FEATURE

Part 2

Health Links — the importance of infrastructure:

examining the role of meso-level support

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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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- Racette, R. Sweden 5, Canada 2: health care not hockey (Webinar: Midnight Sun Chapter Meeting; Yellowknife, NWT). Canadian College of Health Leaders; 2013 Jun 28.
- Seeman, Susan (iCare and Ideal Transition Home, Vancouver Coastal Health, Vancouver, BC). Interview: 2013 Jul 05.
- Smith, Judith (Director of Policy, Nuffield Trust, London, England). Interview: 2013 Jun 18.
- Tomic, Damian (Medical Director, Midlands Health Network, Hamilton, New Zealand). 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).