their families, family physicians and specialty physicians, allied health professionals, hospitals, CCACs, and long-term care and community service providers who will report on a focused set of indicators, which are consistent across those providers. These indicators must be capable of measuring meaningful change in the sector.

Minister of Health and Long-Term Care Deb Matthews signalled the importance of Health Links when she recently referred to the initiative as one of the "major transformational milestones of the past year" (along with the ratification of the Physician Services Agreement, health-system funding reform, and the introduction of the Seniors Strategy).[3]

In the first phase of the Ministry's rollout of the Health Links model, the focus will be on high system users — the 5% of patients who account for approximately 66% of health-care costs in the province. These patients have an array of complex disorders, and while they use a large proportion of health resources, there is accumulating evidence suggesting that neither patients' experience, nor their quality of care, is improving.

While it is hoped that the entire province will eventually be represented by Health Links — with rolling on-boarding of new Links as they are ready to implement — to date, a total of 19 early-adopter Health Links have been announced. Each will have until the end of February 2013 to develop and present a business plan to the Ministry of Health and Long-Term Care. Of these, eight are being led by primary care providers (seven FHTs, and one FHO), one by a community care organization, four are led by community health centres, and six have hospitals or CCACs as the co-ordinating partner.

Transitioning from "silos" to "systems" by closing the gaps within and across health-care sectors was the primary objective in the creation of

the LHINs and should continue to be a central feature of Ontario's vision for health system restructuring.

However, moving responsibility for co-ordination to the local level is not sufficient to enhance quality and efficiency. To succeed, integration initiatives need a clear mandate, committed partners, outstanding physician leaders and a vision that will mobilize system providers and the public.

The OMA is looking to physicians for input that will allow us to best determine where barriers and obstacles to participation exist.

Also, we are working with the Section of General and Family Practice, as well as the Ontario College of Family Physicians, the Family Medicine Alliance, and the Association of Family Health Teams of Ontario to better co-ordinate efforts to support physicians as Links evolve.

The next step is to identify the relevant specialties and to work with them through their OMA Sections to understand their needs and support them in the Health Link initiatives with which they are participating or contemplating participation.

The OMA and Ministry of Health and Long-Term Care have formed a joint committee to explore engagement of the OMA in the process, on behalf of physicians, and ways of advancing a meaningful collaboration. The joint committee provides a mechanism and forum for critical dialogue and meaningful feedback to the Ministry.

By joining efforts to improve the health of Ontarians and support the province's physicians as this new model is implemented, the OMA is building on a renewed partnership with the Ministry to enhance the patient experience and outcomes.

The co-ordination of health-care services is an important element in a high performing health system. The OMA hopes that integrating services, through Health Links, will increase quality and efficiency, as well as access, safety, and patient satisfaction by improving care co-ordination. The OMA will strive to represent the physician voice in this process. To this end, the Association will advocate on behalf of members and patients to ensure that the implementation of Health Links will achieve the goals of integration without imposing burdensome administrative requirements.

The OMA is speaking to many members to answer questions, share information about Health Links, and have dialogue about what this new model might mean to them. We are discussing what questions might arise for a physician considering involvement, and ways to navigate the development of a business plan. The OMA is exploring what the optimal role for the Association is to provide assistance to physicians in the early adopter and emerging Health Links.

The OMA's efforts to support Health Links will leverage the strength of our members, the collective breadth of expertise within the OMA, and will be integral to positioning the new model of care for success. We look forward to sharing more information as the Health Links take shape. ■

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For more information on Health Links and the support the OMA can provide, please contact Maggie Keresteci, Director, OMA Regional Engagement and Constituency Services, at 1.800.268.7215, ext 2883, or email Maggie.keresteci@oma.org.

Health Links: Key Features

- Patient-focused – initially on the needs of patients with complex disorders.
- Local focus – operating at the sub-LHIN level, and accountable to LHINs; defined by existing natural health service utilization patterns (with minimum of 50,000 population).
- Voluntary participation of all providers caring for highest user group (at a minimum, each Link has to have involvement of a hospital, community care access centre, primary care, speciality care, etc.).
- Focus on collaborative initiatives to improve patient care at lower system cost.
- Requires involvement of "robust" primary care providers (all delivery models) within the community.
- Leadership by all participants, with an identified "co-ordinating partner" equipped with the skills to achieve results.
- Collaborating providers include minimum of 65% of primary care providers in the defined region.
- Robust information management practices (shared between all Health Link participants) that allow identification and tracking of improvements for the complex patient population.
- Identified and accepted "lead organization" in good standing in terms of accountability and governance.

FEATURE

Health Links: Physician Leadership As A Key To Success

findings from OMA jurisdictional research

by Maggie Keresteci
OMA Health System Programs

MANY JURISDICTIONS HAVE BEEN STRUGGLING WITH QUESTIONS ABOUT HOW THEIR COMPLEX HEALTH-CARE SYSTEMS CAN EFFECTIVELY IDENTIFY AND IMPLEMENT NEW WAYS OF DELIVERING CARE THAT WILL RESULT IN AN IMPROVED PATIENT EXPERIENCE, IMPROVED CLINICAL OUTCOMES, AND BETTER RETURNS ON INVESTMENT.

Late in 2012, the Ontario Ministry of Health and Long-Term Care (MOHLTC) announced Health Links, which represent a new way of delivering health care. The evidence suggests that several key themes are consistently found in high-performing health systems (see Figure 1, p. 15). Health Links builds on many of these themes and will provide a forum for collaboration among different health sectors focused on high-need patients. They are intended to mobilize the delivery of co-ordinated care across the continuum of care, specifically for those Ontarians with complex conditions.

The aging population and a growing prevalence of chronic diseases necessitate a re-orientation of the health system from a historic emphasis on acute care to a focus on prevention, self care, and more integrated care, particularly for those with complex, often co-morbid conditions.

The Ontario Medical Association and Ontario's physicians are actively contributing to the development process of this integrated care model. As part of the OMA's contribution to Health Links, a research study was undertaken to better understand the international experience in implementing integrated care programs and how those experiences can be leveraged by the emerging Health Links initiative in Ontario.

The analysis we undertook examined the experiences in Australia, Sweden, New Zealand and the United Kingdom, as well as Canadian experiences in the provinces of British Columbia and Alberta.

We asked the question, "What enabled other health systems to effectively implement programs similar to Health Links, and how could their successes and their challenges be applied in Ontario?" Through a systematic literature review, and interviews with key informants in each of the jurisdictions, our question was answered. We will report the results of this analysis in a series of four articles appearing in the OMR, of which this is the first.

In this article, we focus on the consistently reported success factor across jurisdictions — the notion that providers

> ***"System transformation happens from the bottom-up, even when the concepts are derived at the Ministry of Health and Long-Term Care and Local Health Integration Networks (LHINs). Using an intentional, complexity science approach (especially the use of minimum specification), transformational change concepts can be introduced and nurtured. This requires becoming comfortable with uncertainty, and trusting the process of change to occur without knowing the exact outcome at the outset."***
>
> Dr. Jonathan Kerr, primary care lead, South East LHIN

must own the development of the local processes, mechanisms and solutions for transformative integration of health-care delivery.

Many of the jurisdictions examined have seen clinically relevant and positive results from their efforts to better integrate care of patients, particularly complex ones. These positive results have not appeared overnight but rather are the outcomes of long-term strategic planning, and a willingness to adjust as the initiatives evolved. The international jurisdictions considered have all been fine-tuning their program designs for several decades.

Successful models have a number of things in common, and their success is correlated with the ability of the jurisdiction to create a culture of innovation and the necessary infrastructure and resources to support integration efforts. The evidence from these and other integrated health-care initiatives points to the need for highly organized and appropriately incentivized primary care as a requisite for the transformation of health-care services and the enhancement of patient care.

At the systemic level of health policy, government's responsibility is to "steer" the course of a reform. While this steering role is fundamentally seen as useful and appropriate, the jurisdictions we explored make it clear that when a government veers from "steering" and takes on the role of "rowing," or implementing the reform at the programmatic level, there is less success and more scrutiny because, the level at which the government operates often makes doubtful its ability to see reform through by addressing local needs.

The providers interviewed across jurisdictions face similar challenges in this domain in that election cycles can make it difficult for government agencies overseeing the health system to abstain from interventionist management of a reform. While it is understandably challenging at times, success of the reform hinges on the government's ability to accept uncertainty in the short term in a way that allows providers to "row" and truly take ownership of the objectives and program — not just simply "buy-in." Every jurisdiction that informed our results highlighted the integral role of provider ownership and engagement that will facilitate iterative policy development and lead to incremental, but sustainable, progress.

Figure 1
Key Themes Underlying High-Performing Health-Care Systems*

- Consistent leadership that embraces common goals and aligns activities throughout the organization.
- Quality and system improvement as a core strategy.
- Organizational capacities and skills to support performance improvement.
- Robust primary care teams at the centre of the delivery system.
- Engaging patients in their care and in the design of care.
- Promoting professional cultures that support teamwork, continuous improvement and patient engagement.
- More effective integration of care that promotes seamless care transitions.
- Information as a platform for guiding improvement.
- Effective learning strategies and methods to test improvements and scale up.
- Providing an enabling environment buffering short-term factors that undermine success.

** Reproduced with permission. Baker GR. The roles of leaders in high-performing health care systems. London, England: the King's Fund; 2011. Available from: http://www.kingsfund.org.uk/sites/files/kf/Roles-of-leaders-high-performing-health-care-systems-G-Ross-Baker-Kings-Fund-May-2011.pdf.*

This is counter to the more common and perhaps easier approach of getting provider buy-in for an already developed plan of action for reform. Provider ownership, however, is a prerequisite for long-term success. Across all the jurisdictions studied, a dependence on grassroots physician-led primary care organizations as a springboard to launch integrated care efforts have been keys to success. Clinical leadership from primary care physicians has been shown to encourage wider family physician engagement with health-care integration initiatives, suggesting that clinical leadership lends credibility to health-care system transformation agendas.

Dame Ruth Carnall, former chief executive of England's National Health System (April 2007 to April 2013), was appointed with a mandate to lead reform. When asked about what she had learned from her tenure that could serve as advice for her successor, she said that to deliver any sort of transformation agenda, one must first gather around them, "the best, most ambitious, bravest group of clinical leaders that you can possibly muster…without that you can't make any progress on any of the big things you want to do."[1]

Alberta's Tripartite Agreement ensured shared decision-making and shared development of the implementation of the Primary Care Networks (PCN) through meaningful engagement of primary care clinicians.[2] Although the agreement was not renewed in 2012, the Alberta Medical Association and its Primary Care Alliance have a place at the table to provide advice and be part of the decision-making on major issues pertaining to the reform, including new accountability framework for PCN 2.0.

Frequent changes to the health delivery structures in England, which have been largely top-down in design, have left clinicians, executive managers and policy analysts uncertain about the newest model set out in the Health and Social Care Act (2012). The new Act features stronger accountability mechanisms and governance for new commissioning bodies, which means that providers will have to be mindful of the need for full disclosure and conflicts of interest when commissioning care and services. The new regulations have led

to concerns about the risk of over-regulation because it is feared increased regulatory rigour may stifle local innovation.

There is much to be learned from the experience in the United Kingdom, which has undergone seven major health system reforms in the last 20 years — with increased frequency and breadth of reforms in the past decade. Key informants interviewed about the United Kingdom experience noted that the need to renew provider buy-in after top-down changes such as those experienced in England can lead to a lack of engagement, cynicism, and uncertain or stalled progress.

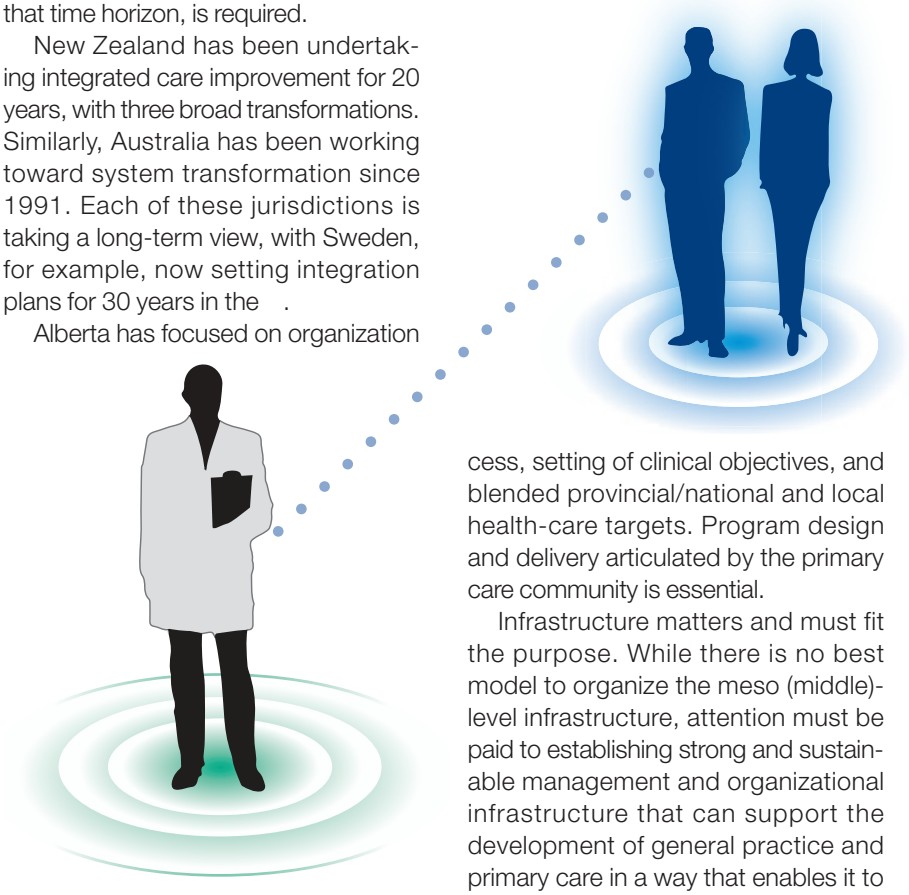
It has been noted that in the case of England's National Health System, structures and systems were changed before they had a chance to prove themselves, and primary care groups were abolished at the point when there was at least emerging evidence that they were in fact getting better at the job that had been put before them.[3]

Successful integration efforts take innovation, flexibility and time — a long time — so patience is necessary. A long horizon, with a solid strategy to span that time horizon, is required.

New Zealand has been undertaking integrated care improvement for 20 years, with three broad transformations. Similarly, Australia has been working toward system transformation since 1991. Each of these jurisdictions is taking a long-term view, with Sweden, for example, now setting integration plans for 30 years in the .

Alberta has focused on organization of primary care, adding disease-specific networks and integration initiatives over the last 15 years. British Columbia has chosen to adopt a variation of the Australian model of integration through multiple related programs and organized divisions of practice, jointly developed and supported by the province's Ministry of Health and the British Columbia Medical Association.

Of note, primary care physician engagement has not been episodic, but rather systematic and iterative in areas, including evaluation frameworks, process, setting of clinical objectives, and blended provincial/national and local health-care targets. Program design and delivery articulated by the primary care community is essential.



Infrastructure matters and must fit the purpose. While there is no best model to organize the meso (middle)-level infrastructure, attention must be paid to establishing strong and sustainable management and organizational infrastructure that can support the development of general practice and primary care in a way that enables it to meet the fiscal and health challenges ahead.[4] Primary care organizations are vital to reform, and engagement should be voluntary but irresistible.[5] British Columbia has utilized this approach to help drive a quality improvement agenda in family practice. A strong primary care system with appropriate infrastructure has been shown to be essential if health system transformation initiatives are to be sustained.

The second article in this series will examine the programmatic (meso-level) structures that have been implemented in successful models of integrated care.

As Ontario embarks on health system reforms, including Health Links, there is an opportunity to learn from and leverage the lessons learned about the importance of finding and implementing the right infrastructure, and the recognition that transformation is a long process that requires patience.

As the model evolves, with more than 30 Health Links now in place, the Ontario Ministry of Health and Long-Term Care has recognized that reforms such as these require a bottom-up approach, led by providers.

As such, the Ministry has designed Health Links purposefully as local initiatives that are generated at the local level, by local health-care providers, to meet the needs of complex patients in the community. ■

For more information on Health Links, contact Maggie Keresteci, Senior Director, Health System Programs, OMA Engagement and Program Delivery, at healthlinks@oma.org, or visit www.oma.org/healthlinks.

New Zealand Ministry Of Health: Statement Of Intent 2012/13 to 2014/15

"Clinical integration of services to better meet people's needs requires effective leadership, including clinical and professional leadership, and effective engagement with the sector.

Collaborative cultures, appropriate governance arrangements and good information systems will be key to the success of this work.

The shift towards a regional planning approach among District Health Boards and effective engagement of the clinical workforce will lead to better health care at the front line."[6]

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FEATURE

Part 2

Health Links — the importance of infrastructure:

examining the role of meso-level support

by Maggie Keresteci
OMA Health System Programs

AS HEALTH LINKS CONTINUE TO EVOLVE, THE ONTARIO MEDICAL ASSOCIATION IS STRIVING TO EQUIP ONTARIO'S PHYSICIANS TO BE SUCCESSFUL IN THIS NEW MODEL OF INTEGRATED CARE.

In this effort, we undertook a review of international experience for similar initiatives, including a literature review and structured interviews with key informants from leadership roles in health care in Sweden, the United Kingdom, Australia, New Zealand, as well as the Canadian experiences in the provinces of British Columbia and Alberta, to seek evidence about key success factors.

The purpose of this research was to inform our understanding of the international experience in developing integrated care models, particularly to gain insight about the enablers for a primary care centred integrated care model.

In the September edition of the OMR, we reported on one of the fundamental findings of our research: that physician leadership is a key to success. In this article, we examine what our research revealed about how effective integration is dependent on a range of diverse factors operating at macro, meso and micro levels of health care (see Figure 1, p. 28).

Specifically, this article explores the requirement to ensure that the supporting meso-level infrastructures are fit for purpose to achieve the objectives of the integrated care strategy — in this case, Health Links.

Health Links seek to integrate care for the most complex of patients across Ontario. Integration, collaboration and care co-ordination are all terms that are often used interchangeably when discussing Health Links. All of these concepts in action contribute to the prevention of care fragmentation, which is a particular problem in high-needs patients. Fragmentation refers to breakdowns in communication and collaboration among the vast array of people and agencies providing services to an individual. Such breakdowns commonly create gaps in the timeliness, quality, safety, efficiency, and patient-centredness of care.

It is useful to think of these concepts along a continuum, with integration being defined as a property of the system that increases the likelihood of good communication and collaboration among health-care providers. Co-ordination refers to specific activities that are undertaken to improve communication and collaboration among those health-care providers who are caring for individual patients.

While one can co-ordinate care for a patient in a non-integrated system,

> ***"…You will not get any momentum, unless you have people with clinicians who can pick up the task after the decisions are made and implement them…You will not be able to do reform off the back of practices…if these practices are not in a network already, you will need to create it somehow and support them…"***
>
> Cathy O'Malley, Deputy Director General, Ministry of Health, New Zealand

and vice versa, the two are presumably positively correlated and should exist alongside each other. Optimal care co-ordination, at its core, requires personal relationships and good communication among a variety of caregivers. Integrated systems, with appropriate infrastructure in place, should foster communication and personal connections among providers.

Alongside clinical leadership, significant management capacity (skills and infrastructure) is required to ensure success in integrated models of healthcare delivery. In this article, we explore a consistently reported key finding in our research: that the meso-level infrastructures to support such a model of integrated care that results in care co-ordination must be fit for purpose.

Meso-level infrastructure is unique in its breadth and is essential to the development of policy at the programmatic level – in other words, it sets priorities for the system. At the same time, meso-level infrastructure encompasses the organizational level that is responsible for the production and delivery of services.[1] In the case of the delivery of health care, this is an important distinction because it means that the meso-level support is connected to government, but grounded in service provision by promoting connections between organizations.

The challenge at the provider (micro) level is in encouraging a diverse group of providers, who generally operate separately, to increasingly work together. Meso-level infrastructure facilitates this process by leveraging effective leadership, physician-management partnerships, and a collaborative approach to identifying and solving shared problems.[1] Ensuring meso-level support is fit for purpose is a fundamental success factor identified in our research and will be integral to the success of Health Links.

While all of the key informants in our research stressed that for integrated models of health care to function well, a strong meso-level support system is needed, we did not uncover an optimal way to organize the meso-level infrastructure. Instead, the conclusion arrived at in the case of all the jurisdictions examined was the requirement to develop strong and sustainable meso-level infrastructure in a way that supports the evolution of general practice and primary care such that it enables them to meet the financial and health challenges ahead.[2]

To explore middle-level support further, we will examine three of the models of meso infrastructure that came to light in our research (British Columbia, Alberta, and New Zealand). These examples illustrate a wide range of organizational possibilities to provide support in a transformation agenda such as Health Links. The supports all share the characteristics of a network, although the names varied. In this article, unless referring to a specific jurisdiction's organization, we refer to primary care networks to describe the networks that can operate as meso-level support.

In the province of British Columbia, a unique model of meso-level support exists. The British Columbia Medical Association (BCMA) is an active meso player in the province's integrated care efforts. The BCMA works directly with the government to determine the services that physicians will provide, and the services that will be provided by government for the physicians.

The support provided by the BCMA and the Ministry of Health is defined as a partnership, and the key informant interviewees stressed a vital feature of their model as being meso support delivered through a partnership arrangement, rather than two agencies providing support in parallel.

The BCMA, in partnership with the Ministry of Health, has developed and administered programs through the BCMA General Practice Services Committee (GPSC). The role of the GPSC is to develop and implement strategies that optimize use of the

Figure 1

Macro Level (i.e., Ministry / Public Health Authority)
- Activities that promote *organization-to-organization* collaboration
- Handles health policy at:
  System level — institutional arrangements for regulation, financing and delivery of care
  Programmatic level — setting specific priorities for the system

Meso Level (i.e., networks, co-ordinating bodies)
- Activities that promote *working between organizations*
- Handles health policy at:
  Programmatic level — setting specific priorities for the system
  Organizational level — production of services with focus on quality assurance and efficiency

Micro Level / Autonomous providers
- Activities that promote integration *among individual practitioners working in a single organization* (practice)
- Responsible for providing services at point of care

cumulative designated funds to support enhancement of primary care. The GPSC also organizes divisions of practice, which are supported by the BCMA. Each division of family practice works in partnership with its health authority, the GPSC, and the Ministry of Health to identify gaps in a division's community, and then to develop solutions to fill these gaps.

The divisions are professionally led, regionally based, and government-funded voluntary associations of family physicians that seek to co-ordinate local primary care services and improve health outcomes. They are self-organized and determine local priorities for family physicians to support and develop.

The Ministry of Health wants to use divisions more because the evidence has led them to conclude that this organizing structure will play a facilitative role to enhance quality of care and contribute to the province's efforts to utilize and add data to its quality framework.

The 32 divisions in the province are funded using a formula that is based on the number of physician members in each division and amounts to several thousand dollars per physician per year. This funding recognizes the need for, and is meant to support, local administrative and organizational infrastructure to co-ordinate the common goals of the division.

In addition to the local supports that divisions can fund directly with per-physician funding, the Ministry is responsible for funding centralized support services. These centralized services are administered jointly through the BCMA, housed within the structure of the BCMA, and directed with meaningful provider input through a joint committee of the Ministry and the BCMA.

An example of these services is a Practice Support Program (PSP) that provides quality improvement training modules for family physicians, specialists, and administrative staff on process improvement (complex patient management) and system-level improvements (improved office flow, etc.).

In Alberta, the Alberta Medical Association (AMA) is an active meso player, and has guided the introduction of the professionally led primary care networks (PCNs). The PCNs are voluntary networks of family physicians. It is these PCNs that provide and co-ordinate delivery of care.

In 2013, there are 40 PCNs with 80% of practicing family physicians in the province enrolled. The AMA has negotiated annual capitated funding, based on the population enrolled, for each network, and new fees for the family physician members who take on a leadership role, assuming additional responsibilities within the network.

The Primary Care Alliance (PCA) housed within the AMA has been requested by the Minister of Health to lead the development of a blueprint and action plan for an enhanced Primary Care Network (PCN) Program in Alberta (the current name of the initiative is PCN 2.0).

The Primary Care Alliance is reviewing policy, operational and performance findings as they relate to the current program, with the objective of identifying key principles for the PCN 2.0 program, and to provide recommendations about how best to put those principles into action.

Finally, the meso-level support model in New Zealand relies on local/regional professionally led networks that negotiate with district health boards to set out the scope of services and budget. Independent Practitioner Associations (IPAs) have weathered significant changes in government and health policy directions. In the 1990s, in true grassroots fashion, physicians organized IPAs, which have evolved over time and are now viewed as the backbone of primary care in the country. The role of meso-level support in New Zealand is filled by these autonomous, non-statutory organizations that bring independent practices together into what in essence are primary care provider networks.[2] Each network has the capacity for planning, development and provision of support to local providers. The system is seen to be nimble and responsive to the local needs of the population, as well as to the needs of providers and their practices.

These networks are cited as being a key factor in the success of many of the Primary Health Organizations (PHO) in the country. These are non-government bodies with community-focused governance contracted to District Health Boards (DHB) to provide primary care and preventive services to a defined population.[3]

> ***"We believe that successful implementation of primary care networks in Canada would turn the dirt road of communication between primary care and the rest of the health-care system into a four-lane highway."***
>
> Dr. Jacques Lemelin, Primary Care Lead, Champlain LHIN

Typically, there is a tendency to underestimate the need for infrastructure and managerial support in system integration efforts. However, it is important to recognize the essential support that is provided by a meso-level organization.

According to the Alberta Primary Care Initiative Policy Manual, "Some physician-led provider organizations have been successful in delivering higher quality care at a lower cost than equivalent organizations, but many initially underestimated the intensity and complexity of management process needed to deliver these benefits and the time and support needed to engage local professionals in delivering a new form of care."[3]

Discussion

While the mechanisms and structures with which to deliver meso-level support vary, a shared feature among all

successful systems examined in our research is that they have organized family doctors into some form of a primary care network that operates at the meso level. In our key informant interviews, governments and providers agreed that if one values clinical leadership, it has to be supported. Government sources we interviewed stressed that government needs to provide resources for management infrastructure that is designed to support the purpose.

In the case of Ontario, there are primary care leads that are attached to each of the Local Health Integration Networks (LHINs) and who support Health Links among other initiatives. Coalitions like these have the potential to provide important meso-level support infrastructure for initiatives such as Health Links.

Primary care networks are well positioned to provide meso-level support for integrated care initiatives. We were prompted to question why primary care networks are so successful in this role. The conclusion we reached is that these networks are positioned for success when they are led and governed by providers, as discussed in a previous OMR article,[4] and when they have integrated clinical and business management and infrastructure.

It is clear that differentiated expertise is required to address all aspects of the Health Links mandate, including building and maintaining relationships, network coherence, and stability. Simply being paired with a business manager is not sufficient for a clinical leader to have the impact that a dual leadership model provides.

Clinicians also need assistance in order to "balance their role in supporting and challenging their peers."[5] The BMCA and AMA models ensure that clinical leadership is supported to drive the reform through business management in parallel with funding mechanisms.

There is a need to find the balance between government directed/funded meso-level support and meso-level support that originates at the local organizational level. Our international key informants cautioned that governments need to tread softly when they engineer primary care networks as meso-level supports.

"The benefits of clinical involvement are at risk, if PCOs (primary care organizations) become unduly bureaucratic, managerially controlled or perceived as belonging to the wider health system, rather than local clinicians."[6]

Physician engagement, and therefore the level of innovation, are negatively correlated with the level of bureaucratization of a primary care network.[7] As such, the objectives of transformation initiatives such as Health Links are best served when government engages providers in open discussions on the details of the initiative, including scope, scale, evaluations and funding mechanisms.

While clinicians guide the clinical process in the evolution of Health Links, determine the clinical need and the optimal patient pathway, people and agencies with business expertise and management skills must be there to pick up the task after the clinical decisions have been made. Solid meso-level support means that the clinical needs and optimal patient pathways can effectively move to implementation.

Primary care networks playing a role as meso-level support to health system transformation initiatives act as a hub to give providers a collective voice, choice and representation. In time, as these networks evolve and mature, they will become more likely to organize among themselves and to link problems with solutions in politically saleable ways to make changes in policy frameworks or the rules of the game.[8] This level of physician leadership and organization will be pivotal to transforming health care in Ontario.

The next article in this series will explore ways in which micro-level infrastructure at the point of delivery of care can contribute to integrated care initiatives. ■

For more information on Health Links, contact Maggie Keresteci, Senior Director, Health System Programs, OMA Engagement and Program Delivery, at healthlinks@oma.org, or visit www.oma.org/healthlinks.

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- Jyu, Christopher (Primary Care Lead, Central East LHIN, Ajax, Ontario). Correspondence 2013 Jul 12.
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- Kerr, Jonathan (Primary Care Lead, SE LHIN, Belleville, Ontario) Correspondence 2013 Jul 12.
- Lemelin, Jacques (Primary Care Lead, Champlain LHIN, Ottawa, Ontario) Interview 2013 Jul 12.
- Ludwick, Dave (General Manager and CEO, Sherwood Park Primary Care Network, Sherwood Park, AB). Interview: 2013 Jun 24.
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Pre-Council Physician Leader Consultation
Friday, November 22, 2013
1:00 p.m. - 5:00 p.m.
Sheraton Centre Toronto Hotel

The Joint Governance Review Working Group (JGRWG) is committed to ongoing consultation with physician leaders to best align the decision-making bodies of the Association. There will be a half-day interactive dialogue, facilitated by the Working Group and **Mr. Glenn H. Tecker**, to examine and provide feedback on the roles and responsibilities of the OMA's governance bodies, including the Board of Directors and Council, and how they relate.

This engaging session will be held at the Sheraton Centre Toronto Hotel, 123 Queen Street West in the Osgoode Ballroom from 1:00 - 5:00 p.m. (lunch will be served from 12:00 - 1:00 p.m.). Please note that the Sheraton Centre is within walking distance from the Hilton Hotel where the Council meeting is being held.

Glenn H. Tecker is a principal partner, Chairman of the Board and Co-Chief Executive Officer of Tecker International, LLC, a firm specializing in research, strategy and leadership that has completed projects for more than 2,000 organizations around the globe. Glenn has assisted a wide variety of trade, professional and philanthropic organizations in the re-design of governance, program and operations so that they might more effectively navigate through today's rapidly shifting environments.

For more information on the November 22 Pre-Council Physician Leader Consultation, please contact: Jennifer Kelly, OMA Corporate Affairs. Email: Jennifer.kelly@oma.org (preferred), or tel. 416.599.2580/1.800.268.7215, ext. 3802.

To register for the November 22 Pre-Council Physician Leader Consultation and the Fall Meeting of OMA Council, please contact Jennifer Csamer via email (Jennifer.Csamer@oma.org).

FEATURE

Part 3

Health Links: enabling physicians to "row" the reform

by Maggie Keresteci
OMA Health System Programs

AT THE LEVEL OF HEALTH POLICY, GOVERNMENT'S RESPONSIBILITY IS TO "STEER" THE COURSE OF A REFORM OR A PROGRAM. HOWEVER, GOVERNMENT'S ROLE IN "ROWING" OR IMPLEMENTING A REFORM (AT THE PROGRAMMATIC LEVEL) REQUIRES SCRUTINY.

Government's ability to see a reform through, while addressing local programmatic and community needs, is challenging. The findings from in-depth interviews that formed the basis of the Ontario Medical Association's jurisdictional review are in alignment with the systematic literature review we undertook. Each concluded that the success of the reform hinges on the government's ability to accept uncertainty in the short run, be patient, and allow providers to do the "rowing" and take ownership.[1]

Frequent interventions and changing health-care agendas can be destructive, costly and demoralizing, particularly for providers. When these interventions and changes are continual and largely top-down, time is seen to be swallowed up by the many reorganizations in the health system superstructures, and for physicians at the "micro" level of delivering care, there is then too little time or too few resources available to accomplish the goal of improving services and outcomes for patients.[2]

Our research sought to identify key success factors in integrated care initiatives in support of Ontario's physicians as Health Links evolve across the province. The results point clearly to the fact that jurisdictions that succeed with structural reform have engaged providers in "rowing" the reform. They have done so by maintaining voluntary participation and supporting flexible funding, as well as putting in place structural and governance designs with minimum specifications. In the stories of success about integration efforts, the interaction with physician providers is not episodic, but rather iterative and purposeful throughout all phases of development and implementation.

In building a system that incorporates the transformative elements of Health Links, it is important to ensure that physician ownership is sought, and that the appropriate meso-level infrastructure is put in place to support providers on the "front line" of care delivery.[3,4] In parallel, it is vital that those providers practising at the micro level are equipped for success. Our research results provide clear guidance about what needs to be in place to accomplish this.

New Zealand has embarked on primary care reform by first establishing the required infrastructure in the form of Tripartite Alliance Agreements (between the ministry, district health board and providers).[5] By doing this, they have ensured that independent primary care provider groups are key informants about how the provision of services will be developed and delivered.

What is important here is that the Alliance Agreement creates a structure to enable clinicians, alongside managers and others, to make decisions about how to apply resources to specific services to achieve the best outcomes. The Alliance Agreement reinforces the necessity of working directly with care providers and practices to increase physician ownership, and to increase the likelihood of success for patients and the system. Effective programmatic support at the point of care delivery was confirmed as a key success factor in our jurisdictional review.[4]

There are three clear elements that need to be in place for a health system integration effort to be effectively implemented by physicians at the program level. Each of the informants we interviewed identified these as essential success factors.

1. Scale And Scope

First, it is very important to identify the optimal scope and scale of the integration initiative that physicians, as

part of an interprofessional team, are meant to implement. Scope in an integration initiative refers to the breadth of the initiative, and in health care normally refers to the population(s) or the disease(s) or condition(s) of focus. It also refers to the specified range of services that are to be offered by the integrated providers.

One of the fundamental features of the scope assessment is to determine which providers and services are included in the initiative, such that a specified range of services can be articulated as requiring and benefitting from the meso-level supports that need to be in place. By having clarity about the scope, physicians can be prepared and equipped for success, and government can work with providers to ensure that meso-level support infrastructures are appropriately designed to advance the integration initiative.

Generally, our informants recommended that the integration initiative have a broad scope, at least initially, and then to focus/narrow that scope as the integration became integral to the system. The majority of the initiatives we examined began with efforts to address integration in the total patient population or a broad proportion of the population.

After establishing process, ensuring outcomes of interest were being addressed, and appropriate infrastructures were in place, the efforts then evolved to focus on specific priority patient populations, which for several jurisdictions included the most complex patients. In our review of other jurisdictions, a focus on a specific population, such as complex patients, was often a secondary initiative within the context of better integration, once achieved.

In Ontario, the Health Links initiative focuses on patients with the most health-care needs, with the most complex conditions, and who, often, as a result of the complexity of their situations, have experienced the most fragmented care. It will be important and interesting to evaluate progress as Health Links evolve so we can assess whether the approach to focus on complex patients at the initial phases of the initiative has differing results than those seen in international integration efforts that began with a broad population approach.

In health system integration initiatives, scale is an important feature that refers to the size of the population or geographic area around which care is centred and integrated. Determining appropriate scale has been noted as a significant challenge for the jurisdictions we examined, with many having experienced several devolution/consolidation cycles as they tried to find the optimal scale for their transformative integration efforts.

For example, New Zealand began with 82 primary care organizations in 2008, and by 2012, it had reduced this number to 31. The United Kingdom had 303 Trusts in 2003, lowered this to 152 in 2005, and then grouped providers into 50 clusters in 2011.

The challenge of scale determination is that policy-makers and providers are facing a trade-off between staying local and responsive versus being efficient and having the right size to exploit economies of scale to maintain necessary management support and handle service risk.

Smith and Thorlby point out that bearing service risk requires a degree of scale.[6] For a consortium such as that required of a Health Link, this translates to the need for primary care providers who are the co-ordinating partners in a Health Link to be able to influence the other providers, such as hospitals and community care providers, to work diligently toward the desired outcomes.

The optimal scale is important in ensuring this leverage because if the scale is right, it means that the providers already have relationships in existence that are local enough to foster shared focus on the outcomes, while at the same time realizing the benefits of economies of scale.

While there is recognition of the need to have the right scale, there is no evidence that specifically identifies the optimal workable, most effective scale for integrated care initiatives. Much depends on the scope of the integration, as well as the existing connectedness of the local community of health-care providers.

> ***"Quality of care improvements for patients could be significant if integration leads to more co-ordination between formerly fragmented service providers. The potential economies of scope and scale from integration are likely, however, to take a considerable time to realize and are unlikely to justify integration on these grounds alone."*** [11]

There are countless factors that affect determination of scale that range from geography and rurality to access to service and maturity of the existing referral and network systems. Furthermore, despite an average of 22 years of experience in the implementation of integration efforts in those jurisdictions we studied, the international researchers, providers and administrators we consulted have not reached consensus on the optimal scale for these initiatives.

The scale of the locus of the initiatives we examined varied from populations of 30,000 to 100,000. It does seem that in health system integration efforts, smaller scale operations require considerable assistance to help them reach economies of scale. For the Health Links initiative in Ontario, the scale that has been set — at least in the initial phases of the implementation — is a population base of 50,000.

The jurisdictions we examined all expended considerable efforts to find the optimal balance in scale between local relevance associated with a smaller scale, and the efficiencies seen with larger scale efforts.

Alberta has devised a way to compensate for a smaller scale of some primary care provider groups. Small networks of primary care providers in Alberta receive a Capacity Building Grant (to compensate for smaller than anticipated patient-based capitation) on top of their capitation funding.[2]

The United Kingdom is moving ahead with more devolution, after consolidated trusts in 2011. However, health-care leaders caution that there is danger in being too local and devolved. Dame Ruth Carnall, former CEO of London National Health Services, doubts the ability of 33 local authorities, plus health and well-being boards, 32 Clinical Commissioning Groups (CCGs), and three commissioning support lines, to work together seamlessly when the previous reform could not make 31 Primary Care Trusts work.[2]

In the jurisdictions we examined, New Zealand leverages among the most mature and developed meso-level support infrastructures based on organized primary care, for physicians who deliver care in an integrated care initiative.

In that country, Independent Practitioner Associations (IPAs) have undergone a variety of organizational forms, governance structures, and sizes since they were formed. They have also been the subject of a series of changes in government policy. Their experience of building strong primary care organizations both within and across general practices, while at the same time responding to change and reform, provides useful insights for all those involved in the provision of integrated practice services.

A leading IPA-based primary care organization and its management arm can provide business and clinical leadership for up to five primary health organizations. Given this capacity, primary care networks with a strong physician foundation are able to manage alliance networks of considerable complexity, and at the same time support the administration of total flexible budgets that are paid at the outset of the initiative. For example, one such primary care organization that is family doctor owned and operated now manages a large scale Regional Alliance that covers four district health boards, cares for 500,000 patients, with 400 family doctors and 500 nurses, and manages a budget of 135 million New Zealand dollars.[7]

2. Flexible Support

A commitment to reach agreement on reasonable and flexible funding support for care providers advancing integration efforts is vital. Funding change is an investment, which reflects increased scope and the need to incent participation. In time, it will generate savings. Three funding issues need to be resolved: management support, programming support, and savings.

Governments and providers agree that if one values clinical leadership, it has to be supported. Key informants from New Zealand stressed that government needs to work with physicians to determine managerial and administrative need, and then provide the resources necessary for management infrastructure.

Similarly, providers in the United Kingdom have concerns about the availability of funding to support the management required for the newly created CCGs.[2] Recognizing the need to provide the required resources, New Zealand offers a management grant to every Primary Health Organization (PHO). The management cost is approximately 12% of the total capitated budget of a PHO-negotiated contract with a district health board.

In Canada, Alberta offers a per-capita funding per enrolled patient in a PCN, and, on average, about 20% of the pooled capitated budget is allocated by the network for management support that takes on administrative duties, while the remainder goes to programming support.

British Columbia pays a set amount directed toward the management costs of each enrolled physician in the "division," or local grouping of primary care services. As well, physicians involved in the initiative have access to central support services that include a range of services, such as additional IT and communication services. Funds are also distributed to involved physicians to conduct research that evaluates the needs of the local community and the strengths and gaps in local primary care resources.

British Columbia has also created new fee codes for chronic disease management and for complex care which recognize the need for services such as patient conferences and the creation of care plans for patients with more than one selected condition.

3. Program Evaluation Frameworks

Providers and policy-makers in reviewed jurisdictions agreed that an evaluation framework to measure success of the integration effort has to be fair, with a robust review of how objectives are being reached, and with providers included in the change management process, instead of change management by decree.

Physicians need to have input into provincial targets to avoid imposition of either unattainable or inappropriate objectives.[8] Timmins summarizes: "The culture of the best organizations is around transparency of performance, and clinical involvement and responsibility at all levels in the running of the organization, rather than one driven by a myopic set of targets, which people were bullied to achieve."[2]

Providers are agreeable to accepting additional reporting requirements and public accountability provided they participate in the process of setting it up. In Australia, the performance assessment framework was implemented in 2011. In a comprehensive and effective way, it has established fair accountability measures. As a guiding principle, an organization may only be held accountable for an indicator that its work is directly responsible for. The framework acknowledges that some indicators cannot be used to hold organizations accountable due to a lack of traceable responsibility. However, these are still moni-

tored for planning and demographic information.[8]

A successful evaluation framework for a large jurisdiction needs to reflect regional diversity and the disparities seen across the region. The baseline measurements can vary significantly. Many reviewed jurisdictions have system-wide objectives that all primary care networks must meet with some regional flexibility, where primary care networks are able to include their own metrics for issues that matter in their local context. Both New Zealand and Alberta leave room for local activities, outputs and indicators.

New Zealand has six national objectives, while the rest of the objectives (20 to 30) are negotiated in a regional agreement between a district health board and a Primary Health Organization, where local clinicians play a key role. These negotiations set graduated targets using the baseline measurements in the region.[9]

In Alberta, Health Authority and Primary Care Networks in a specified area identify service gaps particular to the area, and enter into a joint venture to remedy the situation. They have a choice of activities and outputs to reach provincial objectives and outcomes .[10]

A blend of process and clinical outcome indicators are required in a meaningful and appropriate framework. Alberta has had three parties at the table to reflect different perspectives and needs when it comes to program evaluations. While providers must agree to work toward common broad objectives, the process and clinical indicators have been flexible within certain parameters. The framework purposefully addresses system indicators, as well as process and clinical outcome measures that are more relevant to clinicians.

New Zealand has also incorporated both types in their evaluation frameworks. At the initial stages of implementation, process indicators should be the focus of the evaluation. As networks and meso-level support infrastructures are built, outcome indicators that apply at the micro-provider level can follow.

Summary

Interprofessional teams involved in integration initiatives must have access to the knowledge they require and be supported and equipped to operate within and between organizations with linked infrastructure. In the case of Health Links in Ontario, these teams need shared assessments, common standards, care co-ordination, and shared care plans.

The final article in our series will focus on the experience and needs of physicians in Ontario as they organize to realize the benefits of interprofessional care for their patients, particularly those complex patients for which Health Links seek to enhance care. ■

For more information on Health Links please contact Maggie Keresteci, Senior Director, Health System Programs, OMA Engagement and Program Delivery, at healthlinks@oma.org, or visit www.oma.org/healthlinks.

To view "Health Links: Part 1 — Physician Leadership as a Key to Success" (September 2013 OMR, pp. 14-17), and "Health Links: Part 2 — The Importance of Infrastructure" (October 2013 OMR, pp. 27-31), visit https://www.oma.org/benefits/healthlinks/pages/default.aspx. For a complete list of acknowledgments, please see "Health Links: Part 2 — The Importance of Infrastructure" (October 2013 OMR, p. 30).

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