

Rapid Evidence Profile #39

(18 October 2022)

Key messages

- The purpose of accountability models was frequently related to improving performance on quadruple-aim metrics, however at times they were implemented as part of broader transformations to align health systems with underlying societal values, such as ensuring responsiveness to local health needs
- Primary-care providers are frequently involved in service planning and delivery, for example by contributing to the development and implementation of integrated care pathways
- In three examples - Primary Health Networks in Australia, Clinical Commissioning Groups (now Integrated Care Boards) in the U.K., and Accountable Care Organizations in the U.S. - primary care providers also participate in funding and remuneration (through care commissioning) as well as play key roles in local system governance
- Formal mechanisms were most frequently used to establish accountability, often employing contracts which tie the expectations of primary-care providers (both their participation in the network and performance on care-quality indicators) to economic incentives
- Though there are no examples of local-integrated health systems in Canada, network-based approaches to primary care are becoming more common, offering lessons that OHT's can learn from

Question

What do we know from the best-available evidence and from the experiences of other jurisdictions about accountability models that are focused on primary-care organizations and providers participating in local-health system initiatives?

What we found

We organized our findings using the framework below. See Box 1 for a description of our approach.

Organizing framework

- Focus of the accountability model (i.e., to whom is the model applied)
 - Individual primary-care provider
 - Single primary-care organization
 - Shared accountability across multiple primary-care providers and/or organizations
 - Shared accountability across multiple providers and organizations representing different sectors (e.g., home and community care, primary care, specialty care, rehabilitation care, long-term care, public health)
- Purpose of the accountability model (i.e., why is the model applied)

Box 1: Our approach

We searched Health Systems Evidence and PubMed from the year 2000 onwards to capture any evidence addressing the question.

We searched for full evidence syntheses (or synthesis-derived products such as overviews of evidence syntheses), rapid syntheses, guidelines, and primary studies. We appraised the methodological quality of full evidence syntheses and rapid syntheses that were deemed to be highly relevant using AMSTAR. Note that quality-appraisal scores for rapid syntheses are often lower because of the methodological shortcuts that need to be taken to accommodate compressed timeframes. AMSTAR rates overall quality on a scale of 0 to 11, where 11/11 represents a review of the highest quality. It is important to note that the AMSTAR tool was developed to assess reviews focused on clinical interventions, so not all criteria apply to evidence syntheses pertaining to delivery, financial or governance arrangements within health systems or to broader social systems. We appraised the quality of highly relevant guidelines using three domains in AGREE II (stakeholder involvement, rigour of development, and editorial independence) and classified guidelines as high quality if they were scored as 60% or higher on each domain.

We identified jurisdictional experiences by handsearching government and stakeholder websites for Australia, New Zealand, United Kingdom, and United States, as well as all Canadian provinces and territories.

This rapid evidence profile was prepared in the equivalent of three days of a 'full-court press' by all involved staff.

- Improving performance (e.g., quadruple aim)
- Establishing legitimacy and/or trust
- Aligning with underlying societal values (e.g., transparency, responsibility, integrity, openness, responsiveness, answerability)
- Other purposes specific to jurisdictional/system goals
- Health-system arrangements that are the target of the accountability model (i.e., for what is primary care accountable?)
 - Accountability for financing, funding and remunerating
 - Accountability for service planning and delivery
 - Accountability for other system arrangements (including implementation)
- Mechanisms used in the model to establish accountability (i.e., how is the model applied)
 - Informal mechanisms (e.g., dialogue, negotiations, expectations, demands)
 - Formal mechanisms
 - Legal instruments (e.g., acts and regulations, self-regulation regimes, and performance-based regulation)
 - Economic instruments (e.g., insurance schemes and contracts)
 - Voluntary instruments (e.g., standards and guidelines, formalized partnerships)
 - Information and education instruments (e.g., training, public reporting, audit and feedback)
- Factors enabling the accountability model
 - System-level factors (e.g., political will, stakeholder engagement)
 - Organization-level factors
 - Provider level factors
 - Model/design-level factors (e.g., contextualized model design, data availability, independence of the accountability mechanisms from those who are accountable)

We identified 18 evidence documents relevant to the question, of which we deemed 14 to be highly relevant. The highly relevant evidence documents include:

- one full evidence synthesis; and
- 12 single studies and one policy brief that provide additional insights.

We outline in narrative form below our key findings related to the question from highly relevant evidence documents and based on experiences from the selected countries and Canadian provinces and territories. We provide the key findings from highly relevant evidence documents in Table 1. These have been summarized according to the mechanisms to establish accountability as this we found the most detail. In addition, details about experiences from the selected countries are provided in Table 2 and in Canadian provinces and territories in Table 3. A detailed summary of our methods is provided in Appendix 1, the full list of included evidence documents (including those deemed of medium and low relevance) in Appendix 2, and hyperlinks for documents excluded at the final stage of reviewing in Appendix 3.

Key findings from highly relevant evidence sources

The identified literature largely consisted of descriptive studies of primary care involvement in integrated or coordinated-care initiatives, which often included targeted sections related to accountability structures even if this wasn't the primary focus of the documents. One of the studies included an evaluative component of the fundholding role of clinical commissioning groups in the U.K., and one study developed a conceptual map of primary-care structures and processes.

In general, we found that the purpose of accountability models was most frequently related to improving performance on quadruple-aim metrics, largely focused on patient/caregiver experience (e.g., timely appointments within set time frames, patient experience rating) and population health outcomes and related process measures (e.g., influenza immunization, screening for depression and

development of follow-up plan, and hemoglobin A1c control). At times, they were also implemented as part of transformations to align health systems with underlying societal values, including to increase responsiveness of local systems to local needs, and the importance of placing the patient at the centre of care.

With respect to health-system arrangements, most of the studies focused on the role of primary care in service planning and delivery, with a smaller subset of these focused on quality improvement. However, [one recent medium-quality evidence synthesis](#) and five studies also reported on the experience of U.S. accountable care organizations (1, 2) and U.K. clinical commissioning groups (1, 2, 3) (see jurisdictional scan for descriptions of both initiatives). In each of these initiatives, primary-care providers were also engaged in local-system governance, funding organizations, and implementing local-system transformations.

With respect to mechanisms used to establish accountability, we observed a gradient whereby initiatives in their earlier stages (and where primary care was not responsible for funding and remuneration) or those that were specific to a given local system were more likely to have informal mechanisms or voluntary instruments such as memoranda of understanding. Other initiatives where primary care was involved in funding and remuneration and where system-wide transformations were implemented made use of economic instruments as a key mechanism to ensure accountability. Economic instruments most often included elements of risk sharing as well as carefully crafted incentives. Legal mechanisms were rarely described in the studies. However, one single study examined the development of health and social service centres in Quebec as part of their primary-care reform and the establishment of local health networks. The latter are meant to take a population-health based approach to primary care. They are comprised of family medicine groups, community pharmacies and community organizations and for whom [accountability is maintained through accreditation as a family medicine group and contracts that outline funding, remuneration and service obligations](#).

Three primary studies (1,2,3) explicitly mentioned factors enabling the accountability, including:

- commitment from government and from other (already involved) providers
- involvement of primary-care providers in the development of the accountability model
- aligned incentives
- implementation supports, particularly when establishing new local governance arrangements
- operating in a data-rich environment.

Finally, one single study provides a conceptual overview of accountability in primary care and describes the need to establish both [vertical accountability mechanisms as well as horizontal accountability mechanisms](#). The study notes that there are [five essential components to accountability: legal, financial, professional, political and public](#).

Key findings from the jurisdictional scan

We found relatively few examples – in other countries or in Canadian provinces and territories – of instances in which organizations and providers in primary care were held accountable for their participation in local-health system initiatives. Those that we did identify have been summarized in the text below based on the target of the accountability model (i.e., for what primary care is accountable) and the mechanisms used in the model to establish accountability. Despite the relatively few models identified, as Canadian provinces and territories increasingly move towards team-based care, there are numerous examples of performance-improvement frameworks that have been operationalized in primary care to ensure the quality of clinical care that may form part of an accountability model. These are included in the key findings outlined in Table 2, but haven't been described here since they don't directly speak to primary-care accountability in the context of local systems.

Local-system arrangements that are the target of the accountability model

Most of the primary-care accountability models focused on ensuring accountability for the role of primary care in service planning and delivery (e.g., by setting expectations or requirements of organizations and providers involved in service planning and delivery) as well in aspects of the related financing, funding, and remuneration that support service planning and delivery (e.g., by establishing regional funding bodies, contracts and fee schedules with providers, or financial penalties or incentives for meeting service or health-related targets). For example, [Clinical Commissioning Groups](#) in the U.K., which are made up of local primary-care practices and which were replaced in July 2022 with Integrated Care Boards), are legally responsible for fulfilling the functions and responsibilities in their contract with NHS England. These Clinical Commissioning Groups commission primary-care services through [contracts with individual providers](#) and provide oversight for service quality and ensure financial performance. High-performing networks are identified through benchmarking, as well as by their contribution to system development and sharing of innovations and best practice, and such performance may make them eligible for incentive funding, increased contract length, taking over contracts of regions with poor performers, and public recognition of performance. In the U.S., primary-care providers (or networks of providers) that are contracted under Medicare can join Medicare Accountable Care Organizations (ACOs). ACO providers continue to be remunerated through the traditional Medicare fee-for-service payment system, and the performance of each ACO is measured against benchmarks that determine overall [shared savings](#) or losses and hence [incentives](#) for ACOs. A similar model is also in place in Australia whereby Primary Health Networks are responsible for the strategic commissioning of health services to meet the needs of the local population.

Accountability models based on capitation funding also serve to ensure service delivery from primary care while managing costs. For example, New Zealand's [Foundation Standard](#) provides a national quality benchmark that allows primary-care practices to qualify for capitation funding. The benchmarks assess the practice's capacity to provide high-quality health services efficiently while adhering to regulatory, clinical and legislative requirements. In Quebec, [Bill 20](#) introduced obligations for primary care providers to register a minimum number of patients, meet targets related to continuity of care for these patients, and practice a minimum number of hours in a hospital setting. This is in addition to a contract in place between the Ministry of Health and Social Services and family medicine groups, which defines the range of services (notably the days and hours of operation and after-hours services) these physicians provide to a population, and in exchange they receive human, material, and financial resources.

Select models also incorporate accountability for local system governance and implementation, such as through the establishment and/or strengthening of local primary-care networks consisting of local and regional stakeholders tasked with identifying local needs and organizing primary-care services accordingly. The [Collaborative Service Committees](#) in British Columbia provide oversight for existing and potential local primary care networks and receive funding to support service needs planning and change management to help new networks optimize team-based care approaches. The [Collaborative Service Committee are responsible](#) for:

- ensuring that primary care networks adhere to the principles for Primary Care Networks
- overseeing strategy, implementation, and operations of the primary care networks in accordance with the service plan
- the allocation of funds and other resources for the primary care networks through partners acting as fund administrators in accordance with the service plan
- ensuring that the financial and other reporting relating to the primary care network and required by the Ministry is prepared, approved and submitted
- provide oversight and direction to the primary care network manager and the primary care network administrator that have been hired to support the primary care network.

In Alberta, [Zone Primary Care Network Committees](#) provide regional oversight to five ‘zones’ across Alberta. These committees are made up of representatives from primary-care networks operating within each zone and have been developed to help integrate and align service delivery and ensure consistent standards of the health services offered to Albertans.

Mechanisms used in the model to establish accountability

Mechanisms used to establish and ensure accountability for local systems can take shape either through informal or formal mechanisms. Informal mechanisms used to establish accountability across the models identified often included strategy documents, frameworks, and agreements that outline roles and responsibilities for different organizations and providers in the planning, financing, coordination, and delivery of primary health care. We did not find any examples where informal mechanisms were the only mechanisms in place, however, this may be a result of many of the initiatives already being well-established. Experiences from other jurisdictions suggest that local systems that remain in their infancy may use informal mechanisms more frequently.

Formal mechanisms used by accountability models consisted of economic and reporting instruments such as contracts, financial-incentive arrangements, and auditing and feedback tools for primary-care providers or those who coordinate/commission primary-care services. For example, the CCGs in the U.K. established contracts with primary-care providers, and NHS England evaluated their [annual commissioning plans](#) and monitored service and financial performance monthly. Similarly, delivery and financial performance of Medicare ACO’s in the U.S. are evaluated against benchmarks and subsequently used to determine applicable financial incentives. Contractual relationships between primary-care providers or networks of providers and regional health authorities are frequently used to ensure accountability for primary care service delivery.

Legal instruments, such as Quebec’s [Bill 20](#), were less common as stand-alone mechanisms, although at times legal obligations were built into contracts such as the CCGs’ legal obligations to NHS England and the legal authority of NHS England to discharge CCGs if performance standards were not met. Voluntary instruments such as guidelines and standards were often incorporated into broader accountability models to establish expectations and promote quality and consistency across primary-care services.

Factors enabling the accountability model

System-level factors such as political will were not always made explicit, but broader trends such as the shift in Canada towards team-based primary-care delivery appear to have served as a system-level factor enabling some of the accountability models identified in Canada. For example, accountability models organized around establishing and strengthening primary-care networks to provide oversight and address local needs such as in [Alberta](#) and [British Columbia](#) align well with a teams-based approach to service provision.

The most obvious model/design-level factors identified tying financial incentives to performance indicators, which also supported the collection of standardized data needed to evaluate primary-care practices. For example, the [Practice Incentives Program Quality Improvement Incentive](#) (PIP QI) in Australia provides financial incentives for primary-care practices to participate in quality-improvement activities to improve patient outcomes across 10 improvement measures, and adopt best practices.

Table 1: Key findings from evidence documents about accountability for primary care within local systems

Mechanisms used in the model to establish accountability	Key findings
<p>Informal mechanisms (e.g., dialogue, negotiations, expectations, demands)</p>	<ul style="list-style-type: none"> • One single study reports on findings from surveys and interviews with those involved in establishing patient-centred medical homes and identified that mechanisms including communication and negotiation are critical for initially developing shared accountability arrangements and enable organizations, including primary care, to reach agreements in the short term and begin making long-term commitments to one another
<p>Formal mechanisms</p>	
<ul style="list-style-type: none"> • Legal instruments (e.g., act and regulations, self-regulation regimes, and performance-based regulations) 	<ul style="list-style-type: none"> • One study describes the shift from primary care teams to clinical commissioning groups in the U.K. and focuses on the combination of legal and economic instruments that are used to ensure accountability, including making participation in clinical commissioning groups a condition of practice for all primary care practices • One single study examines the development of Health Service and Social Centres in Quebec as part of their primary care reform and establishment of Local Health Networks, which are meant to take a population-health based approach to primary care <ul style="list-style-type: none"> ○ Local Health Networks are comprised of community pharmacies, community organizations and family medicine groups for whom accountability is maintained through accreditation as a family medicine group and contracts that outline funding, remuneration and service obligations ○ A second single study reported on the effects of the Health Service and Social Centres and found the reform results in an increased sense of shared responsibility for population health across those participating and more formalized partnerships between primary care, specialized services, public health and social services
<ul style="list-style-type: none"> • Economic instruments (e.g., insurance schemes and contracts) 	<ul style="list-style-type: none"> • One older medium-quality evidence synthesis examined the experience of place-based contracting in the U.K. as an accountability mechanism and found the effects on overall population-health management differed significantly given the heterogeneity in the contracting models that exist <ul style="list-style-type: none"> ○ The synthesis noted that any new forms of contracting need to be supported by a program of organisational development and involvement of clinicians • Two single studies (1, 2) describe the economic instruments in place in U.K. clinical commissioning groups to ensure accountability, which include an internal market as well as incentives for better outcomes via a quality premium <ul style="list-style-type: none"> ○ One of the studies noted that significant infrastructure was needed to support primary care practices to take on a role in planning and purchasing services

	<ul style="list-style-type: none"> • One of the single studies also examines the literature on general practitioner fundholding and found that while it reduced waiting times for elective cases, it also led to widened inequities within the health system • One single study reported results from a survey of U.S. accountable care organizations, and found that greater physician engagement was identified in larger, integrated delivery systems and in smaller physician-led accountable care organizations as opposed to hybrid accountable care organizations <ul style="list-style-type: none"> ○ Performance and accountability mechanisms that were used include individual quality measures, individual cost measures, one-on-one review and feedback, individual financial incentives, and individual non-financial awards or recognition • One single study examines the Kaiser Permanente model for integrated care and reports that there are many accountability measures in place for primary care providers including partnership (after three years) and profit sharing as well as incentives for performance features including access, patient satisfaction and ensuring evidence-based care • A policy brief identifies strategies for how state and federal policymakers in the U.S. can involve safety-net providers, which include primary care, into integrated care efforts <ul style="list-style-type: none"> ○ The brief found that financial incentives can be used strategically to reward achievement of desired ends but that the unique circumstances of the providers should be taken into account, including the likely difficulties they face in realizing cost-savings in the short run
<ul style="list-style-type: none"> • Voluntary instruments (e.g., standards and guidelines, formalized partnerships) 	<ul style="list-style-type: none"> • One single study in Australia documents primary care practices' participation in their local Divisions of General Practice, which are local-system organizations that support quality improvement, integration with other services and plan for local population-health issues and notes that while participation is voluntary it is supported by memoranda of understanding <ul style="list-style-type: none"> ○ The study states that while the voluntary approach allows for flexibility it also creates inconsistencies in participation and should the divisions take on a greater role in integrated planning or allocation of funding a more formal accountability arrangement should be implemented • One single study documents the development of quality councils within the Veteran's Health Administration, which provide interdisciplinary leadership for quality improvement projects, and their work with primary care teams <ul style="list-style-type: none"> ○ A memoranda of understanding and non-financial incentives, such as access to additional data, new information and communication technology, and training opportunities were used to ensure accountability for the participation in and implementation of quality improvement initiatives
<ul style="list-style-type: none"> • Information and education instruments (e.g., training, public reporting, audit and feedback) 	<ul style="list-style-type: none"> • One single study describes the accountability model applied to primary care within Danish integrated care systems, which includes participation in quality improvement initiatives by

	<p>submitted data via clinical registries for public reporting, as well as national clinical audits and regional clinical audits to examine lagging indicators</p> <ul style="list-style-type: none"> • One single study reporting on the accountability mechanisms used at later stages in patient-centred medical home models included care compacts with specialists, report cards, patient surveys, real-time feedback to track the performance of providers, and discussions to manage patient transitions and follow-up
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Table 2: Experiences in selected jurisdictions related to accountability for primary care within local systems

Country	Summary of experiences
Australia	<ul style="list-style-type: none"> • The Clinical Governance Framework, which defines clinical governance and its relationship with corporate governance, describes key components of the framework based on the National Safety and Quality Health Service (NSQHS), including standards, and outlines the roles and responsibilities of patients and consumers, clinicians, managers, and governing bodies in implementing effective clinical governance systems across health service organizations • The Practice Incentives Program Quality Improvement Incentive (PIP QI) provides financial incentives for primary care practices to participate in quality improvement activities to improve patient outcomes across 10 improvement measures assessing population health, and best practices taken for screening and care delivery • As part of the 2011 National Health Reform Agreement, the Performance and Accountability Framework (PAF) was developed to promote safe and high-quality health system through improved transparency and accountability <ul style="list-style-type: none"> ○ The framework sets in place indicators to guide reporting across three domains – equity, effectiveness and efficiency of service delivery ○ Accountability for achieving these relies on information and education with results being public reported • The Primary Health Networks (PHN) grant program guidelines describe the funding arrangements of the program as well as the responsibilities of funded PHNs <ul style="list-style-type: none"> ○ The governance arrangements for PHNs include Clinical Councils, Community Advisory Committees, and rules are put in place for interactions with Local Hospital Networks ○ The requirements for PHN contracting, payment, reporting, monitoring and evaluation include: <ul style="list-style-type: none"> ▪ PHNs are responsible for undertaking needs assessments and strategic commissioning to best meet the needs identified, considering value for money that considers efficiency, effectiveness, ethical practice, and avoiding duplication of services, among other considerations ▪ PHNs are required to select and periodically review and revise indicators that reflect local priorities and that help drive quality improvement activity in their region ▪ Additional standardized data will be collected and used to monitor and assess PHNs against national and local indicators ▪ High performing PHNs will be identified through benchmarking as well as by their contribution to system development and sharing of innovations and best practice, and may make them eligible for incentive funding, increased contract length, taking over contracts of regions with poor performers, and public recognition of performance

New Zealand	<ul style="list-style-type: none"> • Primary care in New Zealand is largely delivered by 30 primary health organizations (networks of providers) <ul style="list-style-type: none"> ○ Primary health organizations are funded by Health New Zealand and are responsible for providing or contracting general practice services and ensuring continuity of care for patients ○ The system level measures framework is used to assess the performance of primary health organizations as well as to drive quality improvement • The Royal New Zealand College of General Practitioners has established the Foundation Standard to create a national quality benchmark that enables primary care practices to qualify for capitation funding as per the primary health organization service agreement amendment protocol <ul style="list-style-type: none"> ○ The standard represents a collection of regulatory, clinical, and legislative requirements that all general practices must be compliant with ○ Five domains of standards (with accompanying indicators) are defined in the Foundation Standard: patients, clinical care, medicine management, medical equipment and resources, and the practice ○ Practices are required to complete a self-assessment and then engage an external assessor to meet the Foundation Standard requirements • On 1 July 2022, Health New Zealand, a newly formed national organization, assumed responsibility for hospital, community, and primary care in New Zealand <ul style="list-style-type: none"> ○ This is a departure from the previous use of district health boards to serve this function ○ The accountability model for primary care that Health New Zealand will implement is not yet known
United Kingdom	<ul style="list-style-type: none"> • Clinical Commissioning Groups (CCGs), which were created in 2012 (and dissolved in July 2022 and replaced with Integrated Care Boards), were made up of local primary care practices and were responsible for fund holding and commissioning healthcare, including primary care services, mental health services, urgent and emergency care, and elective hospital services • Clinical Commissioning groups have a legal responsibility for carrying out the functions included within their contract with NHS England and must publish yearly commissioning plans • NHS England issued annual or multi-annual planning guidance to CCGs that sets out performance and financial priorities for the forth coming year, including an annual assessment framework of 51 indicators <ul style="list-style-type: none"> ○ CCGs performance against these plans was monitored monthly by NHS England's local team ○ If CCGs were found to be failing or at risk of failing, NHS England can use its formal powers to discharge its functions • Individual providers sign a contract with the CCG (now with Integrated Care Boards) that lay out their responsibilities for patient care and participation in the CCG/ICB <ul style="list-style-type: none"> ○ Commissions, whether CCGs or ICBs, must conduct a routine annual review of each primary medical care contract ○ Other mechanisms have been put in place to ensure quality, including setting and monitoring of key performance indicators (which are negotiated into relevant contracts), analysis of data provided by NHS England and Care Quality Commission, and practice visits to examine the quality and achievement of each primary care practice (after which practices are generally provided with a list of recommended improvements and follow-up with in 12 months to ensure compliance)
United States	<ul style="list-style-type: none"> • Primary care providers (or networks of primary care providers) that have existing contracts with Medicare (i.e., are Medicare providers) are eligible to join a Medicare Accountable Care Organizations (or ACOs)

	<ul style="list-style-type: none"> • Medicare continues to pay individual providers and suppliers for covered items and services as it does under traditional fee-for-service payment systems • In addition, the Center for Medicare Services also develops benchmarks for each ACO against which ACO performance is measured to assess whether the ACO generated savings or losses for the Medicare program during a given performance year • Individual providers maintain contracts with the ACO that include details on how shared savings are allocated among providers should they be achieved by the ACO • Examples of ACO incentive models include: attribution based on number of beneficiaries in per primary care provider; incremental incentive based on improvement achieved; threshold incentives related to quality and costs; and upfront incentives that can be taken back if quality and cost benchmarks are not met
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Table 3: Experiences in Canadian provinces and territories related to accountability for primary care within local systems

Province	Summary of experiences
Pan-Canadian	<ul style="list-style-type: none"> • None identified
British Columbia	<ul style="list-style-type: none"> • The British Columbia Primary and Community Care Strategy highlights that team-based care is a tool to expand access to primary care and should gradually overtake full-service family practices • The strategy document outlines a plan to develop a budget and policy framework to establish linked community and residential care service practices for older adults with moderate to complex chronic conditions <ul style="list-style-type: none"> ○ The strategy suggest that these practices will be developed by physicians, health service providers, or health authorities, based on community needs and the assembly of a mix of health providers ○ It is mentioned that these teams will be established in partnership with the First Nations Health Authority, where appropriate ○ The strategy document also outlines a similar plan for establish community and residential care service practices for patients with moderate to severe mental illnesses and/or substance use issues ○ The Ministry of Health is charged with overseeing a review of appropriate governance and strategic structures at the regional/community level to ensure that primary and community care organizations that the appropriate account and authority to make change, however this has not yet been publicly released • The General Practice Services Committee of British Columbia has produced an information sheet about primary care network collaborative governance to support the implementation of primary care networks that can improve access to team-based primary care services <ul style="list-style-type: none"> ○ This information sheet identifies the roles and responsibilities for the following organizations at the local and regional level: divisions of family practice, regional health authorities, collaborative service committees, primary care steering committees, and interdivisional strategic councils ○ In general, these regional/local organizations maintain responsibility for clinical network development, fund administration, contract management, data sharing, local governance, hiring, engagement with other local organizations, identifying community needs, and representing local voices at the provincial level

	<ul style="list-style-type: none"> ○ Ongoing decisions about the operation of primary care networks are made by local Collaborative Service Committees or primary care network Steering Committees, with additional input from network participants (including physicians) ○ In addition, local Indigenous partners have been involved in the planning, governance, and implementation of primary care networks ○ The Provincial Health Service Authority’s community profiles provide local surveillance data that can help with the planning and resource allocation in primary care networks ● Local Collaborative Service Committees oversee identifying opportunities for establishing primary care networks and supporting existing networks <ul style="list-style-type: none"> ○ When opportunities have been identified, an Expression of Interest is submitted; if approved this provides \$150 000 for change management support and to develop a plan to meet local needs ○ The first phase of implementing primary care networks is to ensure patients who do not have a primary care provider are attached to one, then the focus shifts to redesigning services to optimize the team-based care approach
Alberta	<ul style="list-style-type: none"> ● The (2013) Family care clinic: Governance and accountability guidelines outlines the governance structure and responsibilities of Family Care Clinics (FCCs) in Alberta, including board membership requirements and reporting requirements for business plans, finances, performance, and service provision of FCCs ● The (2017) Provincial Primary Care Network (PCN) Governance Framework is led by the PCN Committee, which is chaired by Alberta Health and includes representatives from PCNs, Alberta Health Services, the Alberta Federation of Regulated Health Professionals (AFRHP) and the Alberta Medical Association (AMA) <ul style="list-style-type: none"> ○ Zone PCN Committees include representatives from PCNs, Alberta Health Services and local communities to provide a localized and community-based health oversight ○ Collectively, the Provincial and Zone PCN Committees work to 1) integrate and align health service delivery and 2) support standard and consistent delivery of health services for all Albertans
Saskatchewan	<ul style="list-style-type: none"> ● The 2012 Saskatchewan Framework for Primary Health Care report includes ‘policy and accountability’ as a building block of a high-performing primary health care system <ul style="list-style-type: none"> ○ The report highlights the need for a flexible primary care funding approach that would move more funding and spending decisions closer to patients (notably to regional health authorities, communities, and providers) and enable team-based care as well as health promotion ○ In exchange for flexible funding, the report stresses the importance of improved accountability for health care delivery and health outcomes for both regional health authorities and healthcare providers ○ Proposed accountability measures include both specific performance targets (for example, a percentage of patient who report an excellent primary care experience) as well as engagement and joint problem solving with communities ○ The report also proposes using written (though not necessarily legal) agreements between stakeholders (such as between communities and their health care teams) to support mutual understanding of expectations
Manitoba	<ul style="list-style-type: none"> ● Manitoba uses the Manitoba Primary Care Quality Indicators (PCQI), developed in partnership with physicians and other providers/specialists based on indicators originally developed by Canadian Institute for Health Information (CIHI), to monitor clinical quality progress in primary care

Ontario	<ul style="list-style-type: none"> • The accountability framework between Ontario Health and the Ministry of Health and Ministry of Long-Term Care seeks to clarify roles, responsibilities and direction from government through a memorandum of understanding, mandate and strategic priorities letters, and accountability agreements <ul style="list-style-type: none"> ○ The Ministry of Health – Ontario Health Accountability Agreement provides a set of principles, roles and responsibilities for the Ministry of Health and Ontario Health ○ The Ministry of Long-Term Care – Ontario Health Accountability Agreement provides a set of principles, roles and responsibilities for the Ministry of Long-Term Care and Ontario Health ○ Ontario Health as an agency is responsible for providing oversight for health system management and performance, including ensuring financial and performance accountability for primary care providers and organizations such as Family Health Teams, Family Health Organizations, Community Health Centres, and the Home and Community Care Support Services • The LHINs (replaced on 1 April 2021 by Home and Community Care Support Services) provided services through service accountability agreements with more than 800 Community Support Service (CSS) agencies • The <i>Excellent Care for All Act, 2010</i> identified four types of organizations (Community Care Access Centres, interprofessional team-based primary-care organizations, hospitals, and long-term care homes) responsible for submitting Quality Improvement Plans to Health Quality Ontario annually • The Primary Care Performance Measurement (PCPM) Framework in Ontario provides specific performance measures for primary care across nine domains
Québec	<ul style="list-style-type: none"> • A 2011 article describes the governance of family medical groups in Quebec <ul style="list-style-type: none"> ○ In these organizations, approximately 10 physicians, two nurses, and two administrative staff are responsible for the primary care of 15 000 people ○ The family medical group model, a contractual relationship is established between the Ministry of Health and Social Services and physicians which defines the range of services (notably the days and hours of operation and after-hours services) these physicians provide to a population, and in exchange they receive human, material, and financial resources ○ In addition to the contract with the ministry, these groups also sign agreements with local health and social service centres to enable nurses who are formally employed by the local centres to work for, and under the direction of, the family medical group • In 2015, Quebec introduced Bill 20, which included several clauses regarding the operation of primary care practices that were aimed to improve access to primary care in the province <ul style="list-style-type: none"> ○ The bill introduced obligations for primary care providers to register a minimum number of patients, meet targets related to continuity of care for these patients, and practice a minimum number of hours in a hospital setting ○ Physician practices that do not meet these targets are financially penalized
New Brunswick	<ul style="list-style-type: none"> • The provincial government and the New Brunswick Medical Society organize physician services (including primary care services) through the Physician Services Master Agreement, which includes benchmarking and reporting requirements for physicians
Nova Scotia	<ul style="list-style-type: none"> • Primary care teams are active in Nova Scotia and provide interprofessional team-based care with variable service offerings

	<ul style="list-style-type: none"> ○ These teams are accountable to district health authorities and negotiate funding and budgets with the authorities based on the geographic patient panel and disease profile ○ District health authorities work collaboratively with primary care teams for strategic planning and are accountable to the Ministry of Health
Prince Edward Island	<ul style="list-style-type: none"> ● None identified
Newfoundland and Labrador	<ul style="list-style-type: none"> ● None identified
Yukon	<ul style="list-style-type: none"> ● None identified
Northwest Territories	<ul style="list-style-type: none"> ● None identified
Nunavut	<ul style="list-style-type: none"> ● None identified

Waddell K, Demaio P, Bain T, Sharma K, Moat KA, Lavis JN. Rapid evidence profile #39: What do we know from the best-available evidence and from the experiences of other jurisdictions about accountability models that are focused on primary-care organizations providers participating in local-health system initiatives? Hamilton: McMaster Health Forum, 18 October 2022.

RISE prepares both its own resources (like this rapid evidence profile) that can support rapid learning and improvement, as well as provides a structured ‘way in’ to resources prepared by other partners and by the ministry. RISE is supported by a grant from the Ontario Ministry of Health to the McMaster Health Forum. The opinions, results, and conclusions are those of RISE and are independent of the ministry. No endorsement by the ministry is intended or should be inferred.



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Appendices for Rapid Evidence Profile #39

(10 October 2022)

Appendix 1: Methodological details

We use a standard protocol for preparing rapid evidence profiles (REP) to ensure that our approach to identifying research evidence as well as experiences from Canadian provinces and territories are as systematic and transparent as possible in the time we were given to prepare the profile.

Identifying research evidence

We searched [Health Systems Evidence](#) using in the open search (accountability OR accountabilities) using the topic filters for “Sectors” and “Primary care”, as well as searching in [PubMed](#) for studies conducted after 2000 using an open search for (accountability OR accountabilities) AND (primary care).

Each source for these documents is assigned to one team member who conducts hand searches (when a source contains a smaller number of documents) or keyword searches to identify potentially relevant documents. A final inclusion assessment is performed both by the person who did the initial screening and the lead author of the rapid evidence profile, with disagreements resolved by consensus or with the input of a third reviewer on the team. The team uses a dedicated virtual channel to discuss and iteratively refine inclusion/exclusion criteria throughout the process, which provides a running list of considerations that all members can consult during the first stages of assessment.

During this process we include published, pre-print and grey literature. We do not exclude documents based on the language of a document. However, we are not able to extract key findings from documents that are written in languages other than English or French. We provide any documents that do not have content available in these languages in an appendix containing documents excluded at the final stages of reviewing.

Identifying experiences from Canadian provinces and territories

For each REP we search several sources to identify experiences. This includes government-response trackers that document national responses to the pandemic, as well as relevant government and ministry websites. For example, we search websites from relevant federal and provincial governments, ministries and agencies (e.g., Public Health Agency of Canada).

While we do not exclude countries based on language, where information is not available through the government-response trackers, we are unable to extract information about countries that do not use English or French as an official language

Assessing relevance and quality of evidence

We assess the relevance of each included evidence document as being of high, moderate or low relevance to the question. We then use a colour gradient to reflect high (darkest blue) to low (lightest blue) relevance.

Two reviewers independently appraised the quality of the guidelines we identified as being highly relevant using AGREE II. We used three domains in the tool (stakeholder involvement, rigour of development and editorial independence) and classified guidelines as high quality if they were scored as 60% or higher across each of these domains.

Two reviewers independently appraise the methodological quality of systematic reviews and rapid reviews that are deemed to be highly relevant. Disagreements are resolved by consensus with a third reviewer if needed. AMSTAR rates overall methodological quality on a scale of 0 to 11, where 11/11 represents a review of the highest quality. High-quality reviews are those with scores of eight or higher out of a possible 11, medium-quality reviews are those with scores between four and seven, and low-quality reviews are those with scores less than four. It is important to note that the AMSTAR tool was developed to assess reviews focused on clinical interventions, so not all criteria apply to systematic reviews pertaining to health-system arrangements or to economic and social responses to COVID-19. Where the denominator is not 11, an aspect of the tool was considered not relevant by the raters. In comparing ratings, it is therefore important to keep both parts of the score (i.e., the numerator and denominator) in mind. For example, a review that scores 8/8 is generally of comparable quality to a review scoring 11/11; both ratings are considered 'high scores.' A high score signals that readers of the review can have a high level of confidence in its findings. A low score, on the other hand, does not mean that the review should be discarded, merely that less confidence can be placed in its findings and that the review needs to be examined closely to identify its limitations. (Lewin S, Oxman AD, Lavis JN, Fretheim A. SUPPORT Tools for evidence-informed health Policymaking (STP): 8. Deciding how much confidence to place in a systematic review. *Health Research Policy and Systems* 2009; 7 (Suppl1):S8.

Preparing the profile

Each included document is hyperlinked to its original source to facilitate easy retrieval. For all included guidelines, systematic reviews, rapid reviews and single studies (when included), we prepare a small number of bullet points that provide a brief summary of the key findings, which are used to summarize key messages in the text. Protocols and titles/questions have their titles hyperlinked given that findings are not yet available. We then draft a brief summary that highlights the total number of different types of highly relevant documents identified (organized by document), as well as their key findings, date of last search (or date last updated or published), and methodological quality.

Appendix 2: Key findings from evidence documents that address the question, organized by document type and sorted by relevance to the question

Type of document	Relevance to question	Key findings	Recency or status
Guidelines			
Full systematic reviews	<ul style="list-style-type: none"> ● Focus of the accountability model <ul style="list-style-type: none"> ○ Shared accountability across multiple providers and organizations representing different sectors ● Purpose of the accountability model <ul style="list-style-type: none"> ○ Improving performance ○ Establishing legitimacy and trust ● Health-system arrangements that are the target of the accountability model <ul style="list-style-type: none"> ○ Accountability for financing, funding and remunerating ○ Accountability for service planning and delivery ○ Accountability for other system arrangements (incl. implementation) ● Mechanisms used in the model to establish accountability <ul style="list-style-type: none"> ○ Formal mechanisms <ul style="list-style-type: none"> ▪ Legal instruments ▪ Economic instruments 	<ul style="list-style-type: none"> ● The review examines evidence for the use of place-based contracts (incorporating capitated budgets and risk/gain sharing) and other financial incentives to establish accountability ● Previous experience in the U.K. suggests that levers were needed to improve outcomes and encourage place-based accountability and subsequently developed a contract framework to facilitate this ● The contracts merge existing funding streams into a single payment with three different levels of risk and gain sharing ● The review notes that the evidence base around place-based contracting is relatively sparse and has significant heterogeneity given the many different types of contracting models that exist ● The influence of contractual forms on population health is mixed which is suggestive of the impact of different contexts, however does point to tensions between the incentives to compete and to collaborate which lead to confusion within the system ● The review highlights that new forms of contracting need to be supported by a program of organisational development and involvement of clinicians and patients in the development of outcomes and incentives ● In addition to the contracts, the vanguards have created collective provider responsibility through the development of shared outcome measurements <p>Source</p>	Literature last reviewed June 2018 (AMSTAR rating 5/9)
Rapid reviews	●	●	

Protocols for reviews that are already underway	•	•	
Titles and questions for reviews being planned	•	•	
Single studies	<ul style="list-style-type: none"> • Focus of accountability model <ul style="list-style-type: none"> ○ Individual primary-care provider ○ Single primary-care organization • Purpose of accountability model <ul style="list-style-type: none"> ○ Improving performance • Health-system arrangements that are the target of the accountability model <ul style="list-style-type: none"> ○ Accountability for other system arrangements • Mechanisms used in the model to establish accountability <ul style="list-style-type: none"> ○ Informal mechanisms ○ Formal mechanisms <ul style="list-style-type: none"> ▪ Information and education instruments 	<ul style="list-style-type: none"> • The study describes how quality improvement and patient safety initiatives have been organized in the Danish health care system and highlight how accountability has been achieved • Primary care providers participate in quality improvement initiatives by submitting their data via clinical registries for public reporting on particular care quality outcomes • National clinical audits and regional clinical audits are undertaken to accompany public report and to further examine any lagging indicators • Accountability in the Danish health system is expressed in a dialogue-based governance model • National visions, values, targets and financing are provided by the political level and supported by the administrative level in the health system <p>Source</p>	Published October 2015
	<ul style="list-style-type: none"> • Focus of accountability model <ul style="list-style-type: none"> ○ Individual primary-care provider ○ Single primary-care organization • Purpose of accountability model <ul style="list-style-type: none"> ○ Improving performance • Health-system arrangements that are the target of the accountability model <ul style="list-style-type: none"> ○ Accountability for service planning and delivery ○ Accountability for other system arrangements • Mechanisms used in the model to establish accountability <ul style="list-style-type: none"> ○ Voluntary instruments 	<ul style="list-style-type: none"> • Primary care in Australia involves general practice, community health services, private allied health providers and indigenous community controlled health services • General practices are supported by Divisions of General Practice which are organizations funded to support quality improvement, integration with other services and address population health issues • Activities within the Divisions are reported in a series of annual surveys • Participation in the work of the Divisions of General Practice is voluntary for primary care providers, with arrangements often underpinned by memoranda of understanding 	Published October 2009

		<ul style="list-style-type: none"> • In addition, some states have set up regional networks to improve primary care integration called Primary Care Partnerships, which have a focus on improving service coordination across the community health care system, this includes implementing health service innovations • The study notes that while the voluntary approach leads to some inconsistencies in participation, it also permits significant flexibility and does not require services to change their accountabilities or relinquish control from different jurisdictions • The primary care taskforce has recently suggested that the Divisions take on a more formal role to support integrated planning and responsibility for allocating funding <p>Source</p>	
	<ul style="list-style-type: none"> • Focus of accountability model <ul style="list-style-type: none"> ○ Individual primary-care provider ○ Single primary-care organization • Purpose of accountability model <ul style="list-style-type: none"> ○ Improving performance • Health-system arrangements that are the target of the accountability model <ul style="list-style-type: none"> ○ Accountability for other system arrangements • Mechanisms used in the model to establish accountability <ul style="list-style-type: none"> ○ Formal <ul style="list-style-type: none"> ▪ Legal instruments ▪ Economic instruments 	<ul style="list-style-type: none"> • Integrated delivery systems include a variety of techniques, processes, and structures that bring together different providers formally and/or informally to promote coordination and continuum of care • The primary study documented differences in Quebec and Ontario’s approaches to pursuing change in primary care towards greater integration • In both jurisdictions, accountability agreements for integrated outcomes and special incentives for delivering specific types of care (i.e., management chronic care) were critical levels for patient-centred care <p>Source</p>	Published May 2011
	<ul style="list-style-type: none"> • Focus of accountability model <ul style="list-style-type: none"> ○ Individual primary-care provider ○ Single primary-care organization • Purpose of accountability model <ul style="list-style-type: none"> ○ Improving performance ○ Aligning with underlying societal values 	<ul style="list-style-type: none"> • Changes to the NHS will significant change the power and responsibilities of family doctors, who will be asked to work as part of clinical commissioning groups and control 60% of the NHS budget • The aims of the changes are to put power in the hands of patients, increase clinician involvement in 	Published July 2012

	<ul style="list-style-type: none"> ○ Other purposes specific to jurisdictional system goals ● Health-system arrangements that are the target of the accountability model <ul style="list-style-type: none"> ○ Accountability for local-system governance ○ Accountability for financing, funding and remunerating ○ Accountability for service planning and delivery ○ Accountability for other system arrangements (incl. implementation) ● Mechanisms used in the model to establish accountability <ul style="list-style-type: none"> ○ Formal mechanisms <ul style="list-style-type: none"> ▪ Legal instruments ▪ Economic instruments ▪ Voluntary instruments 	<p>decision making, improve outcomes, and reduce bureaucracy</p> <ul style="list-style-type: none"> ● The study looks at the implementations of the proposed reforms for primary care and in particular for general practitioners ● Clinical commissioning groups are made up of local GPs but with a requirement to include expert input from a nurse and hospital clinical ● All GP practices are required to become a member of a local CCG as a condition of their ability to practice ● A new NHS commissioning board will be created that will allocate funds to CCGs and hold them to account for their performance, these board will have a strong role in contributing to the development of local commissioning plans and for promoting joint commissioning between health and social care ● Providers and commissioners are required to meet a set of targets, which are defined by government and linked to a financial incentive system, rewarding CCGs for better outcomes via a new quality premium ● Evidence of previous efforts similar to this such as GP fund holding was inconclusive, though there was some evidence that fundholders reduced waiting times for elective cases and reduced referral rates, though patients reported being unsatisfied with opening hours of their practice and their GPs ability to arrange tests and it is considered to have widened inequities within the health system ● Total purchasing pilots expanded this to allow GPs to purchase all aspects of care which led to in some cases reduced hospital length of stay and emergency admissions but levels of achievements between pilots varied considerably 	
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		<ul style="list-style-type: none"> • The new accountability arrangements are for seen to result in significant pushback, however the newly established peer review may become a significant driver of improved performance • The study highlights the need to achieve a balance between trust and control, however it also highlights some of the tensions at the heart of CCG commissioning largely about conflicts of interest between whether they create services internally or purchase/commission them 	
	<ul style="list-style-type: none"> • Focus of the accountability model (i.e., to whom is the model applied) <ul style="list-style-type: none"> ○ Individual primary-care provider ○ Single primary-care organization ○ Shared accountability across multiple primary-care providers and/or organizations • Purpose of the accountability model (i.e., why is the model applied) <ul style="list-style-type: none"> ○ Improving performance (e.g., quadruple aim) • Health-system arrangements that are the target of the accountability model <ul style="list-style-type: none"> ○ Accountability for service planning and delivery • Mechanisms used in the model to establish accountability <ul style="list-style-type: none"> ○ Formal mechanisms <ul style="list-style-type: none"> ▪ Legal instruments ▪ Economic instruments 	<p>Source</p> <ul style="list-style-type: none"> • The commentary notes that primary care requires payment reform to enable its transformation into a high-performance model • The commentary points out that ACOs predominantly maintain fee-for-service payment rules for practitioners but that this threatens meaningful practice transformation • Numerous elements halt payment reform including elaborate fee for service administrative infrastructure, net new investments of resources, and concerns about productivity faltering under payment systems that do not maintain a strong volume-based incentive • One solution is risk adjusted payments to help ensure that payment will be sufficient to meet the needs of the patients served and reducing the financial risk • The commentary also recommends using a phased approach, where by ACOs use a mixed model of fee for service and partial capitation for compensating employed and contracted primary care physicians and practices • One model that has been used provides a risk-adjusted global payment for delivery of comprehensive primary care, complemented by 	<p>Published August 2012</p>

		<p>substantial risk-adjusted rewards for exceeding desired outcomes in cost, quality and patient experience</p> <p>Source</p>	
	<ul style="list-style-type: none"> ● Focus of the accountability model (i.e., to whom is the model applied) <ul style="list-style-type: none"> ○ Individual primary-care provider ○ Single primary-care organization ○ Shared accountability across multiple primary-care providers and/or organizations ● Purpose of the accountability model (i.e., why is the model applied) <ul style="list-style-type: none"> ○ Improving performance (e.g., quadruple aim) ● Factors enabling the accountability model <ul style="list-style-type: none"> ○ System-level factors ○ Provider level factors 	<ul style="list-style-type: none"> ● The study describes the use of performance measures to improve accountability for access to care in primary care within the VHA ● Implementation support include that a central mission and vision were clearly defined, that objectives were linked to clearly quantifiable measures, and that organizational structure with a clear delineation of accountability was available to review the quality and access data ● The study notes that participation remains voluntary limiting some participation in the initiative <p>Source</p>	<p>Published December 2005</p>
	<ul style="list-style-type: none"> ● Focus of the accountability model (i.e., to whom is the model applied) <ul style="list-style-type: none"> ○ Individual primary-care provider ○ Single primary-care organization ○ Shared accountability across multiple primary-care providers and/or organizations ● Purpose of the accountability model (i.e., why is the model applied) <ul style="list-style-type: none"> ○ Improving performance (e.g., quadruple aim) ● Health-system arrangements that are the target of the accountability model <ul style="list-style-type: none"> ○ Accountability for local-system governance ○ Accountability for financing, funding and remunerating ○ Accountability for service planning and delivery ○ Accountability for other system arrangements ● Mechanisms used in the model to establish accountability <ul style="list-style-type: none"> ○ Formal mechanisms <ul style="list-style-type: none"> ▪ Legal instruments 	<ul style="list-style-type: none"> ● The study examines the shift in the late 1990's towards fund holding for general practitioners ● Under fundholding, large general practices or groups of practices were encouraged to take on responsibility for managing budgets that covered a range of elective hospital and community health services ● However, a systematic review has shown that fundholding is less positive with an audit of the program showing that practices produced only modest improvements despite the high costs ● These approaches were ultimately done away with and the creation of the personal medical service pilots were brought in which introduced a new contractual relationship between the health authority and primary provider which ensured a regular payment from the health authority for the provision of an agreed set of services under a locally negotiated contract (what was essentially a salary) 	

	<ul style="list-style-type: none"> ▪ Economic instruments 	<ul style="list-style-type: none"> • Primary care groups were then brought in which required that the groups of providers build the appropriate infrastructure for an organization • The study noted that this took significant effort and included setting up management arrangements, funding support function, and learning to work together, however the study noted that the propensity for organisational development prevented primary care groups from addressing their principle functions • In general, the competitive nature of the reform was found to hinder integration rather than to advance it, with the exception of select leading edge primary care trusts, however a key exception to this was the development of integration established through fundholding where by the range of services available within a single primary care setting was often extended 	
	<ul style="list-style-type: none"> • Focus of the accountability model (i.e., to whom is the model applied) <ul style="list-style-type: none"> ○ Individual primary-care provider ○ Single primary-care organization ○ Shared accountability across multiple primary-care providers and/or organizations • Purpose of the accountability model (i.e., why is the model applied) <ul style="list-style-type: none"> ○ Improving performance (e.g., quadruple aim) • Health-system arrangements that are the target of the accountability model <ul style="list-style-type: none"> ○ Accountability for service planning and delivery ○ Accountability for other system arrangements • Mechanisms used in the model to establish accountability <ul style="list-style-type: none"> ○ Informal mechanisms 	<p>Source</p> <ul style="list-style-type: none"> • Adaption of patient-centred medical homes model within the VHA system in the U.S. requires innovative procedures and tools for achieving it goals • The initiative focused on the implementation of Quality Councils which provided interdisciplinary leadership for quality improvement projects, submitting them to a regional Steering committee which would assess the progress of and approve the quality improvement projects • The involvement, uptake and leadership of primary care practices for each of the quality initiatives is a key criteria to assess the successful implementation of design element • Memoranda of understanding and non-financial incentives were used to ensure that those participating in work on the front-line in primary care practices and others faithfully completed their role 	<p>Published May 2018</p>

		<ul style="list-style-type: none"> • Many quality improvement initiatives also used online dashboards to support their work however, the study found that these may not be well adaption to primary care use • VHA provided initial support for the PACT transformation including performance measures, policies, funding, training, a Sharepoint site to record local best practices and regional learning collaboratives 	
	<ul style="list-style-type: none"> • Focus of the accountability model <ul style="list-style-type: none"> ○ Shared accountability across multiple primary-care providers and/or organizations • Purpose of the accountability model <ul style="list-style-type: none"> ○ Improving performance • Health-system arrangements that are the target of the accountability model <ul style="list-style-type: none"> ○ Accountability for service planning and delivery • Mechanisms used in the model to establish accountability <ul style="list-style-type: none"> ○ Formal mechanisms • Economic instruments 	<p>Source</p> <ul style="list-style-type: none"> • In 2004, the Québec government created Health Services and Social Centres (HSSC) as part of primary care reform efforts designed to establish and lead a Local Health Network (LHN) and promote a ‘population-based approach’ that takes responsibility for primary care service provision for the population of a local territory • LHNs are comprised of community pharmacies, community organizations, and Family Medicine Groups (FMGs) and aim to integrate and better coordinate access to primary care services • FMGs are practices consisting of a group of physicians who work closely with at least one nurse to provide services to patients on a non-geographical basis (around 10 000 to 20 000) • FMGs follow a formal accreditation process and have contractual agreements with the provincial government that outline funding, remuneration and service obligations • Overall, HSSCs and LHNs have the potential to improve primary health care service delivery, increase access to specialists and diagnostic tests for family physicians working in the community, improve chronic-disease-related services for the population of the LHN, and improve access to family physicians for the LHN population <p>Source</p>	<p>Published July 2010</p>

	<ul style="list-style-type: none"> • Focus of the accountability model <ul style="list-style-type: none"> ○ Shared accountability across multiple primary-care providers and/or organizations ○ Shared accountability across multiple providers and organizations representing different sectors • Purpose of the accountability model <ul style="list-style-type: none"> ○ Improving performance • Health-system arrangements that are the target of the accountability model <ul style="list-style-type: none"> ○ Accountability for service planning and delivery • Mechanisms used in the model to establish accountability <ul style="list-style-type: none"> ○ Informal mechanisms • Factors enabling the accountability model • Organizational-level factors 	<ul style="list-style-type: none"> • This study consisted of case studies of two Health and Social Service Centres (HSSCs) mandated to broaden their range of services provided through the adoption of a population-based plan while integrating public health into their activities • Analysis revealed five key areas through which HSSCs accounted for their population-based mandate: primary health care, specialized services, vulnerable groups, health promotion and social services • Overtime, a territory-based organizational vision emerged for services (primary health, specialized services and care to vulnerable groups) to be delivered more directly to the population • Researchers observed that managers of the HSSCs invested considerable time and effort to help coordinate services at a population-level, such as through negotiations with hospitals for privileged access to high-tech support for primary care organizations, referrals of vulnerable patients with no family physician, and formalizing integrated service networks for specific client groups such as seniors and mental health patients • The activities undertaken by HSSCs under analysis suggest that the reform has resulted in an increased sense of shared responsibility for population-health and more partnerships across stakeholders from primary care, specialized services, and public health and social services <p>Source</p>	Published 2014
	<ul style="list-style-type: none"> • Cross-cutting/general focus across the organizing framework • Focus of the accountability model <ul style="list-style-type: none"> ○ Shared accountability across multiple primary-care providers and/or organizations • Health-system arrangements that are the target of the accountability model 	<ul style="list-style-type: none"> • This article reports on the analysis of a national survey completed by 162 accountable care organizations in the United States that sought to characterize their size, scope of services, and use of performance accountability mechanisms • A cluster analysis found that three statistically different clusters of accountable care organizations 	Published 23 September 2014

	<ul style="list-style-type: none"> ○ Accountability for financing, funding and remunerating ○ Accountability for service planning and delivery ● Mechanisms used in the model to establish accountability <ul style="list-style-type: none"> ○ Economic instruments ○ Voluntary partnerships 	<ul style="list-style-type: none"> ● The first cluster, labelled as ‘larger, integrated delivery system’ accountable care organizations, represents 40.1 percent of respondents ● The second cluster, labelled as ‘smaller, physician-led’ accountable care organizations, represents 34 percent of respondents ● The third cluster, labelled as ‘hybrid’ accountable care organizations, represents 28.1 percent of respondents ● With respect to physician performance and accountability mechanisms, more engagement was found in larger, integrated delivery system and smaller, physician-led accountable care organizations (compared to hybrid accountable care organizations) <ul style="list-style-type: none"> ○ The physician performance and accountability mechanisms surveyed for include individuals quality measures, individual cost measures, one-on-one review and feedback, individual financial incentives, and individual non-financial awards or recognition ● With respect to payment reform strategies, more engagement was found amongst larger, integrated delivery system and hybrid accountable care organizations <ul style="list-style-type: none"> ○ The payment reform strategies surveyed for include bundled or episode-based payments, patient-centred medical homes, pay-for-performance programs, publicly reported quality measures, other risk-bearing contract, and other payment reform efforts <p>Source</p>	
	<ul style="list-style-type: none"> ● Focus of the accountability model <ul style="list-style-type: none"> ○ Individual-primary care provider ○ Single primary-care organizations ○ Shared accountability across multiple primary-care provider and/or organizations 	<ul style="list-style-type: none"> ● This brief outlines strategies for how state and federal policymakers in the United States can involve safety-net providers (those that primarily care for vulnerable populations, such as the uninsured) into integrated care delivery systems that 	<p>Published August 2012</p>

	<ul style="list-style-type: none"> ○ Shared accountability across multiple providers and organizations representing different sectors ● Purpose of the accountability model <ul style="list-style-type: none"> ○ Improving performance ○ Aligning with underlying societal values ● Health-system arrangements that are the target of the accountability model <ul style="list-style-type: none"> ○ Accountability for service planning and delivery ● Mechanisms used in the model to establish accountability <ul style="list-style-type: none"> ○ Information and education instruments 	<p>help coordinate the continuum of healthcare services</p> <ul style="list-style-type: none"> ● It is recommended that financial incentives are used strategically to reward achievement of desired goals, but the unique circumstance of safety-net providers should be taken into account (including the likely difficulties they will face in realizing cost-saving in the short run and their historically lower reimbursement rates) <ul style="list-style-type: none"> ○ It is further recommended that financial incentives, as opposed to penalties, be used for safety-net providers given their financial disadvantages ● With respect to performance measurement, it is noted that safety-net providers have to report different metrics to different funders and the would benefit from having consistent and meaningful measures for reporting <ul style="list-style-type: none"> ○ Furthermore, it is noted that Colorado and North Carolina may serve as exemplars in that their integrated delivery systems include data analysis to support care and performance management <p><u>Source</u></p>	
	<ul style="list-style-type: none"> ● Purpose of the accountability model <ul style="list-style-type: none"> ○ Improving performance ● Mechanisms used in the model to establish accountability <ul style="list-style-type: none"> ○ Informal mechanisms 	<ul style="list-style-type: none"> ● This study uses surveys and interviews to establish how 13 patient-centred medical homes in Colorado use coordination mechanisms to optimize their care networks ● One of the four identified mechanisms was ‘communication, negotiation, and decision mechanisms to introduce shared accountability’ <ul style="list-style-type: none"> ○ These mechanisms enable organizations to reach agreements and make long-term commitments to one another with clear obligations ○ These mechanisms are also complex because they introduce shared accountability and require reciprocity 	<p>Published April 2016</p>

		<ul style="list-style-type: none"> • The specific communication, negotiation, and decision mechanisms used to introduce shared accountability include care compacts and other agreements with specialists; report cards, patient surveys, and real-time feedback to track performance of specialists; and discussions with hospital leadership and staff to manage patients transitions and follow-up • The patient-centred medical homes that did not use care compacts cited geography, size of practice, misaligned payments, and time costs as barriers to doing so • The patient-centred medical homes that implemented care compacts and/or service agreements were most likely to report improved relationships with specialists and hospital neighbours <p>Source</p>	
	<ul style="list-style-type: none"> • Focus of the accountability model <ul style="list-style-type: none"> ○ Shared accountability across multiple primary-care providers and/or organizations ○ Shared accountability across multiple providers and organizations representing different sectors • Purpose of the accountability model <ul style="list-style-type: none"> ○ Improving performance • Health-system arrangements that are the target of the accountability model • Accountability for service planning and delivery 	<ul style="list-style-type: none"> • Key aspects and benchmarks of primary care organizations (PCO) were explored in this paper by using the European framework for PCO and two main domains of structural and service organization described in the WHO operational framework for primary care as foundational documents for conducting PCO assessments • The paper recommended that: <ul style="list-style-type: none"> ○ all PCO should have developed organizational and clinical systems that are documented by policies, protocols, and procedures by government and/or organizational stakeholders ○ actions and interventions related to primary care need to be developed using an inclusive policy dialogue that engages the community and positions management in a guidance role rather than service provider • Five essential components of accountability for PCO – professional, financial, legal, political, and public – were discussed, and the paper recommended that to strengthen accountability, 	<p>Published Sept 2022</p>

		<p>clear and measurable goals and roles for primary care stakeholders should be established</p> <ul style="list-style-type: none"> ○ The key to ensuring accountability is to define it, involve all relevant stakeholders, be realistic, and continuously monitor the job satisfaction of providers ● The paper also recognized that primary care services must integrate better with agencies that address the broader needs of patients (e.g., social care services) <ul style="list-style-type: none"> ○ Successful care coordination will require planned system-level action within and between the relevant organizations that can be enabled by defining referral pathways, patient assessment information agreements, technological facilitators, quality management tools, and self-management support for patients and families <p>Source</p>	
	<ul style="list-style-type: none"> ● Factors enabling to accountability model <ul style="list-style-type: none"> ○ System-level factors ○ Organizational-level factors 	<ul style="list-style-type: none"> ● It was unclear whether patients ESRD that require high-cost interventions would be best served with a general accountable care organization (ACO) or within a renal-focused ACO-like integrated care program ● Investigating this issue, the study points out that fundamentally, a shift towards population management is required to shift toward integrated care for the ESRD community ● To align with the goals of quality care and cost savings within the ACO model, integration initiatives must be designed to be measured and evaluated <ul style="list-style-type: none"> ○ This means data collection at the service provider level must be accurate and consistent, and a high level of statistical expertise will be required to analyze clinical performance and financial data ● The study provided examples of two large dialysis organizations that developed integration initiatives 	<p>Published Dec 2013</p>

		<p>to address immunization outcomes and oral nutritional supplementation:</p> <ul style="list-style-type: none"> ○ One dialysis organization executed a comprehensive system of immunization integration over three years by coordinating patient care teams, operational leaders, and information technology to make vaccine available, create automatic data collection and reporting, develop standardized tools, and apply a communications plan that created a culture of patient and team immunization ○ The second dialysis organization successfully monitored the administration of oral nutritional supplements during dialysis sessions over a year by integrating efforts of dietitians, clinical staff, biostatisticians, and nephrologists <ul style="list-style-type: none"> ● Integration of healthcare delivery requires commitments from providers at all levels to provide evidence-based care while also measuring outcomes that will support improvement of integrated care delivery <p>Source</p>	
	<ul style="list-style-type: none"> ● Focus of the accountability model (i.e., to whom is the model applied) <ul style="list-style-type: none"> ○ Individual primary-care provider ○ Single primary-care organization ● Purpose of the accountability model <ul style="list-style-type: none"> ○ Improving performance ○ Aligning with underlying societal values ● Health-system arrangements that are the target of the accountability model <ul style="list-style-type: none"> ○ Accountability for local-system governance ○ Accountability for service planning and delivery ○ Accountability for other system arrangements ● Mechanisms used in the model to establish accountability <ul style="list-style-type: none"> ○ Formal mechanisms 	<ul style="list-style-type: none"> ● The study documents physician’s views of their participation in Kaiser Permanente’s South California ● Primary care providers agree to sign on as part of a local Permanente Medical Group where they receive a market-based salary for their services as well as incentives for performance features including access, patient satisfaction and ensuring evidence-based care ● Over a three year period, primary care provider practices are eligible for partnership which includes profit sharing as a shareholder ● Physicians participating in the integrated model also described a degree of relational accountability that begins to take shape – that the more you work with 	<p>Published January 2017</p>

	<ul style="list-style-type: none">▪ Economic instruments• Factors enabling the accountability model<ul style="list-style-type: none">○ System-level factors○ Model/design-level factors	<p>people who are all working together the more you buy into the concept and norms begin to set it</p> <ul style="list-style-type: none">• The study describes how the system earned the trust of physicians, making them amenable to new ways of working• Aspects that enabled the model included operating in an information rich environment, encouragement for consultations with specialists rather than straight referrals, and financial incentives that were aligned with the care they wanted to provide <p>Source</p>	
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Appendix 3: Documents excluded at the final stages of reviewing

Type of document	Hyperlinked title
Guidelines	
Full systematic reviews	Organizational models in primary health care to manage chronic conditions: A scoping review
Rapid reviews	
Protocols for reviews that are already underway	
Titles and questions for reviews being planned	
Single studies	Payment incentives and integrated care delivery: Levers for health system reform and cost-containment
	Developing tomorrow's integrated community health systems: A leadership challenge for public health and primary care
	Decentralisation, integration and accountability: Perceptions of New Zealand's top health service managers
	Toward greater integration of the health system
	Challenges facing primary health care in federated government systems: Implementation of primary health networks in Australia states and territories