Table of Contents

1.0 Introduction................................................................................................................... 1
1.1 Background to the Accountability Expert Panel....................................................... 1
1.2 The Panel’s Mandate................................................................................................. 1
1.3 Approach to the Work .............................................................................................. 2
1.4 Defining Accountability .......................................................................................... 2
1.5 Accountability Relationships ................................................................................... 4
1.6 Organization of the Report ...................................................................................... 5

2.0 National and International Environment ....................................................................... 6
2.1 Frameworks from Other Jurisdictions ........................................................................ 6
2.2 Setting Expectations ................................................................................................. 6
2.3 Need for Supporting Infrastructure ............................................................................ 7
2.4 Evaluating and Rewarding Individual Physician Performance ................................ 8
2.5 Defining the AHSCs’ Role ......................................................................................... 10
3.1 Ministry Priorities ................................................................................................... 11
3.2 Hospital Accountability Processes .......................................................................... 12
3.3 Southeastern Ontario Academic Medical Organization (SEAMO) ......................... 13
3.4 Provincial Experience with Shadow Billing ........................................................... 14

4.0 Elements of a Successful Framework ............................................................................ 16
4.1 The Importance of Goals .......................................................................................... 16
4.2 Categories of Performance Measures ...................................................................... 16

5.0 Principles ..................................................................................................................... 18

6.0 The AHSC AFP Accountability Framework ............................................................ 19
6.1 Domains .................................................................................................................. 19
6.2 Goals and Expectations ........................................................................................... 20
6.3 Performance Measures ............................................................................................ 21
6.4 Determining Staffing Complements ......................................................................... 22

7.0 Phased Approach to Implementation ......................................................................... 23
7.1 Consultation and Validation Process ........................................................................ 23
7.2 Further Development of the Framework ................................................................... 24
7.3 Supporting the Framework ....................................................................................... 25

8.0 Recommendations .................................................................................................... 26
1.0 Introduction

1.1 Background to the Accountability Expert Panel

The Ministry of Health and Long-Term Care (the Ministry) has embarked on a course to transform Ontario’s health care system to one that is patient focused, results based, accountable and sustainable and encourages a more effective and efficient use of resources.

As sophisticated clinical care migrates to community hospitals, and with new extended medical education models, Academic Health Science Centres (AHSC’s) face challenges to their traditional role and status. Indeed there have been concerns regarding both the stability and sustainability of these enterprises as well as the recruitment and retention of academic physicians.

One mechanism to address these latter concerns and to encourage renewal and positive change in the AHSC’s has been the introduction of alternate funding plans (AFPs), in which physicians are remunerated, to a greater or lesser extent, through block payments rather than solely on the traditional fee-for-service basis. Through AFPs, the Ministry has hoped to preserve access to high-end clinical services and to encourage physicians to use health care resources in innovative and more effective ways. An AFP also provides a vehicle for direct recognition of the contribution of academic physicians to research and teaching, over and above clinical care alone.

In 2000, the Ontario Medical Association (OMA) and the Ministry negotiated a four-year Physician Services Agreement that called for new funding for physicians in AHSC’s that was distributed via AFPs. In 2004, an additional $150 million was made available to support this AHSC AFP initiative. Appendix G of the 2004 Physician Services Agreement required the establishment of an AHSC AFP Task Force to advise on the development of a common AHSC AFP template agreement and a methodology for the allocation and distribution of the new investment. Appendix G also mandated the establishment of an Accountability Expert Panel (the Panel) to advise the Physician Services Committee (PSC) and AHSC AFP Task Force.

1.2 The Panel’s Mandate

The Panel was asked to develop a framework for the measurement, accountability and reporting of deliverables (i.e., an accountability framework) as well as a methodology for evaluating requests for additions to the existing complement of physicians at each AHSC.
1.2 The Panel’s Mandate (cont’d)

The Panel quickly determined that developing and implementing a new, comprehensive accountability framework for academic physicians participating in the AHSC AFP initiative was beyond the capacity and resources of the Panel alone. Development of valid performance indicators and the necessary reporting and monitoring systems will require extensive stakeholder consultation and a significant investment of financial and human resource. With that understanding, the Panel is recommending a staged approach to the development of the accountability framework. In the short-term this will involve defining principles and a series of recommendations that lay the groundwork for the development of a meaningful accountability framework. Looking to the future, the Panel will create a process for developing performance indicators that link to specific deliverables within selected domains. The concept of an iterative process by which the accountability framework is refined over time is a central underpinning to this exercise.

The Panel’s Terms of Reference are provided in Appendix A. The Panel’s membership is presented in Appendix B.

1.3 Approach to the Work

The Panel’s work has been informed by the following:

- A formal literature review encompassing the years 2000 to the present. The Ministry had already performed a literature review including the time prior to 2000. The detailed findings of the literature review are available in a companion document.1

- An environmental scan of developments in other jurisdictions.

- An assessment of the experience at the Southeastern Ontario Academic Medical Organization, Kingston where one of Ontario’s first comprehensive academic AFPs was established in 1994.

- One-on-one interviews and a focus group session with Ministry representatives in order to understand the Ministry’s priorities for the accountability framework.

- Consultation with the AFP Task Force, the AFP Governance chairs from across the Province and with CAHO medical leaders.

1.4 Defining Accountability

There are many definitions of accountability, four of which follow:

- “Accountability is the obligation to demonstrate and take responsibility for performance in light of agreed expectations. There is a difference between responsibility and accountability:

Responsibility is the obligation to act;
Accountability is the obligation to answer for an action.\textsuperscript{2}

1.4 Defining Accountability (cont’d)

- “Monitoring, measuring, and evaluating the results of policies, programs and processes to ensure that the desired results are achieved.”\textsuperscript{3}
- “Accountability is the obligation of individuals or agencies to provide information about, and/or justification for their actions to other actors, along with the imposition of sanctions for failure to comply and/or to engage in appropriate action.”\textsuperscript{4}
- “Set within an implicit ethical context, accountability is the obligation to answer to an authority that conferred a responsibility, by an agent who accepted it, with the resources and delegated authority necessary to achieve it and with the understanding that inadequate performance will result in intervention. It is part of a dynamic management process.”\textsuperscript{5}

Although each definition has unique aspects certain general themes emerge:

- Accountability goes beyond the need to act and implies the need to answer for actions or decisions;
- Although measurement is an important element of an accountability framework, measurement alone does not constitute accountability. There is also a need to report and evaluate the results;
- The accountable party must agree to the performance expectations and be properly supported in achieving them. Thus accountability and authority are intertwined;
- It is important to evaluate performance against the desired results (i.e., performance expectations); and
- If the entity that is being held accountable does not meet expectations, true accountability would include consequences based on the reported performance. If there are no consequences, then an accountability framework is little more than a reporting exercise.

\textsuperscript{2} Department of Human Resources and Human Development, Canada. http://tbs-sct.gc.ca/eval/pubs/RMAF-CGRR/rmafcgr05_e.asp (July 13, 2006)
\textsuperscript{3} Florida International University. www.fiu.edu/~pie/sec8appglossary.htm – accessed May 3, 2006
1.5 Accountability Relationships

True accountability relies on an effective relationship between the parties that permits the assignment and acceptance of specific responsibilities. Setting out clear expectations is a key requirement of a comprehensive accountability framework. Accountability is made difficult when the relationship between outcomes and behaviour is not immediately obvious or is confounded by other, uncontrollable factors. Designing an accountability framework is more complex than merely selecting a series of performance indicators and identifying data sources. It requires a flexible approach wherein accountability may be viewed as being more than a one way relationship between the parties. There must be a provision for meaningful dialogue regarding the authority and resources necessary to carry out the actions required.

All parties must be committed to the change if a culture of accountability is to be fully adopted. Dr. Nuala Kenny, professor of Bioethics at Dalhousie University, notes that “the identification and adoption of accountability practices in one or other of the domains of healthcare without the complementary development of a culture of accountability in all others is doomed to fail”. Dr. Kenny also suggests that the list of accountabilities extends from government officials through hospitals, physicians, patients and on down to the general public, which need to be engaged in making “accountability a core value”. Leadership, while not broadly documented in the literature, is a prerequisite to successfully implementing change in the AHSC’s. The Committee on the Role of Academic Health Centres in the 21st Century noted “organizational change does not just happen; it requires sound leadership at all levels – leadership that should be unambiguously developed, empowered and supported.”

The graphic in Figure 1 (next page) illustrates the diversity and complexity of the relationships identified as part of the accountability process in the present context.

1.6 Organization of the Report

This report is organized as follows:

- Chapters 2, 3 and 4 provide the background context for the Panel’s deliberations. They present a scan of the national and international environment (Chapter 2), a briefing on the provincial context (Chapter 3), and a summary of best practices (Chapter 4) relating to accountability frameworks for AHSCs.
- Chapter 5 presents the basic principles that the Panel agreed to use in the development of its recommendations.
- Chapters 6 and 7 document the Panel’s preliminary recommendations for elements of the framework (Chapter 6) and implementation considerations (Chapter 7).
- The Panel’s recommendations are summarized in Chapter 8.
2.0 National and International Environment

This chapter presents an overview of the experience with alternative funding arrangements in other jurisdictions, as documented in published and unpublished literature.

2.1 Frameworks from Other Jurisdictions

There was a paucity of relevant literature to inform the Panel’s work. After full-text screening and assessment for the inclusion criteria, only 18 of 138 identified articles remained for review. Much of the literature related to either high-level health system accountability or to accountability at the level of a single academic department and/or individual provider.

Across Canada, all provinces and territories continue to remunerate the majority of their physicians through fee-for-service payments. The proportion of physicians remunerated through alternate funding arrangements varies from 42% in Newfoundland and Labrador to as low as 16% in Alberta and only 10% in Ontario.8

The Panel found little documentation that other jurisdictions (with the exception of some Canadian provinces) have dealt with, or are currently examining, a similar initiative of developing an accountability framework for the provision of physician services in AHSCs in a single-funder environment. A review of existing alternate funding arrangements in British Columbia, Alberta and Nova Scotia revealed that these provinces are currently working towards creating comprehensive accountability frameworks in order to ensure accountability and to stimulate on-going improvements in quality of care and outcomes.

2.2 Setting Expectations

The importance of having clearly articulated performance expectations is a consistent theme in the literature. A ‘value for money’ audit of an alternative funding arrangement in Nova Scotia was frustrated because “with no clearly defined AFP deliverables, outcomes or performance targets, the value for money under an AFP system cannot be accurately analyzed, measured nor audited.”9 This same audit also found that policy and program objectives must be aligned with overall government direction.

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2.2 Setting Expectations (cont’d)

British Columbia has also recognized the need for clearly defined expectations. In 2001/02, the British Columbia government reviewed its own alternate funding arrangements, which prompted the following recommendations:

- Agreements require a specific purpose and common understanding among all stakeholders as to what they are trying to achieve;
- Performance indicators should address areas for immediate improvement but also include long-term outcomes-related issues; and
- Clear, measurable targets should be set within each agreement.10

In general, most jurisdictions have used performance measures that are predominantly based on physician services as defined by billing or other encounter data. This approach is limited to a measure of output or work units. More desirable would be the ability to measure outcomes, ultimately at a population level. In this regard progress on defining meaningful measurement tools has been slow and no one jurisdiction appears to have resolved the complexities.

2.3 Need for Supporting Infrastructure

The Panel recognizes the importance of making the commitment of time and resources to support the infrastructure required to collect, monitor and analyze the information gathered. The need for infrastructure support for data collection and analysis is stressed in a study from the United Kingdom,11 which notes that effective performance measurement requires an investment in resources (time, funds and human resources). The same study further warns of challenges relating to the data e.g., those relating to accuracy, relevance and timeliness, as well as failure to use the data that have been collected. There is also the need to ensure adequate funding for the ongoing management of the accountability framework, including the application of consequences if performance expectations are not met. Management requires timely and accurate information. These issues will need to be addressed as part of developing the accountability framework.

2.4 Evaluating and Rewarding Individual Physician Performance

Numerous attempts have been made to create a robust instrument for evaluating the performance of individual academic physicians. There is a general sense that the fee-for-service compensation model is poorly suited to the AHSC setting. Shortcomings of the current fee-for-service model include:

- Although this model measures physician clinical activity at a very detailed level it provides no measure of the appropriateness or quality of service provided, nor does it measure patient outcomes.
- Fee-for-service models have the potential to create an incentive for a high volume of low intensity or low complexity procedures.
- Fee-for-service is unresponsive to what has been termed the ‘tertiaryness’ and ‘teachingness’ of practice in the AHSC environment.
- Fee-for-service provides a negative incentive for physicians to become involved in new models of care e.g. use of physician extenders, or to become more involved in health promotion or disease prevention activities.
- Fee-for-service does not encourage an appropriate geographic distribution of physicians.
- Fee-for-service is silent with regards to academic activities.

On the other hand the fee-for-service model is not completely without merit, even in the AHSC setting.

- Fee-for-service maintains incentive for physicians to provide clinical services and to maintain access.
- The Ministry is well equipped and experienced in the use of fee-for-service data as a measure of individual physician activity and, by this means, can satisfy the need of government for an audit function.
- Billing information allows comparison of physician performance between AHSC’s and also with community physicians. Therefore it may be help inform decisions regarding addition of new complement.
- Billing information provides an important administrative database for use in clinical services research.
- Fee-for-service billing is the most rapidly responsive to clinical pressures and the need for increased clinical activity, new practice patterns and to accommodating new complement.
2.4.1 Shadow Billing

The ongoing need for physician level activity data has led many provinces to require that physicians participating in AFPs adopt the practice of “shadow billing”. Under shadow billing, a physician completes an encounter record linked to the relevant encounter or procedural codes(s) in the Schedule of Benefits. Unfortunately shadow billing shares most of the disadvantages of fee-for-service billings in an academic setting as listed above. In addition overall satisfaction with this approach has been poor. Physicians are reluctant to invest the time needed to complete detailed shadow billing records because the exercise is not linked to compensation. As a result, compliance with shadow billing requirements is poor. Ultimately shadow billing fails to meet the needs of either payer or provider.

2.4.2 Alternate Compensation Systems

To encourage physicians to be more willing to participate in tracking their own activities, there are many examples from American academic centres of compensation systems with monetary incentives and disincentives. Yale University has a revenue distribution system based on quantitative measures of time spent on scheduled teaching activities (formal lectures and clinical rounds) as well as qualitative measures such as ratings on course evaluations.\(^\text{12}\) Holm and Lipsky describe a case study for a gain sharing system where additional funds are distributed as incentive compensation for clinical performance improvements.\(^\text{13}\) Woodson describes a physician compensation program involving a twenty-seven step pay scale whereby academic advancement was linked to sustained contributions to the organization and performance measured on annual evaluations. In converting from fee-for-service to this new system, no physician's annual remuneration was reduced and an incentive funding pool was created and targeted towards participation in activities determined to be priorities for each department.\(^\text{14}\) Although these alternate compensation schemes provide incentives for regular reporting of activities by physicians, and may increase consistency in performance evaluations, they might also encourage unhealthy competition between physicians and may inadvertently encourage intended behaviour in one area to the detriment of others.


2.4.3 Pay-for-Performance

Rewarding physicians for providing care that is of high quality (consistent with professional guidelines), that is better coordinated, is more efficient and results in better outcomes is seen as an important tool to transform the health care system. Pay-for-performance shifts the emphasis from service utilization to patient outcomes. A 2005 nationwide survey of HMO’s in the US revealed that approximately 50% offered some form of pay-for-performance reward for participating physicians (NEJM 2006). Pay-for-performance is also embedded in Britain’s National Health Service. Despite rapid uptake the literature on such initiatives is limited. Attributing performance to a single physician or group of physicians may be difficult when, as is so often the case in chronic illness, many physicians/groups may have contributed to care. There are issues of statistical robustness, sample size and adequacy of risk adjustment models when performance measures are applied at the individual physician or small group level. Defining adequate performance measures is a challenge as they may not be sensitive to the balance of risk and benefit required in the care of complex patients with multiple co-morbidities. The magnitude of the reward to change practice patterns is uncertain. There may be unintended consequences. For example, in the UK an increase in ‘exception’ reporting resulted in physicians achieving far higher rates of compliance than initially anticipated and, as a result, payments much higher than forecast. Despite these drawbacks there is a sense that ‘the shift from autonomy to accountability and from fee-for-service practice to new methods of payment’ is inevitable. The Panel was challenged to decide whether measures of quality and outcomes belong in what is in reality a physician payment contract. The Panel concluded that quality was integral to this exercise but recognizes the difficulties inherent in achieving this objective.

2.5 Defining the AHSCs’ Role

The accountability framework for physician services at an AHSC should reflect the unique role of these institutions. AHSC’s make an important and valuable contribution to clinical care, research and teaching. However, many community hospitals are now capable of delivering tertiary and, in some cases, quaternary care. Many of these latter hospitals have also become teaching sites and are actively involved in clinical and health services research. AHSC’s have become increasingly dependent on clinical income to support academic activities and yet, as the AHSC’s are forced to compete with entrepreneurial community hospitals, market share is no longer guaranteed. These factors, amongst others, have led to calls for AHSC’s to ‘reinvent’ themselves.
2.5 Defining the AHSCs’ Role (cont’d)

The Panel did not find any source that could clearly articulate the unique role of the AHSC and its physicians. Through its deliberations, the Panel identified the following potential roles that are unique to these academic institutions:

- The health care system still looks to the AHSC’s to advance its understanding of best practices and innovations in the delivery of healthcare.
- Despite the growth in complex case loads at community hospitals, the AHSC’s continue to be the focus of most tertiary and quaternary care within their catchment areas. With the changing physician demographic and the increased emphasis on work-life balance, paradoxically the AHSC may become the last bastion of 24X7 access to advanced medical services.
- As the pressures on our limited physician resources increase, there is a role for the AHSCs to pilot and evaluate new models of care to use these scarce resources more effectively.

The accountability framework should encourage appropriate incentives for physicians at AHSC’s to pursue these roles as a priority.

3.0 The Provincial Context

This chapter continues the description of the existing environment for alternative payment arrangements with an overview of developments unique to Ontario.

3.1 Ministry Priorities

The Ministry is currently developing a 10-year health system strategy that will be available in Spring 2007. It is expected that this strategy will build on the goals and objectives that have already been articulated for two major stakeholders in the health care environment:

- Local Health Integration Networks (LHINs), as documented in a letter to the LHIN CEOs.\(^\text{15}\)
- Hospitals, as outlined in the Hospital Accountability Agreements (HAAs).

These priorities are reflected in the following health system goals, which are based on goals for the newly created LHINs:

1. Renewed community engagement and partnerships across the health care system.
2. Improved health status of Ontarians.
3. Equitable access to the care and services for Ontarians, no matter where they live or their socio/cultural/economic status.
4. Improved quality of health outcomes.

\(^{15}\) Minister Smitherman Letter to the Local Health Integration Networks, June 2006.
5. Establishment of a framework for sustainability of the health care system that achieves the best results for consumers and the community.

The Panel also asked Ministry representatives what it wished to accomplish through the implementation of the AHSC AFP. Based on these discussions, the Panel has identified the following Ministry priorities for the AHSC AFP initiative:

- The AHSC AFP strategy is at the forefront of a new approach by the Ministry that is aimed at securing a meaningful and relevant future for its AHSCs in a transformed health care system.
- With the Ministry moving to a stewardship role, health system transformation will be leveraged through new funding strategies that improve accountabilities and deliverables through new relationships with health providers.
- Traditionally, AHSCs have focused on achieving excellence in each of their constituent roles and generally do not set or measure change and success against the united or overall goals of the AHSC enterprise.
- The ideal role of an AHSC in a transformed health care system is to effectively integrate traditional roles in clinical care, teaching and research such that research develops the evidence base, patient care applies and refines the evidence base, and education teaches evidence-based care, and that this all happens within the context of a commitment to improving health outcomes.
- AHSCs and academic physicians will have to take on a visible and measurable role of active leadership and employ the organizational changes necessary to improve health services and outcomes through innovation in patient care, education on best practices and dissemination of new knowledge.
- Transformation will require some experimentation and not all plans will work as designed. A transition will be required to test new approaches while not abandoning existing systems.

Through the creation of a common agreement supported by new funding, the Ministry expects academic physicians and their AHSC partners to contribute to the achievement of these goals and to advance and enable health system transformation priorities.

3.2 Hospital Accountability Processes

Several years ago, the Ministry launched an intensive collaborative process to develop a multi-year funding and accountability framework agreement for Ontario hospitals. Under the auspices of the Joint Policy and Planning Committee, a number of committees and working groups were formed to support this work, involving over 100 representatives from hospitals and the Ministry over a period of years.

In 2005/06, the MOHLTC introduced Hospital Annual Planning Submissions (HAPS) and Hospital Accountability Agreements (HAAs) to provide hospitals with a streamlined business planning process. These processes were intended to support the government’s goals of stability and efficiency in the hospital sector.
3.2 Hospital Accountability Processes (cont’d)

When HAPS were introduced, the determination of activity type, intensity and volume was already well established. For years, hospital have used a rigorous clinical service abstraction and reporting system to provide patient-level information to the Canadian Institute for Health Information (CIHI).

The HAPS process focused on obtaining agreement across all hospitals on volume measures (within a corridor of activity) and phasing in a small number of new institution-level performance measures. Many of the indicators that were developed by SEAMO in the late 1990s (see next section) are now being used as hospital level performance measures that are captured in the hospital accountability agreements (e.g., length of stay, hospital cases, wait times).

The depth and breadth of the consultation process necessary to develop even a small number of performance indicators across four domains of interest in the hospital system provides a hint as to the extensive processes that will be required to develop a preliminary set of performance indicators that satisfy the monitoring and reporting needs of the final AHSC AFP agreement with respect to accountability.

3.3 Southeastern Ontario Academic Medical Organization (SEAMO)

In 1994, Queen’s University and its hospital partners formed the Southeastern Ontario Academic Medical Organization (SEAMO). SEAMO was formed to ‘enable Members to meet the clinical service, teaching, research and associated management responsibilities of the alternative funding contract’ reached with the MOHLTC. 16 This initiative was undertaken because of concerns regarding the stability and viability of this academic health science centre.

The SEAMO AFP made a fixed sum available to remunerate clinical faculty for all medical care. The total available was largely based on previous fee-for-service payments for the participating physicians. A detailed accountability framework17 was developed for SEAMO that identified four domains that would be evaluated:

- Clinical service,
- Medical education,
- Research and scholarly activity, and
- Administrative medical service delivery.

3.3 Southeastern Ontario Academic Medical Organization (SEAMO) (cont’d)

For each domain, the framework defined a number of deliverables and one or more performance measures for each deliverable. Some performance measures were identified as core measures, to be evaluated annually. Other measures (i.e., target measures) were to be evaluated on an ad hoc basis. The definitions of these terms are provided in Table 1.

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain</td>
<td>Area of control or sphere of knowledge. Overarching categorization of deliverables.</td>
</tr>
<tr>
<td>Deliverable</td>
<td>Expected outcome in exchange for funding, AHSC can be held accountable for deliverables.</td>
</tr>
<tr>
<td>Measure</td>
<td>Quantitative indicator that provides an indication of performance</td>
</tr>
<tr>
<td>Core or target measures</td>
<td>Core measures are evaluated every year. Target measures are evaluated periodically.</td>
</tr>
</tbody>
</table>

Although the initial framework was comprehensive, it was also found to be cumbersome and, potentially, prohibitively expensive. SEAMO found it did not have the resources needed to collect and analyze data for all of the proposed indicators. Instead, a subset of measures was selected for formal review. Even with a smaller number of indicators, SEAMO found the demands of data collection, analysis and reporting demands onerous.

3.4 Provincial Experience with Shadow Billing

As AFPs were introduced across Ontario, some physicians (in SEAMO, for example), were no longer required to provide encounter level data on volumes of clinical activity using the traditional OHIP Schedule of Benefits codes. Although SEAMO did develop a comprehensive reporting system that was capable of addressing service delivery from the level of the enterprise down to that of the individual physician, the Ministry was not comfortable with this situation for several reasons:

- OHIP billing data provided an audit function for the Ministry in assessing service levels (e.g., population-based rates of services and procedures) and for measuring the services delivered within the funding envelops. This information was no longer available when traditional billing was abandoned.

- When considering requests by AHSC’s for an increase to their physician complement, the Ministry had limited data on which to evaluate demand and service delivery within the catchment area. As well, the Ministry was not able to make meaningful comparisons of the overall workload of physicians in one academic setting compared to those in a different academic setting or in a community setting.
3.4 Provincial Experience with Shadow Billing (cont’d)

- Billing data are used extensively in health services research. Where these data were no longer available, the value of this research was compromised.
- The Ministry did not have the capacity and infrastructure to receive and adequately evaluate non-OHIP based performance reports and there were no readily available comparators for many of these measures.

As a consequence the Ministry has required that SEAMO return to ‘shadow billing’. To encourage physicians to submit comprehensive billing data, the Ministry began to offer a small incentive for each billing record submitted. However, compliance with shadow billing requirements is still seen as being lower than desired. Furthermore SEAMO leaders view this return to ‘real’ billing as a step backwards and there appears to be unhappiness on the part of both parties as a consequence.

Thus, until an entirely new framework for negotiating, tracking and remunerating physician services is developed, the Ministry is committed to OHIP billing as the measure of the accountability relationship between physician output and remuneration. Detailed physician- and patient-specific information on service type, volume and price is deemed necessary to allow the Ministry to determine appropriate remuneration for individual physicians and to allow comparison across physician peer groups.

This is not to suggest that performance at the level of an academic centre or specialty group is not an appropriate area of accountability to pursue. However, the link between total clinical volumes delivered by a physician cohort and a determination of individual physician contribution to, and remuneration for, a portion of that clinical volume cannot be made without some measure of individual activity.

The challenge for the development of any new accountability model will be to provide physician-level information on performance, including workload measures, that enables system-wide comparisons.

18 Although this hybrid approach is actually a payment model, it is still often referred to as shadow billing.
4.0 Elements of a Successful Framework

4.1 The Importance of Goals
In reviewing the literature, consulting with stakeholders and examining the accountability systems referenced earlier, the Panel determined that a successful accountability framework must achieve the following:

- Establish a negotiated and mutually agreed set of goals and objectives, with clearly defined deliverables that can be measured against these goals.
- Ensure that the accountable parties have sufficient control over the deliverables and the necessary resources to execute their responsibilities effectively;
- Provide the infrastructure and support needed for all of data collection, analysis and reporting.

A comprehensive accountability framework for academic physicians must define the expectations, benchmarks and measures for clinical, academic and administrative deliverables.

4.2 Categories of Performance Measures
There is considerable literature that addresses desirable attributes of performance measures in evaluating the quality of medical care. It is self-evident that quality measures may also have a role in accountability.

One approach to the classification of performance measures is from the perspective of what is being measured. An example is the structure, process, outcome categorization.\(^\text{19}\) In the type of accountability framework being considered it is important that the performance indicators monitor current activities, but others might help drive the desired changes in behaviour and outcomes articulated in the goals and expectations. Therefore, some measures might be used to assess performance e.g. quality of care, outcomes etc. and others might fulfill an audit function e.g. volumes of encounters, procedures, wait times etc. monitoring indicators. Under the Hospital Accountability Agreements in Ontario, four categories of indicators have been developed: performance, monitoring, developmental and exploratory. Accountability is directly tied to performance indicators for the purpose of these hospital agreements.

When considering the need to understand complex issues such as measuring teaching, research, leadership and innovation, it may be that qualitative in addition to quantitative measures will be required.

The Panel has attempted to identify criteria against which the practical value of an indicator may be judged. The list is not exhaustive but is intended to give some guidance in evaluating the utility of indicators that will be suggested.

4.2 Categories of Performance Measures (cont’d)

Collectively, the performance measures can be evaluated against the following criteria:

Individual performance measures should be:

- be linked to an overarching strategic goal
- have a clear and compelling use / meaning
- be parsimonious
- not impose undue burden on those providing data
- help providers improve care delivery
- help stakeholders make more informed decisions, and
- balance the need for continuous improvement with the stability needed to track progress over time. (modified from McGlynn, Medical Care. 41(1) Supplement:I-39-I-47, January 2003.)

In addition:

- There should be a limited number of measures, so that the data collection, analysis and reporting burden is not too onerous. At the same time, however, the suite of measures should be sufficiently comprehensive to provide a general picture of progress against the stated goals.
- The indicators should be of value to the providers who are supporting the data collection efforts. Ideally, these measures would help all stakeholders to make more informed decisions related to the delivery of health care.
- There must be some quantitative measures of activities within the AHSCs. However, not all of the measures will necessarily be used to drive funding decisions (at least not initially).

Even if a performance measure meets the above criteria, there may be data considerations that result in the indicator being rejected. For example:

- The needed data must be available, or the effort to create a process to collect the needed data is not prohibitively expensive.
- If the data are available, they must also be timely.
- Data should be high quality so that the reports are credible.
5.0 Principles

The Panel has established six principles to guide the development of the accountability framework.

1. Until such time as a new accountability framework has been developed, implemented and adequately evaluated, individual physician level clinical encounters will continue to be measured by OHIP reporting.

2. Until a comprehensive accountability framework, agreed to by the parties, can be fully implemented, the current AFP agreement will be implemented as a blended model of AFP payment and OHIP billing. “Real” OHIP billing will provide the necessary incentive to each participating physician to track their services using the Schedule. The blend of AFP payment versus OHIP billing is still under consideration.

3. The accountability framework will respect the Ministry’s strategic priorities. It will also respect the existing accountabilities of the hospitals for clinical care, the universities for teaching and the academic departments and their associated practice plans for individual physician compensation.

4. There will be a common processes for review, reporting and dissemination of results of performance measurements under the accountability framework. The results shall be transparent within and between the participating AHSCs.

5. The accountability framework will acknowledge that the accountable party can be held responsible only for the deliverables over which it has authority, control and adequate resources.

6. The discussion of physician complement should be limited to the resources required for the areas for which the accountability framework has described deliverables.
6.0 The AHSC AFP Accountability Framework

6.1 Domains

Based on the Panel’s consultations and review of the academic literature, the Panel has agreed on four domains within which performance should be evaluated:

- Clinical services,
- Teaching,
- Research, and
- Administration (including leadership activities).

| Recommendation 1: The domains of clinical services, education/scholarly activity, research, and administration (including leadership activities) should all be addressed in the accountability agreement. |

The domain of administration is meant to encompass a variety of activities, including routine administrative functions and activities that can be described as leadership (e.g., participation in regional, provincial or national policy initiatives).

The Panel felt innovative leadership is critical to advancing the unique role of AHSCs in Ontario’s health care system. Innovative leadership would encompass many possible activities:

- Adapting or changing health care practices in light of changing health needs and improved health technologies.
- Developing innovative health care delivery models to offer health care more effectively and efficiently with the resources available to them. These activities are particularly important because of the increased demands for health care services and limited health human resources available to meet the demand for care.

The importance of innovation in academic medicine has been recognized in Appendix G of the 2004 Physician Services Agreement, and the Panel believes that a comprehensive accountability framework will reward innovation in AHSCs.

By including innovation, the Panel believes that this accountability framework can not only serve to audit and monitor current performance, but also will act as a catalyst for change and improvement. The Panel recognizes the importance of leadership and encourages AHSCs to foster the education of leaders within their organizations.

The Panel felt there was no objective approach to determining whether one domain was necessarily more important than another within the accountability framework.
Recommendation 2: In developing the performance measures, and implementing a new accountability framework, there will be no attempt to assign a relative value to the various domains.

6.2 Goals and Expectations
The Panel has determined that the AFP deliverables should reflect existing obligations of the AHSCs under the Hospital Accountability Agreement as well local priorities determined in collaboration with, and participation in, LHIN planning activities.

Goals for the AHSC AFP initiative have been set out below to support each of the broad system goals that underpin the Ministry’s strategic direction for Ontario’s health care system, as described in Section 3.1 of this report.

Based on the five key priorities articulated by the Ministry, the Panel has articulated companion goals for the AHSCs and academic physicians as follows:

1. New partnerships that: (i) within an AHSC, provide governance and accountability for effective management of the AFP; and, (ii) outside of the AHSC, actively engage AHSCs with community providers and planners.
2. Effective integration of clinical, teaching and research roles to maintain and enhance approaches to population-based lifelong patient care.
3. Improved access to the full range of services provided at AHSCs.
4. Leadership in developing and implementing patient-centred initiatives that improve patient safety and quality of care.
5. Leadership in innovative, collaborative and evidence-based approaches to more effective and efficient health care delivery.

The Panel has further articulated draft objectives for each of these five goals. The objectives cover the following areas:
- Governance and planning
- Community engagement
- Maintenance and improvement of population health
- Recruitment and retention
- Improved access to services
- Patient safety
- Quality of care
- Sustainable AHSCs
- Sustainable health system.
6.2 Goals and Expectations (cont’d)
These draft objectives are described in more detail, including their relationship to the Ministry and AHSC accountability framework goals, in Appendix C.

As goals and objectives for the larger health care system change, the accountability framework must be responsive to change and attach an “incentive value” to ensure the goals and objectives are achieved.

6.3 Performance Measures
The Panel agreed on the following principles for performance measures:

- Wherever practical, performance measures will be common to all AHSCs. However, the accountability framework may need to include measures that are either centre-specific or specialty-specific.
- All goals should be set in both the short (one to two years) and longer term (three to four years).
- The framework needs at least high-level accountabilities for teaching, research and administration.
- Sentinel activities used in measuring performance must have applicability outside of the AHSC to ensure comparability with community-based physicians within the same specialty.

Recommendation 3: Performance measures, in particular those relating to clinical performance, will be tailored to individual specialties and reflect the unique circumstances for each institution.

The Panel was frustrated in its search for an alternative measurement system for clinical services that is ready to replace fee-for-service billing (or shadow billing) data. Although there was acknowledgement of the limitations of billing data, no clear alternative exists at this time. The Panel believes that, in the short term, the fee-for-service model must continue while additional work proceeds on an alternative measurement system for clinical activity that better meets the needs of all parties. In the recommended blended model, it is recognized that a uniform degree of conversion may not be appropriate for all specialties or all physicians.

Recommendation 4: The mechanism for measuring clinical activity should be initially constructed as a blended model, with partial billing conversion (percentage to be determined) until a more extensive measurement system can be implemented and evaluated.
6.4 Determining Staffing Complements

An important role of the accountability framework is to provide a methodology for evaluating requests for additions to the existing complement of physicians at each AHSC. The Panel felt that such discussions should be guided by the specific deliverables outlined in the accountability framework. The Panel also felt that all discussions about physician complement should consider the opinion of peer physicians.

**Recommendation 5:** Decisions regarding physician complement should be overseen by an independent physician advisory committee that draws its membership from participating Academic Health Science Centres.
7.0 Phased Approach to Implementation

The Panel is of the opinion that developing an acceptable, valid and sustainable accountability framework will be an iterative process over time. This approach is necessary to develop ideas, test and evaluate them, and move gradually towards the ultimate solution. This approach will also allow all stakeholders an opportunity to provide input to the framework and to test various elements before a full commitment is made.

**Recommendation 6:** Both the Academic Health Science Centres and the Ministry of Health and Long-Term Care must commit fully to the development, evaluation and ongoing infrastructure (i.e., human resources, information technology, funding) required for a new accountability framework to quantify activities under the Alternate Funding Plan. There will be a commitment to iterative development of the performance measures under the accountability framework.

This process of consultation, validation and refinement of the accountability framework should be guided by a provincial Steering Committee with representation from all affected stakeholders.

**Recommendation 7:** A provincial Steering Committee will be established with representation from academic physicians, the Ontario Medical Association, the Ministry of Health and Long-Term Care, academic hospitals and universities.

This Steering Committee would convene in early January 2007 to oversee the consultation process for the development of all elements of the framework, including performance measurements.

The Panel identified three levels of accountability within the AHSC AFPS: the AHSC, the specialty or department, and the individual physician. It would be prudent for the staged approach of developing the full framework to begin with the first level of accountability, (i.e., the accountability of the AHSC to the Ministry).

7.1 Consultation and Validation Process

The findings from our environmental scan, including the literature review, experience in other jurisdictions, and the advice of representatives from SEAMO, confirm that the success of any accountability framework depends on having the support of all stakeholders. Because of the importance of this framework and the potentially significant impact it will have on the participating physicians, AHSCs, and, ultimately, on health outcomes, the Panel believes that a broad and comprehensive consultation process is needed to refine the proposed framework and solicit stakeholders’ support.
7.1 Consultation and Validation Process (cont’d)

**Recommendation 8:** Performance measures will be developed with the direct participation of the affected physician groups and under a common set of guidelines, mandate and specific consultative processes to be established by the Steering Committee.

These consultations will be conducted in two separate processes to develop:

- General performance measures that are common to all AHSCs and all specialties.
- Specialty- and institution-specific measures, especially for clinical measures.

All of the literature that dealt with setting performance expectations was adamant that the accountable party (in this case, the physicians), must agree to the performance measures in advance of them being used. Therefore, the Panel believes that physician groups must be involved in identifying meaningful performance indicators and associated benchmarks and targets (particularly for specialty-specific indicators). The Panel also believes that extensive stakeholder consultation will help to ensure that performance measurement becomes a priority for all parties.

7.2 Further Development of the Framework

The Panel sees the consultation process under the Steering Committee as guiding the development of the remaining elements of the accountability framework. For example, the literature emphasized the need for consequences in any accountability framework. However, this aspect of the framework has not been fully examined yet.

While some of the issues surrounding consequences will likely be dealt with by a companion Governance Working Group it is also clear that an important part of any accountability framework is an objective and fair dispute resolution process. The Panel has not defined that process, but recognizes that this must be developed during the first iteration of the development of the framework.

**Recommendation 9:** The accountability framework should include a mechanism and process for dispute resolution.
7.3 Supporting the Framework

The published literature, the environmental scan, and representatives from SEAMO consistently highlighted the investment required for the initial development and on-going maintenance of systems for data collection, analysis and reporting. The investment is significant and will be required both at the AHSCs and within the Ministry. There must be total commitment from all parties to the development and utilization of a new system.
8.0 Recommendations

The principles and recommendations described in this chapter are intended to guide the development of a new accountability framework for the AHSC AFP. They describe a staged approach to implementing a comprehensive accountability model that provides for an initial framework that satisfies the immediate requirements of Appendix G. At the same time, the Panel is laying the foundation for a more exhaustive process that not only ensures accountability but also stimulates innovation and continuous improvement in quality of care and patient outcomes.

<table>
<thead>
<tr>
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</table>
8.0 Recommendations

The following recommendations are directed towards the establishment of processes to develop a new accountability framework that will, at the individual physician level, replace the existing accountability scheme embodied in the fee-for-service billing system.

**Recommendation 6:** Both the AHSCs and the Ministry must commit fully to the development, evaluation and ongoing infrastructure (i.e., human resources, information technology, funding) required for a new accountability framework to quantify activities under the AFP. There will be a commitment to iterative development of the performance measures under the accountability framework.

**Recommendation 7:** A provincial Steering Committee with representation from academic physicians, the OMA, the Ministry, academic hospitals and universities will be established.

**Recommendation 8:** Performance measures will be developed with the direct participation of the affected physician groups and under a common set of guidelines, mandate and specific consultative processes to be established by the Steering Committee.

**Recommendation 9:** The accountability framework should include a mechanism and process for dispute resolution.
APPENDIX A: Accountability Expert Panel Terms of Reference

Accountability Issues of Importance to the AHSC-AFP Task Force

Purpose:

1. The Accountability Expert Panel (AEP) should consist of membership appointed by the PSC based on the recommendations of the AHSC AFP Task Force. Its membership will consist of (TBD).

2. The AEP should be struck by the PSC as soon as possible due to the importance to the Task Force of having an early understanding of potential methodologies for measuring AHSC deliverables and the measurements to guide the development of the template.

3. The AEP will report regularly to the AHSC AFP Task Force on its progress.

Ideal Elements for Accountability:

a) Appropriate legal status

b) Does not affect the professional autonomy of participating physicians as independent practitioners

c) Clear expectations that ensure everyone knows what is required

d) Clear roles and responsibilities that spell out who is responsible for each commitment. Accountabilities among hospital agreements and alternate funding plans must align with each other and with overall strategic health system plans as developed by the ministry and, eventually, by Local Health Integrated Networks (LHINs)

e) Credible reporting and performance measures that define the data elements to be used including financial reporting and the manner in which they will be reported

f) Improvement through evaluation and feedback that highlights the fact that accountability is a continuous process and requires communication and transparency

g) Where possible, utilize data already gathered and approved for other purposes
APPENDIX B:

Accountability Expert Panel Terms of Reference

Deliverables

It is expected that the AEP will have completed its work by December 2006. However, it is also expected that the AEP will provide deliverables in accordance with key dates and priorities as determined by the AHSC AFP Task Force.

1. Establish a consultative and transparent process for developing uniform performance measures and benchmarks for quality of care, clinical, teaching and research services and others as prescribed by the AHSC AFP Task Force to be used in the AHSC AFP template

2. Advise on viable alternatives to shadow billing

3. Advise on structures and processes for reporting AFP performance measures and benchmarks against a clear set of deliverables

4. Advise on processes and reporting structures on which to base accountability for deliverables and tracking the delivery and outcome of health services to the population

5. Advise on appropriate feedback loops that ensure linkages with relevant agreements that allow for re-evaluation of AFP deliverables as a consequence of changes introduced through other accountability instruments

Reporting Relationship

The Task Force will appoint one member to the AEP who will be responsible for keeping the Task Force Chair informed of progress.
APPENDIX C:

Accountability Expert Panel Membership

Chris Morgan, MD (Chair), Sunnybrook Health Sciences Centre

Andreas Laupacis, President & CEO, Institute for Clinical Evaluative Science

Peter Munt, MD, Chief of Staff, Kingston General Hospital

Mark Rochon, President & CEO, Toronto Rehabilitation Institute

Stewart D Saxe, Partner Baker & McKenzie LLP

Karen Stanley, Director, Alternative Payment Programs, Ministry of Health and Long-Term Care

Ex officio members:

Bernita Drenth, Project Director, AHSC AFP Project, Ministry of Health and Long-Term Care

Sandy Nuttall, Project Manager, AHSC AFP Project, Ministry of Health and Long-Term Care

Brenda Edwards, Project Coordinator, AHSC AFP Project, Ministry of Health and Long-Term Care

Marcella Sholdice, Report Writer
### APPENDIX D:

**Ministry Health System Goals and Possible AHSC AFP Goals and Objectives**

<table>
<thead>
<tr>
<th>Health System Goal</th>
<th>AHSC AFP</th>
<th>Objective</th>
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<tbody>
<tr>
<td>1. Renewed community engagement and partnerships across the health care system</td>
<td>New partnerships that: (i) within an AHSC provide governance and accountability for effective management of the AFP; and,</td>
<td><strong>Governance and Planning</strong>&lt;br&gt;• Build strong governance organizations that engage in proactive strategic planning at the level of the AHSC and are accountable for meeting defined deliverables&lt;br&gt;• Coordinate and integrate hospital infrastructure, physician payments and university resources to meet defined deliverables&lt;br&gt;• Ensure active AHSC AFP participation in Hospital Accountability Agreement and LHIN planning processes to enable appropriate alignment with physician resources and the AHSC AFP Agreement.</td>
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<td></td>
<td>(ii) outside of the AHSC, actively engage AHSCs with community providers and planners</td>
<td><strong>Community Engagement</strong>&lt;br&gt;• Foster academic medicine engagement with LHINs and community providers to create and share knowledge that integrates wait times, alternate models of care, patient safety and quality of care initiatives into the LHIN Health System Plan</td>
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<td>Health System Goal</td>
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<td>2. Improve the health status of Ontarians</td>
<td>Effectively integrate clinical, teaching and research roles to maintain and enhance approaches to population-based lifelong health management</td>
<td>Maintain Population Health</td>
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<td>• Maintain comparable population health results across key indicators</td>
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<td>Improve Population Health</td>
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<td>• Demonstrate leadership in developing, testing and integrating population health strategies across the academic mission from preventive care to chronic and palliative care</td>
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<td>• Educate new physician leaders in innovation and early application and dissemination of new knowledge that advances care and service practices</td>
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<td>Health System Goal</td>
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<td>3. Ontarians will have equitable access to the care and services they need no</td>
<td>Improve access to the full range of services provided at AHSCs</td>
<td>Recruitment and retention</td>
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<td>matter where they live or their socio/cultural/economic status</td>
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<td>- Reduce the migration of academic physicians to the community due to competitiveness issues</td>
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<td>- Increase attraction of physicians to the academic setting through better remuneration of academic and related clinical activities</td>
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<td>- Build a climate of collaboration and innovation that attracts the most appropriate trainees as future academic physicians</td>
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<td>- Produce short- and longer-term physician human resource plans that better align hospital, university and Ministry resources to achieve common objectives</td>
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<td>Improved access to services</td>
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<td>- Meet or exceed service volumes set out in the Hospital Accountability Agreement</td>
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<td>- Maintain and enhance monitoring and reporting on wait times for agreed-upon services and targets</td>
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<td>- Maintain the provision of specialized services in AHSCs – e.g. focus on services that can only or primarily be provided in AHSCs such as tertiary and quaternary care and identified provincial programs (e.g. transplant) and identify medium to longer term approaches to ensuring and improving access to these services</td>
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<td>- Implement strategies to ensure timely access for those services identified as Ministry priorities</td>
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<td>- Collaborate with LHINs to ensure appropriate and timely access to specialized services within a region</td>
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<td>Health System Goal</td>
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<td>3 (cont’d) Ontarians will have equitable access to the care and services they</td>
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<td>• Integrate clinical practice, teaching and research into the development of evidence-based best practices to improve hospital flow-through (e.g. access management)</td>
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<td>need no matter where they live or their socio/cultural/economic status</td>
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<td>4. Improve the quality of health outcomes</td>
<td>Leadership in developing and implementing patient-centred initiatives that improve patient safety and quality of care</td>
<td><strong>Patient safety</strong></td>
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<td>• Provide measurable leadership in creating, developing and implementing best practices to improve patient safety</td>
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<td>• Develop and test valid evidence-based indicators and benchmarks that reliably measure patient safety and improved outcomes</td>
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<td><strong>Quality of care</strong></td>
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<td>5. Establish a framework for sustainability of the health care system that</td>
<td>Leadership in innovative,</td>
<td><strong>Sustainable AHSCs</strong></td>
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<td>achieves the best results for consumers and the community</td>
<td>collaborative and evidence-based approaches to ensure more</td>
<td>• Maintain and enhance productivity where appropriate and measure</td>
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<td>effective and efficient health care delivery</td>
<td>through key indicators</td>
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<td>• Implement and report on evidence-based, specialty-specific best</td>
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<td>practices that ensure appropriateness of care, where such</td>
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<td>guidelines/care maps exist</td>
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<td><strong>Sustainable Health System</strong></td>
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<td>• Lead in the development and implementation of more effective and</td>
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<td>appropriate models of care, including team-based approaches</td>
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<td>• Provide academic physician leadership to LHIN local area planning</td>
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<td>teams to create and share knowledge that integrates wait times,</td>
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<td>specialist supply, alternate models of care, patient safety /</td>
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<td>quality care into the LHIN Health System Plan</td>
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Johnston, Mary Anne, Gifford, Robert. A Model for Distributing Teaching Funds to Faculty. Academic Medicine. vol. 71(2) February 1996.


