

## Part 3

# Health Links: enabling physicians to “row” the reform

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**A**T 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.<sup>1</sup>

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.<sup>2</sup>

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.<sup>3,4</sup> 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).<sup>5</sup> 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.<sup>4</sup>

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

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 identi-

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**“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.”<sup>11</sup>**

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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.<sup>6</sup> 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.

fies 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.

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.<sup>2</sup>

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.<sup>2</sup>

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.<sup>7</sup>

## 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.<sup>2</sup> 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 “divi-

sion,” 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.<sup>8</sup> 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.”<sup>2</sup>

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.<sup>8</sup>

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.<sup>9</sup>

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.<sup>10</sup>

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. ■

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*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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