Shared Accountability: the next step in Ontario’s integration journey?

Abstract

By comparing the current state of system integration in Ontario with Saskatchewan, the author proposes a new relationship option for Ontario - a shared accountability model – suggesting it can achieve the benefits of regional health authorities without engaging in “structural consolidation”.

While the Ministry and LHINs can enable and support this kind of change, leadership needs to come from the health service organizations themselves. Operational accountability rests with the providers and organizations that deliver care and it is their responsibility to step forward.

Key words:
healthcare, system integration, shared accountability, Ontario, Saskatchewan

Author/Corresponding Author
Stephen Elson, BA, MA, CHE
Regional Integration Specialist
London Health Sciences Centre & St. Joseph’s Health Care, London

For the last 11 years Steve Elson has been responsible for facilitating partnerships and collaboration between the two London hospitals and other health care organizations throughout Southwest Ontario

Contact Information
London Medical Arts Building
746 Baseline Rd. E., Suite 100
LONDON, ON N6C 5Z2

steve.elson@lhsc.on.ca

Tel: 519-685-8500 ext. 72012

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Entity
A person, partnership, organization, or business that has a legal and separately identifiable existence

Organization
A social unit of people, systematically structured and managed to meet a need or to pursue collective goals on a continuing basis. All organizations have a management structure that determines relationships between functions and positions, and subdivides and delegates roles, responsibilities, and authority to carry out defined tasks. Organizations are open systems in that they affect and are affected by the environment beyond their boundaries

Preamble
In May 2012 the author had the opportunity to spend a week visiting and learning about the Saskatoon Health Region. This provided the author with the opportunity to compare the directions being set out by Ontario and Saskatchewan and reflect on the way in which the health and healthcare systems are organized and function.

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Ontario and Saskatchewan Health Plans
A significant portion of Ontario’s Health Action Plan (2012) focusses on what the Ministry of Health and Long-Term Care will do as an organization to address province-wide issues, and the plans and strategies it will implement either directly or through provincial agencies such as LHINs and Health Quality Ontario.

The Saskatchewan’s Health Plan (2012) is not a plan that defines what the Ministry will do as an organization so much as it is a plan for the entire health system. This plan and the way it is structured would not be out of place if it was a strategic plan for an individual organization in Ontario – but the fact that it applies to the entire system illustrates that the fundamental structure of the two healthcare systems is different. For details on both of these plans see pages 8 and 9.

In Ontario it would stretch the imagination of most to suggest that multiple healthcare organizations could agree to have one common strategic plan or even have one plan for an entire LHIN. The fundamentals are simply not in place, at least not yet, to support such an endeavour.

In Ontario unless there is a compelling political and financial case made to restructure the system, it’s safe to assume that Ontario will not move to formalize health system integration through disbanding organizations and creating regional health authorities. The evidence is overwhelming that not only would it be an extremely expensive proposition – somewhere in the $4-5 billion range to harmonize wages – but it would also be extremely disruptive – taking some 4-5 years to re-establish some form of equilibrium – and could also have a significant negative impact on foundation fundraising on which hospitals in particular are dependent. The bottom line is that Ontario can’t afford this option even if it wanted to implement it. Individual organizations are therefore likely to continue to exist with distinct mandates, boards and staff. LHINs are moving to encourage mergers, especially in the community mental health services sector and the Ministry has hinted in its Health Action Plan that they will encourage more of this to occur.

While most healthcare organizations in Ontario come under the umbrella of the LHINs – most recently family healthcare (to be defined) exclusions include both public health units and land ambulance services. These two services are run by upper tier municipalities (counties and regions in Ontario) although both are cost shared with the MOHLTC. This situation presents a structural impediment to planning for and coordinating the full continuum of healthcare from a systems perspective. In spite of this impediment, the broader issue continues to be the continued role of literally thousands of self-governing health care organizations.
In Saskatchewan as with other provinces with regional health authorities, the full continuum of health and healthcare services come under regional health authority jurisdiction. While most services are provided directly by the regional health authority, many – especially community services are provided through affiliation or contractual agreements with external organizations – so not all services are owned and operated directly by the health authorities.

**Reframing the scope of health service accountability in Ontario**

As noted above, Ontario is unlikely to disband the current governance of health service organizations and replace them with regional health authorities. So the question for Ontario is whether it can operationally deliver what regional health authorities have done structurally without going the “structural consolidation route”.

The best answer to this question is Yes But. That is, if certain conditions and pre-requisites are met, then it’s not only possible but likely that Ontario can succeed in truly integrating the delivery of healthcare.

**Shared Accountability**

Shared accountability in the context of this paper means being able to provide consistent, standardized, effective, efficient and integrated health services. It means organizations and providers sharing accountability for the process and outcomes that they collectively provide to patients through their healthcare journey.

Typical journeys involve primary healthcare, specialized physician services, hospital services, community care and support and perhaps continuing or long-term care. See Figure 1 for an illustration.

**Figure 1**
Shared accountability is a key concept because if accountability for patient outcomes, the processes and continuum of care is not held by a definable, accountable entity – however that is defined - then it defaults to those who hold responsibility for only parts - but not the whole patient journey. Fragmentation and inconsistency are inherent.

By opting to apply a shared accountability model individual organizations would need to formally redefine their mandate. This could begin with a focus on the identification of shared interests and commitments to meet the needs of a specific and shared population – at a minimum at a program or service level. Strategically, it would also require a formal commitment to shared accountability at the organizational level. Structuring this shared accountability through a formal alliance or partnership would embed the on-going integration of care.

At the present time in Ontario the LHIN has system-wide accountability for integration but it is the only organization in the system – other than the MOHLTC – that does. But it is limited in that the LHIN does not have any operational accountability or responsibility – this rests with the individual health service organizations. So what is fully integrated in a regional health authority setting like Saskatchewan is fragmented in Ontario.

There are examples of formal organizational alliances in Ontario – hospital alliances that continue to be independent legal entities with their own Foundations but function with a unified staff, management team and a single Board. One example in the South West LHIN area is the Huron Perth Healthcare Alliance – an alliance of four hospitals.

However, from a continuum of care perspective this does not go far enough. From a patient’s perspective, encounters with hospitals are only part of the typical patient journey and it is the patient’s journey into, through and out of different parts of the care process that defines the continuum of care.

In Saskatchewan the pay for performance system for senior leaders reflects a shared accountability for province-wide performance. Last year, all executive teams shared accountability for results on surgical wait times. There is also a shared accountability to improve system-wide performance. This is done through “wall walks” where results are put on a wall and then groups come together to review the results. It is part of the Saskatchewan healthcare management system being adopted across the entire province. There are now visibility walls in every region, the Cancer Agency, Health Quality Council and Ministry of Health. Every three months, a provincial wall walk is conducted at the Ministry of Health, where each CEO must report on selected regional and provincial results, including provision of a written corrective action plan (called an A3) if results are off target. This same approach is being applied within each organization.

To implement a shared accountability model and to expect it to have any chance of success, three levels of leadership are required: system leadership, organizational leadership and operational leadership.

**System Leadership**
The shared accountability model could be implemented on a voluntary basis among participating organizations, but it would require a very unique set of circumstances to be successful. More likely than not, the process would begin with good intentions and then flounder.

It is proposed therefore that the shared accountability, to be taken seriously, needs to be a model of organization that is recognized and supported by both the MOHLTC and LHINs.

Organizations that come forward with proposals to move in this direction need to know that the policies of the Ministry will enable the redefined relationship among the participants and that the LHINs will support the process. The system leadership role being proposed for the MOHLTC and LHINs is therefore an enabling rather than a directive one.

**Organizational Leadership**
Both boards and senior leaders need to be champions to bring this kind of a proposition to life. Being able to engage with other organizational leaders to create a shared vision of the future takes leadership, strength, time, effort and tenacity.
From a system change perspective, leadership and courage is required to step outside the status quo and reframe the mandate of an organization. The motivation to do so cannot just be altruistic; it needs to deliver returns for the significant investment in time and resources required to make it successful. There needs to be returns not only in terms of improved quality and outcomes for patient care but also to the participating organizations and providers. Sustainability is built on shared success and rewards.

- From a system and organizational perspective the shared accountability model needs to be more efficient and effective, take waste out of the system, prevent duplication, improve productivity and be innovative – in other words improve system performance
- From a patient care perspective it needs to be truly patient- and family-centred
- From a provider perspective it needs to be coordinated, apply best practices and deliver high quality care and outcomes

**Operational Leadership**

In addition to board and senior leadership vision and commitment, having an on-going management structure that brings front line decision-makers together to provide operational accountability, leadership and direction is essential. The key deliverable is not the structure but process and outcome improvements. Operational leadership translates the intent and goals of the structure into a living, breathing reality. Key enablers include redefining job descriptions, defining cross organization responsibilities and accountabilities as well as defining operational outcomes and targets. In essence it fundamentally redefines the nature and scope of work.

**Health system performance improvement**

Having stated that performance improvement is a key deliverable of the shared accountability model, a very useful framework to consider applying is the Institute for Healthcare Improvement’s (IHI) **Triple Aim** framework. To quote from IHI’s web site:

The IHI **Triple Aim** is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance. It is IHI’s belief that new designs must be developed to simultaneously accomplish three critical objectives, which we call the “Triple Aim”:

- Improve the health of the population
- Enhance the patient experience of care (including quality, access, and reliability); and
- Reduce, or at least control, the per capita cost of care

Agreeing to adopt and use this framework might be a very productive starting point for the change journey being described. It’s one many organizations have adopted including the Ministry of Health in Saskatchewan and its health regions.

Another key reference framework is the chronic care model originally developed at the MacColl Institute of Healthcare Innovation in Seattle, Washington.

Ontario has adapted this model and has added healthy public policy, supportive environments and community action to the top of the model and activated communities and prepared, proactive community partners to the bottom segment. This gives it an added prevention and community focus. See Figure 2 for details.
This is an important framework, not only because it deals with a growing phenomenon – chronic disease – but it also incorporates prevention and looks beyond the traditional healthcare system for partnerships, strategies and action.

Chronic disease is also a major cost driver for the healthcare system. To quote from the May 2007 MOHLTC paper, *Preventing and managing Chronic Disease: Ontario’s Framework*:

Statistics Canada estimates that major chronic diseases and injuries account for over 33% of direct healthcare costs. In Ontario, chronic diseases account for 55% of direct and indirect health costs, which includes years of healthy life lost from premature death and lost productivity from disability as well as direct healthcare costs. Moreover, Ontarians with multiple serious chronic conditions consume disproportionately more healthcare than others with chronic conditions.

A focus on chronic disease prevention and management readily satisfies the three core components of Triple Aim – better care for individuals, better health for populations and lower per capita costs.

Adopting these two frameworks not only gives a solid foundation around which to operationalize the shared accountability model, but they reflect best practices and international standards and benchmarks against which to measure progress and successes. They also come with a broad constituency of organizations that are following a similar path from which organizations can learn and grow.
Closing Remarks

The dynamics that are driving direction— and goal-setting in Ontario and Saskatchewan are not that different, although economically the two provinces have essentially reversed roles – Ontario currently has a 'have-not' status and is wrestling with a significant financial debt, while Saskatchewan has a recent 'have' status and is enjoying both economic and population growth.

The health plans of both provinces are not that different and contain many of the same themes.

If Ontario is going to move from its current state and provide the conditions to make serious improvements in the performance of health care as a system – then it needs a middle ground that will enable health service organizations to come together in a new way. This paper suggests that the middle ground can be found in the shared accountability model.

While both the Ministry and LHINs need to enable and support such a model, organizational leadership needs to come from health service organizations themselves, reaching out to each other in a way they may not have done before. As noted in this paper, operational accountability rests with the providers and organizations that deliver care and provide health services - it is their accountability to step forward once the conditions for success are put in place.
Provincial Health Plans

The F2012-13 Health Plan for the province of Saskatchewan states:

**Mission Statement:** The Saskatchewan healthcare system works together with you to achieve your best possible care, experience and health

**Provincial Strategy:** Better Health, Better Care, Better Value and Better Teams

**Provincial strategic priorities**
- Transform the surgical patient experience
- Strengthen patient-centred primary healthcare
- Deploy a Provincial Continuous Improvement System
- Focus on Staff and Patient Safety
- Identify and provide services through a shared services organization

Ontario’s “Action Plan for Healthcare: Better patient care through better value from our healthcare dollars” released in 2012 has three priorities:
- Keeping Ontario Healthy
- Faster Access to Stronger Family Healthcare
- Right Care, Right Time, Right Place

The Saskatchewan Ministry of Health’s Health Plan identifies four strategies: Better Health, Better Care, Better Value and Better Teams. For each one of these strategies five year outcomes are defined along with five year improvement targets and 2012-13 breakthrough initiatives. For each improvement target and breakthrough initiative, specific indicators to measure success are stated.

The stated five year outcomes are as follows:
- Unless otherwise noted these outcomes are to be reached by March 31, 2017

**Strategic improvements**
- There will be a 50% improvement in the number of people surveyed who say, “I can contact my primary healthcare team on my day of choice”
- There will be a 50% reduction in the age-standardized hospitalization rate for ambulatory care sensitive conditions
- (by March 31, 2014) All patients have the option to receive necessary surgery within three months
- Zero surgical infections from clean surgeries
- No adverse events related to medication errors
- The healthcare budget increase is less than the increase to provincial revenue growth
- The healthcare budget is strategically invested in information technology, equipment and facility renewal
- Zero work place injuries

Additional actions to reach five year outcomes
- (by March 31, 2022) there will be a 5% decrease in the rate of obese children and youth
- There will be a 50% reduction in the incidence of communicable disease
- Seniors will have access to supports that will allow them to age within their own home and progress into other care options as their needs change
- Patients’ ratings of exceptional overall healthcare experience are in the top 20% of scores internationally
- There will be a 50% reduction in patient waits from General Practitioner referral to specialist and diagnostic services
• (by March 31, 2015) all cancer surgeries or treatments are done within the consensus-based timeframes from the time of suspicion or diagnosis of cancer
• Individuals with severe complex mental health issues with alcohol co-morbidity or acquired brain injury will have access to supportive housing in or near their community
• No patient will wait for emergency room care (patients seeking non-emergency care will have access to more appropriate care settings)
• Employee engagement provincial average score exceeds 80%
• Increase physician engagement score by 50%

Ontario’s Action Plan is more general in nature and less specific outcomes and goals are stated.

Keeping Ontario Healthy
• Ontario’s plan targets childhood obesity, smoking rates and cancer risk screening
  o reduce childhood obesity by 20% over five years

Faster Access to Stronger Family Healthcare
• Ontario’s plan targets improved access to family healthcare providers; increased financial support for house calls, online and phone consultations; integration of the latest evidence-based care into family healthcare; and integration of family healthcare into LHINs
  o Reduce the likelihood that patients will be admitted, or readmitted, to hospital.
  o Fewer patients will be readmitted to hospital within 30 days of discharge
  o More patients will have access to same-day and next-day appointments and after-hours care

Right Care, Right Time, Right Place
• High quality care
  o Ontario’s plan targets the use of evidence to drive decisions; an expanded mandate and tools for Health Quality Ontario; and, maximizing the scope of practice of healthcare professionals
• Timely, Proactive Care
  o The Wait Time Strategy will be continued and expanded; and, a Mental Health Strategy will be implemented starting with children and youth
    ▪ more patients receive medically appropriate waits for their procedures
    ▪ reduce the number of broken hips, improving the quality of life of our seniors and freeing up resources in our hospitals
    ▪ reduce the number of unnecessary hospital visits and improve the quality of life for patients
• Care as Close to Home as Possible
  o A Seniors Strategy will be implemented focussed on supporting seniors to be healthy and stay at home longer
    ▪ An expansion of house calls
    ▪ More access to home care through an additional 3 million Personal Support Worker hours for seniors in need
    ▪ Care Co-ordinators that will work closely with healthcare providers to make sure the right care is in place for seniors recovering after hospital stays to reduce readmissions
    ▪ The Healthy Homes Renovation Tax Credit, which will support seniors in adapting their home to meet their needs as they age, so they can live independently at home, longer
    ▪ Empower LHINs with greater flexibility to shift resources where the need is greatest, such as home or community care.

System Changes
To bring system support to these changes LHINs will be given support “to promote more seamless local integration”; more procedures will be shifted out of hospital and into non-profit community-based clinics; and, the move to patient-based payment systems will be accelerated
References

On-line citations

www.businessdictionary.com


http://www.longwoods.com/content/21092

http://www.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx


http://www.health.gov.sk.ca/pfcc-framework