Improving Accountability in Primary Care

Report to the Primary Care Planning Group

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Glossary of Acronyms

ACO	Accountable Care Organization
CCAC	Community Care Access Centre
CCM	Comprehensive Care Model
CHC	Community Health Centre
ED	Emergency Department
FFS	Fee for Service
FHG	Family Health Group
FHO	Family Health Organization
FHT	Family Health Team
GP	General Practitioners (GP consortia)
HQO	Health Quality Ontario
ICES	Institute for Clinical Evaluative Sciences
IHP	Interdisciplinary Health Provider
LHIN	Local Health Integration Network
MOHLTC	Ministry of Health and Long-Term Care
NP	Nurse Practitioner
NPLC	Nurse Practitioner-Led Clinic
OHTAC	Ontario Health Technology Advisory Committee
OMA	Ontario Medical Association
PSC	Physician Services Committee
RNPGA	Rural Northern Physician Group Agreement
THAS	Telephone Health Advisory Service

Executive Summary

Accountability refers to the mechanisms by which parties take responsibility for their actions. In the context of health care, and primary care in particular, accountability takes on particular complexity. Relationships in primary care are dynamic, multi-directional and there are several loci of responsibility – to the patient, to the funder, to regulatory colleges and elsewhere. In this complex environment, a clear and cohesive approach to accountability management is necessary to ensure the primary care system is performing in such a way so as to achieve the objectives set out for it.

Improving accountability in primary care is no easy task. Ontario invests over $3 billion annually in its primary care sector. It is a sector comprised of a range of health care providers and health care settings, from individual fee for service physicians to interdisciplinary provider organizations such as Family Health Teams, Community Health Centres and Nurse Practitioner-Led Clinics. It is also a sector consisting of more than one direct funder; namely, the Ministry of Health and Long-Term Care (MOHLTC) and Local Health Integration Networks (LHINs). Above all else, it is for most Ontarians the first entry point to the health care system and as such there is much at stake to ensure that primary care is being held accountable for the important role it plays.

In addressing this issue, the key question that the Improving Accountability in Primary Care Working Group set out to answer is how current structures and processes within the primary care system can be modified and improved to enhance how the system in general is accountable to its principal agents, the most important of which are Ontarians. Instead of examining the several loci of accountability within primary care individually, the discussion and recommendations of the Working Group focus on primary care at a system level, focusing on the accountability mechanisms embedded in the structures and processes in the primary care system.

The paper undertakes an examination of the current state of accountability in primary care in Ontario and makes a case for change based on three identified deficiencies, which include: (1) that current accountability mechanisms do not reflect the multi-directional relationships in primary care; (2) that current measurement and monitoring activities are inadequate to properly assess the degree to which primary care goals and objectives are being achieved, and; (3) that current corrective action and remediation processes are ill defined and provide no clear mechanism to address areas where the primary care system is not achieving its prescribed goals and objectives. The paper surveys other models of accountability in primary care, looking at recent reforms in the U.S (the Accountable Care Organization), in the U.K. (Primary Care Trusts and GP consortia) and looks at an option for improved measurement and accountability in primary care (Multispecialty Provider Networks).

A key element of the paper are 10 recommendations that the Working Group has put forward to improve how Ontario's primary care system is accountable to its principle

agents. First and foremost, the Working Group recommends that a structure be put in place to act on these recommendations and the recommendations from other working groups. Additional recommendations have been formulated based on the guiding principles of practicality, inclusiveness and appropriateness. In other words, no recommendation has been put forward that cannot be achieved within existing primary care models and fiscal framework. A summary of the remaining nine recommendations is as follows:

- Develop clear and measurable objectives for which Ontario's primary care sector is to be held to account, including such elements as access to care, patient satisfaction, relationships with other parts of the system and resource utilization.
- Design and implement a simplified and efficient primary care measurement and monitoring strategy to assess how the primary care system is performing, relative to measurable objectives, on an on-going basis. The strategy, at a minimum, is to include patient feedback and regular public reporting.
- Explore alternative units of analysis to support the measurement and monitoring strategy, consistent with the principles of the Multispecialty Provider Network approach developed by ICES.
- Immediately review current physician incentives and premiums related to preventive care, after hours, chronic disease management, patient enrolment and others incentives related to access.
- Develop a policy or series of policies to guide corrective action/remediation in circumstances where accountability requirements are not being met and ensure that funders are also subject to the policy(ies).
- Finalize a policy or program to formally track and analyze the activities of Interdisciplinary Health Providers in primary care.
- Review and report on the current way in which access to after hours primary care is measured and the degree to which it is/is not being provided.
- Develop and implement a comprehensive strategy for advanced access to enable greater access to primary care.
- Identify, track and measure evidence-based best practices for use at the practice level to promote more cost effective resource utilization.

Due to the complexity of relationships within Ontario's primary care, the current deficiencies in the way in which accountability is managed requires more than a quick fix. Rather, organizations in the primary care system need to come together with a shared, sustained commitment to identify Ontario's goals for primary care, measure and report on system behaviour in relation to those goals and work together if those goals are not being met. Primary care needs to be regarded as more than simply an access point to the health system; it needs to operate based on the premise that it is where most Ontarians should be cared for. Together, these recommendations, if implemented, will enable Ontario to move in this direction and help to ensure Ontario's primary care system remains robust, sustainable and patient-focused in the present and future.

Section 1: Background

A. Development and Establishment of the Primary Health Care Planning Group

At the McMaster Health Forum in June 2010 on the topic of "Supporting Quality Improvement in Ontario", a number of stakeholders and experts identified the need for an overarching framework for strengthening Primary Health Care in Ontario.

Forum participants concluded that two parallel initiatives should be pursued. These include:

1. A small planning group should draft and build consensus on an approach for strengthening primary healthcare in Ontario, and plan a summit at which the proposed approach would be debated, finalized, and approved by a broad-based group of key stakeholders, including citizen and patient groups, and representatives from Local Health Integration Networks and from public health units; and

2. The Quality Improvement and Innovation Partnership should convene one or more meetings to discuss the need and a plan of action for a strategic alliance focused on supporting quality improvement in primary healthcare, and then provide leadership and support to the strategic alliance

The purpose of the Primary Health Care Planning Group is to address the first plan of action, as outlined above. The mandate of the Primary Health Care Planning Group includes the following activities:

- Draft and build consensus on an approach for strengthening primary healthcare in Ontario;
- Address key issues such as the business case for primary healthcare investments; articulation of goals related to improving access and quality within primary care; a plan to monitor and evaluate progress against the goals, and; assess the impacts of investments and activities

Membership of the Primary Health Care Planning Group includes representatives of the following organizations:

- Ministry of Health and Long-Term Care
- Registered Nurses Association of Ontario
- Ontario Medical Association
- Ontario Association of Ontario Health Centres
- Ontario College of Family Physicians

Five working groups were established, representing key areas of analysis deemed important to achieve this mandate. These include: Efficiency, Access, Quality, Governance and Accountability. The structure is represented in Figure 1

Figure 1: Structure of the Primary Healthcare Planning Group

B. Mandate of the Improving Accountability in Primary Care Working Group

The mandate of the Improving Accountability in Primary Care Working Group is to develop a long-term strategy with staged, short and medium term deliverables to enhance accountability both in the funding and delivery of primary health care services in Ontario.

The key areas of focus for the Working Group include an examination of the structures and processes involved with accountability in primary care. In particular, the Working Group is tasked with providing recommendations that address: effective measurement in primary care, including access and wait times; transitions through care; the role of Interdisciplinary Health Providers; resource utilization, and; the alignment of current primary care incentives.

Attached as Appendix A is the Terms of Reference.

Section 2: Current Structures and Process for Accountability in Primary Care and the Change Imperative

A. Current State

Accountability – Theory and Practice

Accountability is a general concept that is applied in several contexts. Simply put, accountability can be understood as the mechanisms by which one party takes responsibilities for its activities.[1] Within health care, accountability is multi-directional. It can be described in terms of payer accountability (where resources go); patient accountability (how resources are used) and provider accountability (how resources are used and how services are delivered, individually or in teams). Within these general categories, health care is said to have up to 11 different loci of accountability (including those held accountable and those who hold others accountable).[2] Although each of these aspects could be examined individually in the context of primary care, the discussion and recommendations of this paper focus on primary care as a system and how current structures and processes within the system can be modified and improved to enhance how the system in general is accountable to its principal agents.

The system of primary care in Ontario is funded primarily through the Ministry of Health and Long-Term Care (MOHLTC). Funding for primary care in Ontario is over $3 billion annually. The principal mechanism by which the MOHLTC attempts to achieve accountability for investments made is through accountability agreements, which establish an accountability relationship by describing the responsibilities of each of the parties. In most cases, the responsibility of MOHLTC is to provide funding for the delivery of primary care services and the responsibilities of the recipient are to deliver services as prescribed in the agreement.

Moreover, accountability relationships also exist between and among several other loci within primary care and the broader health system. These include, but are not limited to, physicians and interdisciplinary health providers as well as between providers of all types through the continuum of care (e.g. primary care, acute care, other specialists providing out-patient care, long-term care, public health, etc.). Some of these are associated with an exchange of funding for services delivered, whereas others are based on a reciprocal arrangement of services. An overarching regulatory accountability applies to all providers, which includes their responsibilities to various regulatory colleges to uphold the standards of the profession in the performance of duties.

Accountability also extends to the patient. This is less well understood than other accountability relationships in health care. Patient accountability is a key locum of

[1] Emanual, E and Linda Emanual. *What is Accountability in Health Care?.* Annals of Internal Medicine (1996: 124, no 2). pg. 229.
[2] Ibid (1996) pg. 230.

accountability, as there is a degree of responsibility that ought to be associated with the choices made in accessing the various health care options available and using resources appropriately.

Primary care reform in Ontario over the past 15 years has resulted in several models of primary care delivery. These include various physician compensation models, non-physician delivery models including midwives, interdisciplinary care models such as Family Health Teams, Nurse Practitioner-Led Clinics and Community Health Centres in addition to specialized or alternative models to address unique circumstances such as for rural or northern primary care. Each of the models is associated with a basket of funding, which is tied to an accountability agreement. A listing of these models is included in Table 1.

Table 1: Primary Care Models

Provider	Primary Care Model (examples)	Description
Physician	Comprehensive Care Model (CCM)	Solo physician providing comprehensive primary care services to enrolled patients and some after hours care.
	Family Health Group (FHG)	Groups of physicians (3 or more) providing comprehensive primary care to enrolled patients on a 24/7 basis (through office hours and Telephone Health Advisory Services).
	Family Health Network (FHN)	Groups of physicians (3 or more) providing comprehensive care to enrolled patients on a 24/7 basis (through office hours and Telephone Health Advisory Services) , compensated through capitated payments and fee for service. Chronic disease management, disease prevention and health promotion are integral to these models. The Main difference between FNH and FHO is the base rate payment and the basket of core services.
	Family Health Organization (FHO)	
	Fee for Service (FFS)	Physicians compensated for services performed according to the Schedule of Benefits.
Interdisciplinary	Family Health Team (FHT)	Teams of physicians, nurses, social workers dieticians and other interdisciplinary health providers (IHPs) providing comprehensive primary care to enrolled patients. Governed by a Board of Directors. IHP and operational funding is received through a business/operational agreement between FHT Board and ministry; physician funding through separate agreements in most cases.
	Nurse Practitioner Led Clinics	Teams led by Nurse Practitioners and consisting of RNs, RPNs, collaborating physicians and others to provide comprehensive services to unattached patients. Once registered to the NPLC, patients have access to all services as required through their primary care NP. NPLC's are governed by a Board of Directors who receive funding through a business/ operational agreement with the Nursing Secretariat of the MOHLTC. All members of the team are compensated within a salary model.
	Community Health Centres	Interdisciplinary teams in a non-enrolment model serving unique population groups.
Specialized	First Nations Agreements	Special arrangements with providers delivering primary care in unique circumstances, such as rural and northern Ontario, to high needs populations, etc.
	GP Focused Practice models	
	Homeless Shelter Agreements	
	Rural Northern Physician Group Agreement (RNPGA)	

In addition to, or embedded within, many of these accountability and funding mechanisms are incentives, premiums and bonuses to encourage specific types of behaviours. These primarily take the form of financial incentives for physicians. Examples of such incentives, premiums and bonuses are described in Table 2.

Table 2: Primary Care Physician Incentives, Bonuses and Premiums[3]

Goal	Premiums, Bonuses, Incentives (examples)
After hours availability through Telephone Health Advisory Services (THAS)	Monthly payments to physicians in eligible models.
After hours availability through clinic hours	Premium payable for the delivery of specified service codes during regularly scheduled and after hours clinics.
Continuous, comprehensive care for a patient by a single provider or group of providers	Bonus group payment when enrolled patients receive core services from within the physician group versus other providers such as walk-in clinics.
Patient enrolment, including patients with complex medical conditions.	Payment of a per patient rostering fee to encourage enrolment; physicians are eligible for additional fees for enrolling complex/ vulnerable patients.
Delivery of comprehensive care	Premium payable for specified service codes.
Labour and Delivery	Two levels of premiums available: one for 5+ patients served and one 23+ patients served.
Palliative Care	Two levels of premiums available: one for 4+ patients served and one 10+ patients served.
Preventive Care	Annual bonus payment based on level of preventive care services performed in 5 categories: Childhood Immunizations; Influenza Vaccine for Seniors; Mammograms; Pap Smears; Colorectal Cancer Screening.
Chronic Disease Management	Incentives for Diabetes Management and Heart Failure Management
Provision of prenatal care	Annual premium for prenatal services for 5+ patients.
Provision of hospital services	Annual premiums for services performed in hospital.
Performing in-office procedures	Premium available for performing procedures in office.

Accountability agreements and incentives, bonuses and premiums are based on pre-designed goals and objectives. These goals can include and range from improving primary care for the individual patient to improving system efficiency and performance to attracting more practitioners to the profession. Family Health Teams, for example, were created with the goal of expanding access to care through increased patient enrolment. One reason for funding for IHP's was to allow physicians to care for more patients. The expansion of after hours primary care, as another example, has been a system goal to expand access to care and attempts have been made to operationalize this goal by providing after hours premiums – for telephone and clinic access – as part of physician compensation schemes.

Although accountability agreements and various incentives and premiums form the basic accountability and funding infrastructure in the primary care system, these alone are not sufficient to ensure parties are being held responsible for their activities. On-going monitoring, measuring and, where necessary, corrective action or remediation are key elements in how accountability is operationalized as these activities can inform parties on

[3] Ontario. Ministry of Health and Long-Term Care. Presentation: *Payments in Blended FFS and Capitation Models*. (Toronto: May 2009). pg 1-3.

both sides of the accountability relationship if established goals and objectives are being realized and how to rectify if not.

Monitoring and Measuring

There are currently a variety of ways in which accountability requirements are being monitored and measured on a system-wide basis in Ontario. However, at present there appears to be no cohesive strategy or approach to measure how the primary care system is performing relative to the goals for which it is supposed to be held accountable.

Physician services are largely monitored through the Medical Claims Payment System, which contains data on the services for which physicians are billing. Periodic audits occur where billing anomalies are identified and other activities are performed to improve compliance on a reactive basis. For instance, if higher than average volumes are being billed for a particular service, there may be direct contact by the ministry to the primary care provider (through an inquiry or audit) in an effort to either gather more information or prompt corrective action. As applied, this approach tends to be more focused on identifying areas of potential abuse or wrong doing than on measuring the degree to which the system is performing towards its goals.

Although team-based primary care has expanded considerably in Ontario, the activities of many Interdisciplinary Health Providers (IHPs) are not well understood, as formal monitoring mechanisms are lacking. Family Health Teams are required to submit quarterly reports which attempt to describe and quantify IHP services but the self-reported data is crude and compliance is inconsistent. Nurse Practitioner Led Clinics will be using a self-reporting based mechanism to monitor patients served on an interim basis, but the ministry has not yet formalized a permanent mechanism to monitor performance. Community Health Centres at present also do not have formal information tracking and management practices to quantify the activities of providers in this setting. As a result, despite the considerable expansion of Nurse Practitioners, nurses, social workers and others in delivering primary care services there is no quantitative sense of the impact they are having on patients, peer providers or the system in general.

Efforts are underway to implement a more formal Claims-based system of monitoring service encounters of Nurse Practitioners (NPs) in Family Health Teams. Although this is in the early days of implementation, it has the potential to provide a better understanding of the role of NPs in primary care and has the potential to apply to other IHPs in a range of interdisciplinary care environments.

One area in primary care where measuring and monitoring activities are routine and help to inform whether or not the system is achieving pre-designed objectives is with respect to patient enrolment. MOHLTC monitors the number of patients enrolled with a primary care physician on a monthly basis, in part, as a proxy indicator for the number of Ontario patients that have access to comprehensive primary care. The latter was an objective in the

design of enrolment models and the on-going data tracking has been instrumental in measuring progress. Although regularized measurement is a best practice, narrowing it to enrolment to a physician does not account for the role of IHPs nor does it account, as is discussed below, for the type of access enrolled patients are receiving or who gets access. Further, enrolment data is not provided to physicians in a manner that is clear, accessible or timely.

Corrective Action & Remediation

Similar to measuring and monitoring, there is no consistent and timely approach to corrective action or remediation in circumstances where it is determined that accountability requirements are not being met. This is an essential element of the accountability process, as mechanisms need to exist that put the system back on track should it not be heading in a direction prescribed for it. Typically, compliance issues are addressed in a consultative approach between the funder (MOHLTC) and the recipient and/or their association. The approach, however, differs depending on the compliance issue and the type of service provider. Several bilateral structures are in place between the MOHLTC and Ontario Medical Association (OMA) to address issues related to physician services and ministry obligations, but this is not mirrored with other primary care providers. Accountability agreements do include enforcement provisions; however, these are quite strong and seldom utilized.

Example: Access to Primary Care

A practical illustration of where current accountability mechanisms fall short is with respect to timely access to primary care services. A study performed by the Institute for Clinical Evaluative Sciences (ICES) on access to primary care in Ontario presents data that ranks Ontario low in the area of access in comparison with other jurisdictions. Ontario ranks nine out of 11 countries in patient-reported difficulty in accessing after hours care, 10 out of 11 countries for patient reported ability to get a same day or next day appointment and 11 out of 11 for emergency room use.[4] Despite the reforms put in place over the past decade, the data shows little or no improvement in same day/next day access, walk-in clinic use or emergency department use.[5]

This is not a new issue in Ontario, nor can the full extent of the problem be attributed to primary care providers (there is a degree of patient accountability associated with expectations and choice of care setting). However, the ICES findings do reveal shortcomings in the design of current models of care for enhancing access and also with current accountability mechanisms in primary care. In the area of after hours access (where Ontario ranks 9/11 countries), accountability agreements and financial incentives have been designed to require and encourage the provision of such care. As described in

[4] The Commonwealth Fund. *International Health Policy Survey in Eleven Countries.* (2010)
[5] Glazier, Rick et. al. Presentation: *Access to Primary Care in Ontario.* (Toronto: May 2011) pg. 37.

Table 2, this includes Telephone Health Advisory Services (THAS) and for after hours clinics.

Where current accountability mechanisms fall short on this issue is in pro active measuring and monitoring as well as corrective action and remediation. Recent efforts to understand the extent of after hours care being provided has been reactive in nature and not the result of an active program to ascertain whether or not the goals behind contractual requirements and financial incentives are being achieved. Furthermore, where this reactive monitoring does show non-compliance with contractual obligations, the only recourse and corrective action prescribed for in the physician's accountability agreement with the ministry is contract termination. As such, there is no allowance contractually for a remediation process that can be entered into by both parties for corrective action.

B. The Change Imperative

In examining how to enhance accountability in primary care, there are three main elements of accountability that require focused attention: (1) the mechanisms that establish the accountability relationship (i.e. the 'agreement' and goals and objectives embedded within); (2) the measurement and monitoring required to determine whether or not goals and objectives are being met, and; (3) the process for corrective action and remediation in circumstances where there is non-compliance.

In view of these core elements of accountability and within the context of current accountability arrangements within Ontario's primary care system, the Working Group has identified the following deficiencies with the current state:

1. Current accountability mechanisms do not reflect the multi-directional relationships in primary care.

With some exceptions, accountability agreements are largely bi-directional; between a single funder and a service provider. As a consequence, there is no mechanism to capture the diversity and range of relationships embedded within primary care.

One of the key features not captured in current accountability mechanisms is transitions through care. Primary care providers both lead and follow a patient through his or her care continuum, yet most current accountability mechanisms only address a provider's interaction with a patient within the primary care environment. Through this approach, key accountability relationships are not being captured. A clear example of this is the relationship between after hours access to a primary care provider and emergency department visits. There are other examples with respect to long-term care, community care access centres, public health, etc.

Another key feature is effective resource utilization by primary care providers in their decisions to refer patients to specialists or for specific diagnostic tests. It is assumed within

existing accountability structures that providers will make decisions based on the needs of the patient in addition to effective use of health care resources. However, there are very few evidence-based guidelines in place to facilitate this and as such, expensive tests or specialist resources may be pursued when not required.

Additionally, at a system-level, patient feedback is seldom incorporated into the accountability process. Provider satisfaction and number of patients served are often cited as approaches to accountability management; however, direct patient feedback into how the primary care system is performing is currently lacking.

2. Current measurement and monitoring activities are inadequate to properly assess the degree to which goals and objectives are being achieved.

In particular, current structures and processes for monitoring the activities of IHPs are insufficient to ascertain the impact they are having in primary care environments. Additionally, structures and processes for measuring the effectiveness of premiums, bonuses and incentives are insufficient to determine if they are having their intended effect. Overall, the lack of a cohesive monitoring and measurement strategy, with no public reporting, has resulted in a reactive patchwork of undisclosed data related to how the system is performing relative to its accountability obligations.

3. Current corrective action and remediation processes are ill defined and provide no clear, effective mechanism through which timely corrective action can be taken to address areas where the primary care system is not achieving its prescribed goals and objectives.

The lack of existing remediation structures and processes limit the degree to which corrections can be made to optimize system performance. Moreover, contract termination – the remediation measure included in most accountability agreements – is not a practical mechanism through which to address most circumstances where corrections are deemed necessary. Rather, there is ample opportunity between these two extremes to find useful ways in which to address failures or shortcomings in system behaviour once identified. Although extreme measures may be required from time to time, incremental collaborative steps could be taken prior to this course of action in an effort to optimize system behaviour.

Section 3: Accountability Models in Primary Care

Health Care Reform in the U.S: The Accountable Care Organization

Recent health care reform in the U.S. has brought with it new approaches to care delivery in an attempt to enhance accountability in primary care. Through the Medical Shared Savings Program, the *Patient Protection and Affordable Care Act 2010* legally establishes a provider organization called an Accountable Care Organization (ACO), a new service delivery model under the U.S Medicare program. Although still in the early days of implementation, the ACO has been created for a dual purpose of enhancing the coordination of care for Medicare recipients and lowering Medicare costs.[6]

ACOs have several features in common with reforms made in Ontario's primary care system. Firstly, ACOs manifest themselves as group-based care organizations, similar to some of Ontario primary care physician models, Family Health Teams, Community Health Centres and Nurse Practitioner Led Clinics. This is to encourage more comprehensive, continuous care versus what has been considered as a fragmented model of care associated with individual fee for service practices.[7] ACOs can include a team of physicians and other practitioners, networks of physician practices, joint arrangements between hospitals and other providers or other models approved by the Department of Health and Human Services. Unlike Health Maintenance Organizations (HMOs), ACOs will be responsible for delivering direct health services to Medicare patients.

Furthermore, similar to some of Ontario's primary care models, ACOs are required to have formal governance and management structures to ensure there is an accountable partner for the objectives ACOs are responsible for achieving: good patient outcomes, quality improvement, cost savings, etc. This is particularly important for the financial management and shared savings features of ACOs described below. ACOs are also required to implement health information management tracking and reporting and are to be held accountable for performing these activities.

There are also features of these new ACOs that have distinguishing characteristics setting them apart from Ontario's primary care models. First, ACOs have been designed to offer rewards where there are financial savings achieved as a result of providing care to patients through this coordinated care delivery model. The shared savings program allows ACOs to receive a portion of the savings they achieve on Medicare service expenditures relative to a spending target, while still adhering to quality standards. Though not mandatory in the first years of implementation, a risk model is being proposed that would have ACOs also share in losses where savings are not achieved as well. The Congressional Budget Office has

[6] U.S Department of Health and Human Services. *Fact Sheet: Accountable Care Organizations: Improving Care Coordination for People with Medicare.* (Washington: March 31, 2011). pg. 1.
[7] The Commonwealth Fund. Commission on a High Performance Health System. High Performance Accountable Care. (April 2011).

estimated that providing ACOs with the incentive of shared savings would save Medicare $4.9 billion over a ten year period.[8]

A second distinguishing characteristic is the degree of active data collection and measurement that ACOs will be required to perform. The shared savings program described above as well as the care coordination feature of ACOs requires extensive data collection and reporting in order to accurately assess the degree of savings (or losses) to be attributed to an ACO. According to the Department of Health and Human Services, ACOs will regularly monitor and report on their activities against pre-designed standards, which are to be based on: the patient/care giver experience, care coordination, patient safety, preventive health and at-risk populations and frail/elderly health.

The Commonwealth Fund has also recommended performance tracking metrics for ACOs that delve into additional detail on reporting standards. The Commonwealth Fund report *High Performance Accountable Care: Building on Success and Learning from Experience* states that "to gain public trust and to stimulate innovations that improve patient care, it is essential to link ACO accountability to a commitment to track and report performance."[9] The metric put forward by the Commonwealth Fund as a best practice for performance measurement includes: patient surveys, 30-day readmission rates and ED use, chronic care outcomes, total cost of chronic care for chronically ill and targets for each.

Critics of the ACO model question the degree of change and savings that this new model of care can be expected to achieve. Despite the goals of the model, the critics argue, it is still primarily premised on fee for service provider compensation.[10] As such, the more defined accountability structures and anticipated cost savings will be off set by the inherent financial incentive to perform more services, regardless of cost.

National Health Service: Primary Care Trusts and the Proposed GP Consortiums

Primary Care Trusts have become a major feature in the way in which the National Health Service (NHS) in the UK structures care delivery and accountability. Primary Care Trusts are local organizations responsible for ensuring a comprehensive range of health services are available for the local population. Primary Care Trusts commission health services for the areas in which they serve and receive approximately 80% of the NHS budget to allocate to a variety of services, including and beyond primary care.[11] Trusts engage in contracts with several NHS-funded health service providers based on population need who are held

[8] U.S Department of Health and Human Services. Fact Sheet: *Accountable Care Organizations: Improving Care Coordination for People with Medicare. (Washington: March 31, 2011).* pg 8.
[9] The Commonwealth Fund. Commission on a High Performance Health System. High Performance Accountable Care. (April 2011).
[10] Numerof, Rita. Backgrounder: *Why Accountable Care Organizations Won't Deliver Better Healthcare – And Market Innovation Will.* (The Heritage Foundation: April 18, 2011). p1.
[11] Pollack, Alison M et al. *The Market in Primary Care* in British Medical Journal. (2007: 335)

accountable through accountability agreements. Primary Care Trusts are accountable to 10 regional Strategic Health Authorities who hold fiscal responsibility within the NHS.

Before the Primary Care Trusts, General Practitioners were contracted to work for the NHS under a general medical services contract between the individual practitioner and the NHS. The terms of the contract were negotiated nationally. In 2003. Primary Care Trusts became authorized to contract for medical services, using four template agreements addressing different circumstances for which a Trust may engage the services of providers. This meant that 151 Trusts held several contracts, through which there was significant variability in the types of services contracted and the level of accountability held for various services.

Pollack et al point out that this approach to accountability through contract has proven to be challenging, as contracts for complex services, such as clinical services, can never account for the details required to perform such services.[12] The authors use after hours services an as example. After hours services in the UK are provided through one of two mechanisms: a physician or group of physicians perform these directly or they forgo an after hours premium for the Primary Care Trust to administer it centrally. The House of Commons Committee on Public Accounts in the UK, after commissioning an audit, found that in instances where the Primary Care Trust was contracting for this service there was inadequate performance objectives or information to show whether or not objectives were being met for the investments made into the system. This was exacerbated by the fact that there were so many Primary Care Trusts contracting for this service differently. The audit found a £70 million overspending gap between departmental allocations and actual expenditures.

Reaction to the current accountability structures in place through the Primary Care Trusts has most recently manifested itself into proposed reforms in the British government *Health and Social Care Bill 2011* and various white papers advocating for change. One of the criticisms driving this change is a perception that the Primary Care Trusts duplicate efforts and are too far removed from clinical decision-making that occurs at the practice level. New proposed reforms call for the abolishment of Primary Care Trusts and instead use consortia of General Practitioners (GP consortia) to undertake the role of identifying and delivering local health services.

GP consortia are to consist of groups of GP practices who work with other providers and agencies in a geographic region. Although limited in the number of services they can mandate be provided, GP consortia will receive an allocation from the NHS to engage in contracts with service providers, including the group of GP practices which make up the consortia. GP consortia will be accountable to an overarching NHS body and are to receive financial incentives for achieving pre-established outcomes and financial performance.[13] As local organizations that include primary care, GP consortia will be required to use

[12] Ibid (2007)

[13] U.K. Department of Health. Equity and Excellence: Liberating the NHS. (London: The Stationary Office, 2010) pg.27.

information management system to report on their progress in achieving pre-established local outcomes that are linked to national outcome data.

One of the unique features of these current reforms is the degree of patient feedback to be included. HealthWatch England will be a new agency created under legislation as an independent consumer champion. HealthWatch England and local HealthWatch organizations will be mandated to ensure that patient feedback is included in local decisions on the organization of health services and will have the powers to propose investigations of poor services.

Accountability structures in NHS – existing and proposed –differ from how Ontario operationalizes accountability in primary care. One intriguing feature of the Primary Care Trust as well as the proposed GP consortium is the degree of service integration and organization between primary care and other care environments. Although primary care is a centrepiece of these models, they are also responsible to ensure other health services are provided, including hospitals, dentistry, mental health services, walk-in clinics, patient transport and others. Although perhaps more similar to a LHIN than group-based primary care environments, the Primary Care Trust and GP consortium model is one that offers a more organized approach to primary care than perhaps currently in place in Ontario.

Another attractive feature is a formalized role for patient feedback included in the proposed NHS reforms. No analogous approach exists in Ontario whereby consumer advocacy and action is formally embedded in the accountability process. Whereas patient feedback is all but absent in Ontario's approach to primary care accountability, reforms in the NHS may see legal authority in the hands of patient advocates to recommend corrective action.

Multispecialty Provider Networks

One of the consistent themes in areas where primary care and broader health system reforms are taking place is the measurement imperative and how closely related are the concepts of accountability and measurement. One of the challenges in Ontario, as compared with the UK and US case descriptions above, is that primary care is not well organized at the local level. Family Health Teams, Nurse Practitioner Led Clinics and Community Health Centres all have a degree of organization (such as a defined practice area, management and governance structures, etc). However, primary care providers that stand outside of these organizational structures are less of a manageable entity from a systems management perspective.

Where this becomes challenging in the context of accountability is with respect to measuring primary care system behaviour in reference to prescribed goals and objectives. In particular, with the majority of accountability relationships in primary care held between providers and the ministry (with the exception of Community Health Centres whose funding accountability is to the LHIN) the unit of measurement is province-wide,

and as such measurement tends to be at such an abstract level that it is not instructive to inform whether or not providers are fulfilling obligations and if goals are being achieved.

Furthermore, the current process of measuring physician activity through the Medical Claims Payment System does not reflect the role performed by interdisciplinary health providers in primary care. Patients may see a variety of health professionals through the continuum of care and current measurement structures and processes do not account for this. This is best illustrated with respect to Community Health Centres, where very little data is currently available to quantify or qualify the care being provided.

ICES has undertaken research that describes one alternative to the current practice, which is the creation of Multispecialty Provider Networks. These are virtual measurement networks that consist of defined patient and provider populations. The model uses existing patient flow to physicians and the hospitals where their patients are admitted. Through a methodology formulated by ICES, the result is approximately 70 physician networks with a 65,000+ population, including 50+ physicians and 1+ hospital hubs per network. Please see Appendix B for an illustration of these networks.

The value of this approach is that it provides a more precise and useful unit of analysis than provincial roll-up data or LHIN-level data, which may not capture variation between communities within a LHIN. Further, being based on patient flow to primary health care providers and hospitals the model is more inclusive of the continuum of care, reflecting the porous nature of primary care and its relationships with other care settings. In terms of enhancing accountability, using Multispecialty Provider Networks as a unit of measurement can provide for more accurate and inclusive data on how the primary care system is performing relative to indicators and system goals and objectives.

In sum, if we accept the notion that good measurement of system activity can provide a basis for enhanced performance and accountability in primary care then reforms in the current way in which the system is measured are necessary. The benefit of the Multispecialty Provider Network approach, versus the current state, is that measurement follows intersectoral patient movement patterns in a community-based model, enabling early identification of problems and a basis upon which they can be addressed in an intersectoral manner. Such organization at the local level also provides the opportunity to build the capacity for intersectoral action. Examples of locally organized structures for intersectoral improvement of care are divisions of general practice in Australia and divisions of family practice in British Columbia, which work closely with hospitals, community agencies and other health care sectors.

Section 4: Moving Towards Improved Accountability in Primary Care

Guiding Principles

The overarching question which guided deliberations of the Working Group is how current structures and processes within the primary care system can be modified and improved to enhance how the system in general, and individual practitioners, are held accountable to its principal agents. In answering this question, the Working Group established the following guiding principles:

- *Practical and focused. Recommendations need to have a defined objective linked to current deficiencies in current accountability structures and processes.*
- *Changes should be bold where needed. Bold changes are needed to enhance accountability, but they should not jeopardize effective primary care reforms that are currently underway.*
- *Inclusiveness. Recommendations for improved accountability need to include the full range of primary care providers within the system.*
- *Follow-up work to be done where most appropriate. Follow up work associated with the recommendations should reflect existing mandates and responsibilities.*

Proposed Reforms and Recommendations

It is the position of the Working Group that, if implemented, the following reforms and recommendations will help to enhance accountability in Ontario's primary care system as currently configured:

Recommendation #1

To ensure the work of the Primary Health Care Planning Group and its constituent working groups continues, the ministry should create a time-limited Primary Health Care Secretariat tasked with implementing the recommendations of this initiative. At a minimum, the mandate of the Secretariat should include the following:

- Prioritize the recommendations of the working groups and develop an implementation plan for action;
- Work with professional associations and other primary care stakeholders to develop and contribute to the implementation plan;
- Assign resources to support implementation activities;
- Adapt and amend the recommendations to reflect changes in the environment, such as regulatory/legal changes, fiscal changes, etc.
- Track progress with respect to the implementation of key recommendations.

Recommendation #2

The ministry, in consultation with professional associations, patient groups and other stakeholders in primary care, should develop a clear and measurable statement of goals and objectives for which the primary care system is to be held to account. At a minimum, these goals and objectives should include:

- timely access to care (including after hours)
- relationships with other parts of the health system, including hospitals, community health agencies and other specialists
- patient satisfaction
- provider satisfaction
- appropriate resource utilization
- patient outcomes (e.g. immunization rates, preventive care rates)
- attraction and retention, distribution of health human resources in primary care

Recommendation #3

The ministry, in partnership with Health Quality Ontario and others, should develop and implement a measurement and monitoring strategy to identify how the primary care system is performing in reference to its goals and objectives. Attributes of the measurement and monitoring strategy should include:

- On-going, proactive measurement and monitoring
- Inclusion of patient feedback as an indicator of performance
- Development of benchmarks
- Regular reporting to stakeholders, providers and the public
- Quality improvement

Recommendation #4

To assist in the implementation of a primary care measurement and monitoring strategy, the ministry, in consultation with partners, should pursue regional units of analysis that are more local than the LHINs. Consideration could be given to the principles of the Multispecialty Provider Network approach to address the activities of IHPs, regional circumstance and intersectoral relationships.

Recommendation #5

The MOHLTC-OMA Physician Services Committee (PSC) should immediately initiate and complete a review of existing premiums, bonuses and incentives associated with physician compensation which includes recommendations for better alignment with primary care system goals and objectives. At a minimum, the following high priority items require PSC review:

- Preventive care incentives
- After hours premiums

- Patient enrolment incentives
- Chronic disease management incentives
- Other incentives to enhance access to primary care

Recommendation #6

The ministry, in consultation with professional associations representing Interdisciplinary Health Providers, should develop a formal mechanism to track and analyze the activities of Interdisciplinary Health Providers to better understand the impact they are having in primary care, including in CHCs.

Recommendation #7

The ministry, in consultation with accountability partners, should develop a policy or series of policies to be adhered to in circumstances where accountability requirements are not being met and where corrective action/remediation is required. Policies should reflect a graduated and consultative approach to corrective action. Funding organizations, including MOHLTC and LHINs, should be subject to these policies particularly as it relates to the principles of timeliness and responsiveness.

Recommendation #8

The ministry should undertake a review of the current way in which access to after hours primary care is measured and report on the degree to which after hours care is or is not being provided or accessed, in reference to current provider obligations.

Recommendation #9

The ministry, in consultation with relevant professional associations, should develop and implement a comprehensive strategy for advanced access. Such a strategy, if implemented, will enable patients to have more timely access to their usual primary care provider.

Recommendation #10

The ministry should work with Health Quality Ontario, the Ontario Health Technology Advisory Committee and professional associations to identify evidence-based best practices for health care resource utilization and to address gaps in quality. Once identified (and periodically updated), the ministry should work with stakeholders to determine how providers can be held accountable at the practice level and measure the degree to which resources are being utilized effectively and how quality is improving in care delivery.

Section 5: Implementation Plan

Activity	Responsible Agent(s)
Short-Term Deliverables (within one year)	
Create a Primary Health Care Secretariat tasked with implementing the recommendations of this initiative. (Rec #1)	MOHLTC; primary care stakeholders
Develop clear and measurable objectives for which Ontario's primary care sector is to be held to account, including such elements as access to care, clinical outcomes, patient satisfaction and resource utilization. (Rec #2)	MOHLTC; professional associations; primary care stakeholders; patient groups
Immediately review current physician incentives and premiums related to preventive care, after hours, chronic disease management, patient enrolment and other incentives related to access. (Rec #5)	OMA-MOHLTC Physician Services Committee
Develop and implement a comprehensive strategy for advanced access to enable greater access to primary care. (Rec #9)	MOHLTC; OMA; professional associations; primary care stakeholders
Medium-Term Deliverables (within two years)	
Design and implement a primary care measurement and monitoring strategy to assess how the primary care system is performing, relative to measurable objectives, on an on-going basis. (Rec #3)	MOHLTC; Health Quality Ontario
Develop alternative units of analysis to support the measurement and monitoring strategy, consistent with the principles of the Multispecialty Provider Network approach developed by ICES. (Rec #4)	MOHLTC; ICES; Health Quality Ontario
Develop a policy or series of policies to guide corrective action/remediation in a graduated manner in circumstances where accountability requirements are not being met and ensure that funders are also subject to these policies. (Rec #7)	MOHLTC; professional associations; primary care stakeholders
Finalize a policy or program to formally track and analyze the activities of Interdisciplinary Health Providers in primary care. (Rec #6)	MOHLTC; professional associations

Long-Term Deliverables (within three years)	
Identify and distribute evidence-based best practices for use at the practice level to promote more cost effective resource utilization.	Health Quality Ontario; Ontario Health Technology Advisory Committee
Track and measure the degree to which best practices are being utilized	Health Quality Ontario; Ontario Health Technology Advisory Committee

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Appendices

APPENDIX A: TERMS OF REFERENCE

Improving Accountability in Primary Care Working Group

TERMS OF REFERENCE

1.0 BACKGROUND

Ontario is faced with increasing health care costs and economic and fiscal constraints. It is critical that investments in primary health care are accompanied by robust accountability mechanisms to increase value for money for Ontario taxpayers. While current investments have had benefits to the health system through stabilizing the primary care health force, and improving access to primary care providers, the benefits to patients are less clear.

2.0 OBJECTIVES

To develop a long-term strategy with staged, short and medium term deliverables to enhance accountability both in the funding and delivery of primary health care services in Ontario.

3.0 KEY AREAS OF FOCUS

- Effective measurement in primary health care:
  - Access and wait times
  - Transitions through care
  - Role of Interdisciplinary Health Providers
  - Resource utilization
  - Structures and process involved with accountability in primary care
  - Others
- Alignment of incentives

4.0 AREAS FOR DISCUSSION

1. Current state of measuring and monitoring in primary care.
2. Current state of incentives and premiums in primary care.
3. Current state of structures and processes involved with accountability in primary care.
4. Identify long-term vision and goals for measurement and monitoring, incentives and premiums and accountability.
5. Identify short- and medium- term priorities for each of the above for 2011-2014
6. Develop an action plan for achieving goals and priorities identified above

6.0 COMMUNICATIONS

The communication and sharing of any materials developed by the Working Group to external parties will require prior approval by the Primary Healthcare Planning Group.

7.0 REPORTING AND SUPPORT

Working Group Co-Chairs are:

Dr. Scott Wooder
Dr. Ruth Wilson

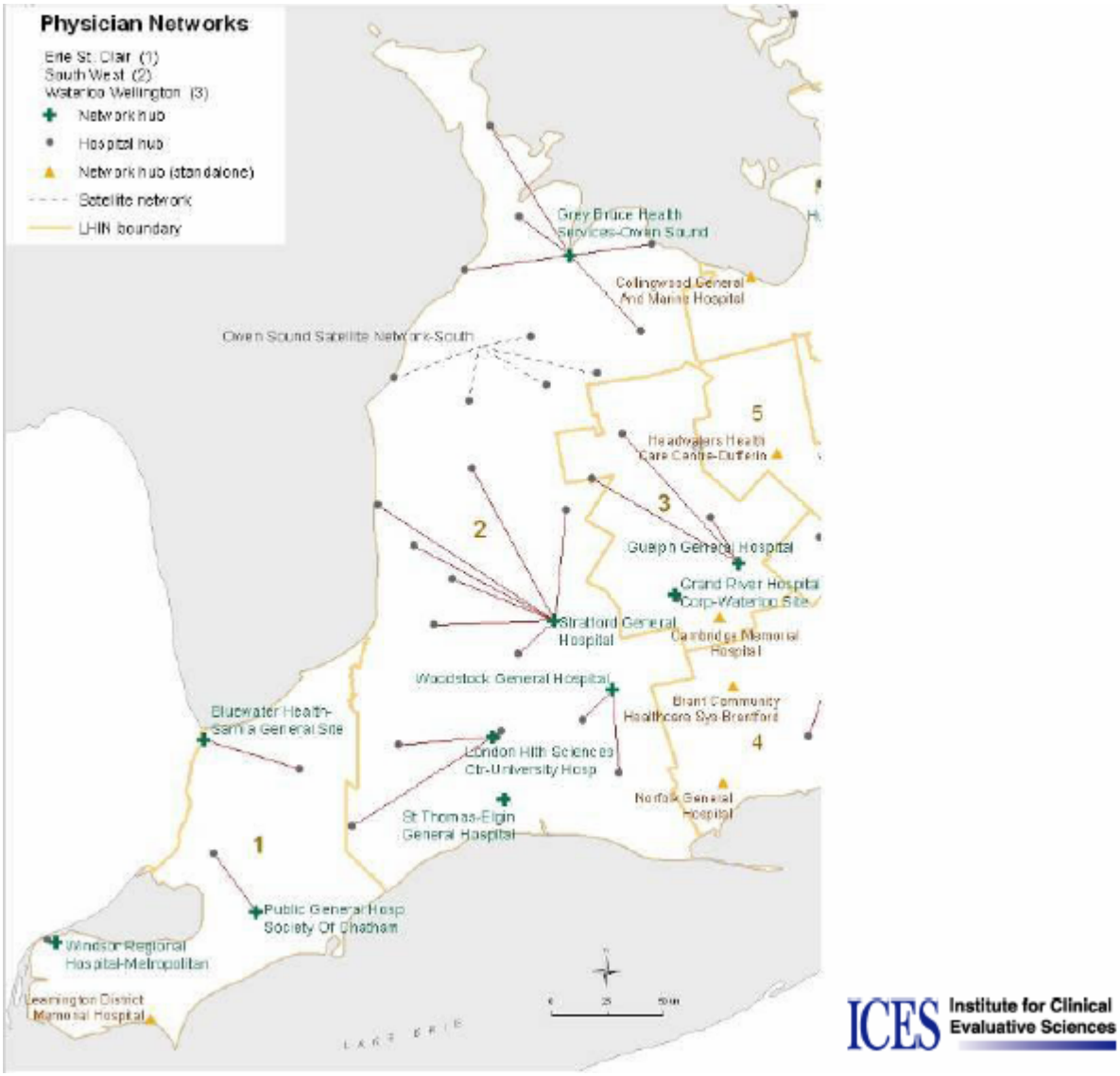
The working Group Co-Chairs will report to the Primary Health Care Planning Group, chaired by Susan Fitzpatrick, ADM, Negotiations and Accountability Management Division, Ministry of Health and Long-Term Care.

Secretariat support is provided by the Ministry of Health and Long-Term Care.

8.0 PARTICIPANTS

- Rick Glazier, Institute for Clinical Evaluative Science
- Andreas Laupacis, Li Ka Shing Knowledge Institute
- Shirlee O'Connor (NP), Registered Nurses Association of Ontario:
- John McDonald, Association of Family Health Teams of Ontario

APPENDIX B: Multispecialty Provider Networks



ICES Institute for Clinical Evaluative Sciences