

Rapid Evidence Profile #41 (11 November 2022)

Key messages

- The functions that local health systems or networks of care are responsible for executing differ based on their maturity and whether they are a one-off initiative (where they are responsible almost exclusively for improving the delivery of services and some planning efforts) or part of a significant system transformation (where they are also responsible for establishing formal governance arrangements, fundholding for and/or funding partner organizations, and the implementation of elements of transformation).
- The most fulsome example of such local networks in the research literature are U.S. Accountable Care Organizations, U.S. patient-centred medical homes and associated medical neighbourhoods, and U.K. Integrated Care Systems (which build on the experience of Clinical Commissioning Groups).
- The research literature on accountability models for performing these functions is in its infancy, with relatively few evaluative findings.
- In general, economic instruments (including risk-sharing agreements) and education and information instruments (such as performance-measurement frameworks) alongside aligned incentives are most frequently used ensure accountability.

Question

What do we know from the best-available evidence and from the experiences of other jurisdictions about the functions that local-health systems or networks of care are responsible for and the ways in which they are held accountable for performing these functions?

What we found

To identify the best-available evidence and experiences about the functions for which local-health system or networks of care are responsible for and the ways they are held accountable, we identified evidence as well as experiences from Australia, New Zealand, United Kingdom, and the United States and all Canadian provinces and territories (see Box 1 for a description of our approach). We organized our findings using the framework below.

Organizing framework

- Focus of the accountability model (i.e., to whom is the model applied)
 - Local systems or networks of care
 - Multi-disciplinary teams of providers (whether formal or informal)
 - Individual providers

Box 1: Our approach

We searched from 2000 onwards to capture any evidence addressing the question by searching Health Systems Evidence and PubMed. We identified jurisdictional experiences by handsearching government and stakeholder websites.

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.

- Purpose of the accountability model (i.e., why is the model applied)
 - 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 the local-system accountable?)
 - 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 (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 20 evidence documents relevant to the question, of which we deemed 14 to be highly relevant. The highly relevant evidence documents include:

- two evidence syntheses
- 11 single studies that provide additional insights
- one grey-literature report from an international organization.

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 key findings from highly relevant evidence documents in Table 1. These have been summarized according to the mechanisms used in the models to establish accountability as this is where 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

Similar to the evidence-base identified in the accompanying [rapid-evidence profile on accountability for primary care participating in local-health systems or networks of care](#), the majority of the research literature consisted of descriptive studies of establishing local networks of care, which included targeted sections related to accountability structures although this wasn't the primary focus of the document. In addition, we identified [one report](#) developed by the WHO Regional Office for Europe, which outlines the five dimensions of accountability for coordinated or integrated care

(legal, financial, professional, political and public) as well as actions that can be taken and tools that can be used to enhance accountability in these systems. However, the report does not provide a review of the effects of any of these tools or actions.

Included in the identified literature were two frameworks that may help when considering the elements of accountability arrangements for local networks. We identified [one primary study](#) that describes one organizing framework. The study reviews the decade of experience from the Centres for Medicare and Medicaid Innovation (CMS Innovation) in the U.S. and presents a framework for promoting joint accountability by identifying the levers that have been previously used in the Medicare and Medicaid Innovative models. These include:

- payment levers that apply upside and downside financial risk through retrospective and prospective payments
- measurement levers that track performance on specific outcome metrics overtime or cross-sectionally
- public reporting levers that make data on performance publicly available
- accreditation levers that require certain behaviours or actions to be certified as safe or of sufficient quality
- regulatory levers that apply standards to networks through federal regulation.

These levers have been used to establish system accountability in many different types of initiatives and the reports that have been prepared did not get into sufficient granularity about whether and how these levers differed by ownership type. However, in general, CMS Innovation is responsible for issuing funds, and for monitoring and evaluating the service delivery models it is testing. Authority is provided to the Secretary of Health and Human Services to expand the scope or duration of a model following the review of evaluations from CMS Innovation.

Similarly, [a second primary study](#) provides a framework to break down the dimensions of accountability, describing the need to define inclusion (i.e., who is included in the accountability model), publicity (i.e., ensuring there is enough information available to hold the network to account), and responsiveness (i.e., what actions are available to hold the network members to account).

Focus, purpose and target of the accountability model

All of the included literature addressed focused on local systems or networks of care as being the focus of the accountability models, though at time there were mentions of additional accountability mechanisms, such as contracts with individual providers. The purpose of the accountability model was most frequently found to be related to the quadruple aim, particularly at improving population health and reducing per-capita costs for larger, more mature initiatives and at improving the individual experience of care for smaller and one-off networks.

With respect to health-system arrangements, local systems or networks of care were frequently responsible for service planning and delivery. Transformations that included broader system changes also targeted local-system governance, often creating governance boards that exist on top of individual organizational boards or new legal entities, and funding of partner organizations, through for example, pooled capitated budgets and other aligned incentives.

Mechanisms used in the model to establish accountability

Similar to observations in the accompanying [rapid evidence profile](#), we observed a gradient whereby initiatives in their earlier stages or those that were specific to a given local system (i.e., a one off initiative) were more likely to have informal mechanisms and voluntary instruments as collective

partnership agreements or care compacts ([1](#), [2](#), [3](#)). Larger-scale initiatives, such as U.S. Accountable Care Organizations and U.K. Clinical Commissioning Groups (now Integrated Care Systems), make up a significant amount of the research literature and focus accountability mechanisms on a combination of economic instruments such as risk-sharing agreements. This is detailed in [one overview of evidence syntheses](#), [one older medium-quality evidence synthesis](#), and three single studies ([1](#), [2](#), [3](#))

Factors enabling the accountability model

[One overview of evidence syntheses](#) and five single studies ([1](#), [2](#), [3](#), [4](#), [5](#)) explicitly mentioned factors enabling the accountability model, including:

- an established culture of trust and collaboration among partners
- co-production of outcomes and indicators that make up the performance measurement
- timely availability of robust data (which in some cases was provided by funders as part of the implementation process)
- capacity and capability to manage contracts
- prior experience with risk sharing (when the accountability model includes these types of financial arrangements)
- aligned incentives.

Key findings from the jurisdictional scan

We found relatively few documented examples in other countries or in Canadian provinces and territories of instances of accountability models for local health systems or local networks of care. Those that we did identify have been summarized in the text below based on the target of the accountability model (i.e., for what the local system is accountable) and the mechanisms used in the model to establish accountability.

Focus, purpose and target of the accountability model

Most of the local-system accountability models we identified focused on the creation of networks of care. These entities are established to provide oversight for 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, Australia's local health-system governance is organized through 31 [Primary Health Networks \(PHN\)](#) that act as independent organizations responsible for improving access, effectiveness, efficiency and coordination of care as well as for commissioning health services and building health-workforce capacity based on local needs. In the U.K., the NHS [established 42 Integrated Care Systems](#) (ICSs) across England, which include local authorities which are responsible for the social care and public health functions (including Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs)). ICBs have taken over [responsibility for commissioning services](#) from the clinical commissioning groups (CCGs) and are overseen by NHS England. In the U.S., the focus is on organizations which provider of Medicare services and individual Medicare providers that are eligible to join Medicare Accountable Care Organizations (or ACOs), that are responsible for coordinating services and ensuring quality and cost-effectiveness.

In Canada, local-system accountability models we identified were largely focused on service planning and delivery. In Quebec, [Integrated Health and Social Services Centres \(CISSS\) or Integrated University Health and Social Services Centres \(CIUSSS\)](#) were created as local service networks formed to meet the health and psychosocial needs of Quebec residents. They are responsible for

managing the delivery of healthcare services provided by organizations within their regions. They are responsible for monitoring and evaluating the care that is provided and use a range of methods to do so, including regular audits and inspections of facilities, patient-satisfaction surveys, monitoring of healthcare outcomes, and providing ongoing training and education for healthcare professionals.

Mechanisms used in the model to establish accountability

Mechanisms used to establish and ensure accountability for these networks 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 regional and local organizations and providers in the planning, financing, coordination, and delivery of services. 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 being well established.

Formal mechanisms used by accountability models consisted of legal, economic, and information and education instruments such as contracts, financial-incentive arrangements, and auditing and feedback tools for local system entities and provider networks. As an example of a legal instrument, in Quebec, the National Assembly adopted [*An act to modify the organization and governance of the health and social services network, 2015*](#) which legally consolidated a majority of the health and social services into either CISSS or CIUSSSs. In addition, other accountability mechanisms are in place including regular reporting requirements to the Quebec Ministry of Health and Social Services on performance, including on their quality of care and financial performance, complains and feedback mechanisms, and submission to regular accreditation reviews by external organizations including Accreditation Canada.

To facilitate the development of ICSs, NHS England has also used legal instruments and has begun implementing [*Integrated Care Provider \(ICP\) Contracts*](#) and Local Authority Integration Agreements. Where previously many different contracts were written between the NHS and individual organizations, [*Integrated Care Provider Contracts bring many different providers under a single contract for the delivery of care for a given geographic area*](#). [*Local Authority Integration Agreements*](#) are agreements made between local authorities, social care partners (not covered under the NHS) and, NHS trusts. The agreement aims to support joint working arrangements between local authorities and health organizations covered under Integrated Care Provider Contracts by defining working arrangements between the parties of the agreement despite their separate funding streams. Both the contracts and agreements are in the process of being implemented across England.

In the U.S., the performance of each ACO is measured against benchmarks that determine overall [*shared savings*](#) or losses which then determine [*incentives*](#) for ACOs. As an example of combined economic and information and education instruments, in the U.S., the Center for Medicare Services develops benchmarks against which ACO performance is measured to assess whether the ACO generated savings or losses for the Medicare program during a given performance year. [*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.

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 local-system 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 clearest model/design-level factors identified included tying financial incentives to performance indicators, thereby simultaneously promoting the collection of standardized data needed to evaluate primary care practices. For example, ACOs in the U.S. obtain [financial incentives](#) by comparing performance against benchmarks developed by the Center for Medicare Services. Australian PHNs are incentivized to collect standardized data used to monitor and assess PHNs against national and local indicators, as it can make them eligible for incentive funding, increased contract length, taking over contracts of regions with poor performers, and public recognition of performance.

Finally, several local-system accountability models appear to be supported by the involvement of multiple stakeholders groups involved in the organization and integration of services. In the U.K., for example, Integrated Care Partnerships are joint committees consisting of members of the integrated care board and local authorities to jointly develop strategies to address local needs. Zone PCN Committees in Alberta include representatives from PCNs, Alberta Health Services and local communities to provide a localized and community-based health oversight.

Table 1: Overview of type of number of documents that were identified about the functions and accountability of local systems

Mechanisms used in the model to establish accountability	Key findings
Informal mechanisms (e.g., dialogue, negotiations, expectations, demands)	• One recent primary study of 30 integrated care initiatives, found that the majority (23) reported being supported by a new form of collaborative partnership agreement, many of which took the form of steering committees, with representatives from partner organizations who were responsible for ensuring new ways of working among the partners • One recent primary study describes the experience of setting up an integrated network in the Netherlands of health and social care providers that is largely reliant on informal mechanisms for accountability and reports the need for increased formalization of the partnership which is suggested to initially take the form of integrated data infrastructure to enable performance measurement and tracking ○ It is suggested in the study that this could be complemented by aligned financial incentives
Formal mechanisms	
Legal instruments (e.g., act and regulations, self-regulation regimes, and performance-based regulations)	• None identified
Economic instruments (e.g., insurance schemes and contracts)	• One recent overview of evidence syntheses examines the effects of place-based contracting or value-based contracting, whereby multiple services are brought under a single contract and a capitated budget with the expectation that the local network of care will be responsible for governing, funding, planning and providing services for the whole population ○ The overview found inconclusive results on population-health measures and costs, largely due to the significant heterogeneity in the models used and variable reporting ○ Facilitators of successful place-based or value-based contracting were found to include: ▪ a culture of trust and collaboration; ▪ co-production of measurable outcomes and indicators; ▪ robust data and information; ▪ capacity and capability for contract management and procurement; ▪ aligned incentives. • One older medium-quality evidence synthesis examined four models of contracting for Integrated Care Systems, namely, Accountable Care Organizations, the alliance model, the lead provider/prime contractor model, and outcomes-based commissioning and found limited evidence of effectiveness, largely attributed to the recency of their widespread use

	• One recent single study examining 30 integrated care initiatives found that over half of the programs made financial changes, the most centralized of which involved the creation of new pooled budgets, which frequently included sophisticated risk-shared contracts between delivery organizations • One recent single study examines the provision of six round one state innovation policy awards from the Centre for Medicare and Medicaid Innovation to help align state systems with multi-payers ○ States were provided with between 25 and 45 million dollars to implement new payment and service delivery models that would provide broad-based accountability for population outcomes and include alignment with private payers ○ Participating states designed ACO-type models, frequently with one-sided risk, through two states created two sided-risk arrangements ○ The study reported that the initiative helped to increase state and provider accountability for patient outcomes through the expansion of the value-based payment model ○ Facilitators of the success were found to be previous experience with value-based payment models, the use of state law to compel participation in the initiative (for those receiving Medicaid funds), and availability of data resources • One older single study reported results from a survey of U.S. Accountable Care Organizations, and found that moderate sizes ACOs, typically led by hospitals or coalitions scored relatively low on performance management and accountability as compared to either small or large physician-led ACOs ○ 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
Voluntary instruments (e.g., standards and guidelines, formalized partnerships)	• One recent single study identifies the use of care compacts as accountability mechanisms for medical neighbourhoods in the U.S. ○ The care compact is used to articulate and make explicit the mutual responsibilities for communicating and coordinating shared patient care ○ Additional accountability measures included in the compact were report cards, patient surveys, and use of information technology to provide real-time feedback
Information and education instruments (e.g., training, public reporting, audit and feedback)	• One older single study reports on the development of a surgery network which is responsible for establishing clinical priorities, collective tracking and improvement of surgical outcomes, and establishing local surgical standards ○ The study reports that accountability for participation in the network is maintained through training, education and team development as well as the tracking of key performance indicators • One older single study documents the Mayo Clinic Arizona's approach to improve service quality across their networks which include changes to the accountability model to focus on the robust collection of data on quality and its comparability across the health system including on patient satisfaction surveys

	○ Accountability for improving quality is maintained through scorecards presented to both senior executives and front-line staff, the development of action plans for underperforming organizations, education and training, and network-wide improvement plans each year ● One primary study describes the development of coordinated elder care networks in Sweden and notes that accountability is largely maintained through the publishing and sharing of quality reports, however notes that the limited presence of external scrutiny (i.e., outside the network) results in uncertainty regarding the responsibility for the care delivered within the network ● One recent primary study described the use of intervision meetings, which consisted of methodical discussion among network members on the quality of care being delivered, alongside worksite visits by other member of the network to create joint accountability within a health and social care network in the Netherlands ○ While the approach reportedly resulted in improved understanding and trust, the relatively low levels of shared accountability among partners resulted in barriers for moving forward as network members did not feel they had sufficient ownership over the change process
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Table 2: Experiences in selected jurisdictions on functions and accountability of local networks

Country	Summary of experiences
Australia	● No additional local systems identified beyond those included in accompanying rapid evidence profile on primary care accountability
New Zealand	● No additional local systems identified beyond those included in accompanying rapid evidence profile on primary care accountability
United Kingdom	● Since 1 July 2022, the NHS established 42 Integrated Care Systems (ICSs) across England, which include local authorities which are responsible for the social care and public health functions (including Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs)) ○ Within localities and neighbourhoods, place-based partnerships (e.g., NHS, local councils, community, voluntary organizations, local residents) will lead the design and delivery of integrated services ● The legislation recommended that ICSs should have minimum national legislative provision and maximum local operational flexibility, in addition to ensuring transparency for accountability ○ ICSs must include a chair, CEO, and a minimum three other members from NHS trusts, general practice, and a local authority ● ICSs will be statutory organizations with board members responsible for corporate accountability of their performance and functions ○ ICBs are directly accountable to NHS England and NHS Improvement, even if they delegate responsibilities and functions to ICPs

	○ ICBs responsible for developing a plan, allocating resources, establishing joint working arrangement, establishing governance arrangements to support collective accountability (underpinned by statutory and contractual accountabilities of organizations), arranging for the provision of health services, and any delegated functions ▪ Accountability includes clearly agreed arrangements for the system and decision-making board for the next five years, capital spending plan developed jointly by its partner NHS trusts and foundations, public meetings and minutes, regular updates, annual plans and progress based on priorities, accountability principles, and independent audit committee within the ICB ○ Executives of provider organizations will continue to be accountable to their boards in addition to the performance of the ICB should they decide to be a member of the ICB ○ Providers of NHS services will continue to be accountable through their provider license and registration requirements, and delivery of any services commissioned by the ICB under an agreed contract ○ Related to involving people and communities in ICS, the NHS recommends defining the role and accountability of members in governance structures, including public meeting minutes and related reports ○ The shift to ICS will include the current CCG and ICB leadership with increasing involvement of the new leaders ● ICPs are statutory joint committees with the ICB and local authorities to develop a strategy that address their local needs, which could include delegation of responsibilities and budgets to place-based partnerships
United States	● Since 2005, when the Physician Group Practice Demonstration program was launched, six different iterations of ACO models have been developed ● Each of the ACO models permits hospitals, networks of physician groups, and other community organizations participate in a shared savings program, whereby if they incur costs below an established threshold they are permitted to share in all of or part of the difference between actual costs and the threshold so long as costs were not lowered at the expense of the quality of care provided ● All ACOs participate in a shared savings program, however the extent of savings (and any downside risk incurred depends on the chosen model) ● To benefit from shared savings ACOs must sign a three-year contract and agree for all providers to meet at least 70% of 33 quality indicators categorized across four domains (patient experience of care, care coordination and safety, preventative healthcare, and chronic disease management) ● Participating providers are reimbursed using a fee-for-service model, while participating organizations receive a budget based on population case-mix ● ACOs are also eligible for additional incentives for specific population-health initiatives based on national or local-priorities

Table 3: Experiences in Canadian provinces and territories on functions and accountability of local systems

Province	Summary of experiences
British Columbia	No additional local systems identified beyond those included in accompanying rapid evidence profile on primary care accountability
Alberta	No additional local systems identified beyond those included in accompanying rapid evidence profile on primary care accountability
Saskatchewan	None identified
Manitoba	None identified
Ontario	- As outlined in Ontario Health Teams: Guidance for Health Care Providers and Organizations prior to becoming an approved Ontario Health Team, the Team first undergoes a self-assessment process to determine implementation readiness. - Once a team is approved as an Ontario Health Team, teams must establish a collaborative decision-making arrangement between members to be eligible for implementation funds
Québec	- The 2015 Act to Modify the Organization and Governance of the Health and Social Services Network set the legal groundwork for local system governance and expectations of provincial, territorial and local partners involved with health and social service provision - The act established Integrated Health and Social Services Centres (CISSS) or Integrated University Health and Social Services Centres (CIUSSS) which act as regional networks of care responsible for managing the delivery of health services within a specific geographic area. - CISSSs and CIUSSSs are governed by a board of directors made up of health professionals and community leaders and is accountable to the Ministry of Health and Social Services - Accountability for CISSSs and CIUSSSs is established through performance monitoring, complaints and feedback mechanisms and accreditation by external organizations
New Brunswick	None identified
Nova Scotia	None identified
Prince Edward Island	None identified
Newfoundland and Labrador	None identified
Yukon	None identified
Northwest Territories	None identified
Nunavut	None identified

Waddell K, Demaio P, Bhuiya A, El-Kadi A, Moat KA, Lavis JN. Rapid evidence profile #41: What do we know from the best-available evidence and from the experiences of other jurisdictions about the functions that local-systems are responsible for and the ways in which they are held accountable for performing these functions? Hamilton: McMaster Health Forum, 11 November 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 #41

(11 November 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

For this REP, we searched [Health Systems Evidence](#) using accountability AND (system or network) in the open search. As well as searching in [PubMed](#) using (accountability OR accountabilities) AND (health system OR network).

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 Chinese, English, French or Spanish. 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, Chinese, French or Spanish 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	• Focus of the accountability model ○ Local systems or networks of care • Purpose of the accountability model ○ Improving performance • Health-system that are the target of the accountability model ○ Accountability for financing, funding and remunerating ○ Accountability for service planning and delivery • Mechanisms used in the model to establish accountability ○ Formal mechanisms ▪ Economic instruments ▪ Information and education instruments	• The review examines the literature base behind the ‘5 year forward view’ transition and in particular behind place-based contracting and its implications for accountability • The approach brings multiple services under a single contract and a capitated budget, in the case of the U.K., the MCP framework provides a capitated payment to cover the whole population alongside risk/gain sharing and incentives • In the case of the MCP framework, the performance payment can amount to 10% of the total contract value • The literature review notes that there is little empirical evidence supporting the use of place-based contracting largely a result of the heterogeneity and variable reporting • The outcomes of place-based contracting on population health are relatively mixed, with some evidence noting that well-developed and comprehensive pooling arrangements across a range of sources, creating large health and social care budgets demonstrate a positive impact • Findings from early evaluations of ACOs point to mixed results on cost, suggesting that the success of the ACO model may derive from the shift to lower cost-facilities and emphasis on outcomes rather than activities • Lessons from earlier initiatives suggest that potential savings could be limited by the time and set-up costs to design and implement new	Published June 2018

		contracts, outcome frameworks and performance management systems • Review of contracting arrangements have found that alliances benefit from incentives to collaborate, improved relationships, active involvement of commissioners, information-sharing, reduced capital costs and better coordination • The following were identified as facilitators to enable successful place-based contracting: organisational forms (context) and governance structures and behavioural change from staff engagement and development, specialist capacity and capability with clear roles and responsibilities in contract and procurement Source	
	• Focus of the accountability model ○ Local systems or networks of care ○ Multi-disciplinary teams of providers • Purpose of the accountability model ○ Improving performance • Health-system that are the target of the accountability model ○ Accountability for financing, funding and remunerating ○ Accountability for service planning and delivery • Mechanisms used in the model to establish accountability ○ Formal mechanisms ▪ Economic instruments ▪ Information and education instruments	• Review of 30 integrated care initiatives to develop a framework that sorts insights into four broad categories of new or augmented policy support for integrated care, including: governance and partnerships; workforce and staffing; financing and payment; and data sharing and use • Twenty-three of the 30 programs reported being supported by a new form of governance or collaborative partnership agreement, many of which took the form of steering committees that consisted of local care providers, health insurance companies and public authorities ○ These committees frequently took on the role of ensuring that necessary conditions and prerequisites were met creating local accountability ○ One Canadian initiative was overseen by a board of directors made up of representatives of the partners that contributed to the program either financially or with personnel • Nealy all of the programs that had supportive workforce or staffing policies also had new local	Published April 2020

		efforts to have health and social care providers work together and the dominant approach was multi-disciplinary teams ○ Staffing policies involved creating new roles particularly for care coordination, navigation and case management ● Over half of the programs identified financing and payment policy changes, the most centralized of which involved new budgets created to cover the full cost of all health and social care services for the target populations ○ In these cases, insurance funds were pooled and used to provide a wide range of services for all enrolled people ○ In many cases these included sophisticated risk-sharing contracts with savings shared between the delivery organization and insurance companies ○ In other instances such as the U.K., Canada and Australia relied on new envelopes of funding for central programs of supports ○ Other programs were supported by highly flexible local financing and payment policies for instance that permitted payment for non-medical supports that insurers would traditionally not cover ● Only half of the programs had data sharing in place, instead it was frequently left up to individual organizations to determine how best to share data, which was typically limited to viewing data instead of inputting data in a shared longitudinal patient care record ● A few programs used rigorous third-party external evaluators to manage data and report on program outcomes, however there were other programs at the other end where there was little formal	
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		evaluation but a clear focus on rapid-cycle data from patients • A mix of national and local support were in place with some being support by very formal top-down governance structures while others had less formal and more local, with the essential activity being to support the program through interactive local partnerships • Innovative programs of care for populations with complex needs were found most frequently to rely on shared resources who allocation is determined on a local level Source	
	• Focus of the accountability model ○ Local systems or networks of care • Purpose of the accountability model ○ Improving performance • Health-system arrangements that are the target of accountability models ○ Accountability for local-system governance • Mechanisms used in the model to establish accountability ○ Informal mechanisms ○ Formal mechanisms ▪ Legal instruments • Factors enabling the accountability model ○ Organizational-level factors	• The review highlights different governance models for integrated delivery systems, the accountability requirements for an integrated delivery board, and considerations for choosing the right model • The identified models include: the consortium model, whereby each of the entities maintains ownership and identity and the role of the board is largely coordinating and setting strategy; the parent holding model is similar however the role of the board is expanded to include fund-holding among other functions; the corporate model has only one system board in place responsible for high-level decisions • The accountability requirements of an integrated delivery system board include aspects of political (i.e., achievement of externally imposed mandates such as integrating care), commercial (i.e., focus on creating value within the services offered and reducing overall costs) , clinical (i.e., ensuring high-quality care is being provide to clients) and community accountability (i.e., accountability for the health status of the population served)	Published February 1997

		• It is noted that to have community accountability there must be sufficient demographic, sociological and epidemiological information about the health of the community • The review notes that contracts are one mechanism to ensure accountability but that contracts can look very different and may evolve as the integrated delivery system, for example moving from relational contracts to a hierarchical design • Another mechanisms is to establish performance assessment strategies and strategic monitoring • The review notes the participation of different organizations in governance can occur either as constituent representatives or as strategic experts Source	
	• Focus of the accountability model ○ Sector-specific partner organizations • Purpose of the accountability model ○ Improving performance • Health-system arrangements that are the target of the accountability model ○ Accountability for service planning and delivery • Mechanisms used in the model to establish accountability ○ Formal mechanisms ▪ Legal instruments ▪ Economic instruments	• The review examines the link between provider financial risk bearing and physician-hospital integration • Provider financial risk bearing for care delivery has been one method of increasing accountability • Many countries have adopted processes which shift risk towards providers, resulting in greater accountability and the development of value-based purchasing • Accountability arrangements for the integration of primary and secondary care have typically taken the form of the establishment of legal entities or shared financial arrangements • Despite identifying nine studies, the review found that the studies failed to show the effects of risk shifting on the hospital-physician relationship Source	Published March 2015
Rapid reviews	•	•	
Protocols for reviews that are already underway	•	•	

Titles and questions for reviews being planned	•	•	
Single studies	• Focus of the accountability model (i.e., to whom is the model applied) ○ Local systems or networks of care • Purpose of the accountability model ○ Establishing legitimacy and/or trust • Mechanisms used in the model to establish accountability ○ Formal mechanisms	• The study reports on the development of the integrated-people centred health system standard, the methodology that went into its creation, the core content, and the lessons learned that may be applied to subsequent integrated care initiatives • The framework eventually developed into 10 key principles for integrated health systems ○ One of the principles notes the need to establish shared governance and clear accountability structure as well as ultimately formalizing accountability arrangements • Additional details are made available in the Health Standards Organization standard however these are not publicly available and require a fee to access Source	Published February 2022
	• Focus of the accountability model ○ Local-system entities ○ Sector-specific partner organizations ○ Teams of providers ○ Individual providers • Purpose of the accountability model ○ Improving performance (e.g., quadruple aim) • Health-system arrangements that are the target of the accountability model ○ Accountability for local-system governance ○ Accountability for financing, funding and remunerating ○ Accountability for service planning and delivery • Mechanisms used in the model to establish accountability ○ Formal mechanisms ▪ Legal instruments	• Using data from the national survey on ACOs, the study develops a taxonomy of ACOs, one element of which includes the accountability measures in place • The accountability measures include both performance management used internally with the ACO to ensure physician performance as well as payment/financial models in place between the ACO and CMMI ○ More recently these also include the development of accreditation criteria by the National Committee for Quality Assurance • It was found that there were a few different types of ACOs ○ The first was large ACOs, largely physician-led, that had the most experience with payment reforms but relatively less with performance management/ accountability mechanisms	Published December 2014

	▪ Economic instruments ▪ Information and education instruments	○ The second group was smaller ACO's that were also primarily physician-led and offering a relatively narrow scope of services, these were found to have little prior experience with payment reform and have a relatively high degree of internal performance management/accountability in place ○ The third group are of moderate size and offer a moderately broad scope of services and tend to be hospital-led, coalition-led, state/region/county-led, or some other arrangements and have some experience with payment reform but score relatively low on performance management/accountability • With respect to accountability mechanisms, it appears that physician-led ACOs report and share individual measures on quality and cost and use individual incentives and one-on-one feedback more than the other two types, however both hybrid led and IDS ACOs have more experience than physician-led ACOs with regard to patient-centred medical homes, pay for performance, public reporting on quality, and exposure to risk bearing contracts Source	
	• Focus of the accountability model ○ Local-system entities • Purpose of the accountability model ○ Improving performance ○ Aligning with underlying societal values • Health-system arrangements that are the target of the accountability model ○ Accountability for local-system governance ○ Accountability for financing, funding, and remunerating ○ Accountability for service planning and delivery	• Study provides an overview of the ACOs in the U.S. and charts parallel developments in Europe • ACOs assume financial responsibility and clinical accountability for the care they provide to a defined patient population, where their accountability extends beyond organizational boundaries • ACOs need to have a formal legal structure and capable governance to overcome fragmentation, reward providers for achieving quality and cost-benchmarks, and to foster cooperation • Structures also need to be in place to negotiate and manage new types of contracts, such as shared	Published October 2014

	○ Accountability for other system arrangements ● Mechanisms used in the model to establish accountability ○ Formal mechanisms ▪ Legal instruments ▪ Economic instruments	savings and/or bundled payment models with multiple payers ● To share in savings, ACOs must meet quality performance standards each performance year in four domains ● European countries are also adopting this approach, particularly in which coordinated care from a network of providers is reimbursed through bundled payments and/or shared savings this includes ○ Clinical Commissioning Groups in the U.K., which GPs are legally obliged to join and are intended to have a greater role in the purchasing of health services and meeting local health care needs ○ In Germany, integrated care has largely taken place through sickness funds and has aimed to cover only episodes of care, however more similar to the U.S. ACO model is <i>Gesundes Kinzigtal</i> which is a regional health management company with shared savings contracts with two sickness funds and which subcontracts integrated care in cooperation with the physician's network in the region Source	
	● Focus of the accountability model ○ Individual providers ● Purpose of the accountability model ○ Improving performance ● Health-system arrangements that are the target of the accountability model ○ Accountability for service planning and delivery ○ Accountability for other system arrangements ● Mechanisms used in the model to establish accountability	● The study describes the development of a collaborative cardiac surgery pilot which began working together to exchange information to improve the quality of surgical care and to contain costs ● Participation in the collaborative is voluntary, however it maintains the following functions: establishing clinical priorities; collective tracking of particular outcomes and improvement initiatives, periodic reporting, establishing documentation standards, and creating incentives	Published July 2009

	○ Informal mechanisms ● Factors enabling the accountability model ○ Provider-level factors	● Accountability is founded on effective communications, training, education, team development, interpretation of performance indicators and transmission of best practices Source	
Editorial	● Focus of the accountability model ○ Local-system entities ○ Sector-specific partner organizations ○ Teams of providers ○ Individual providers ● Purpose of the accountability model ○ Improving performance (e.g., quadruple aim) ● Health-system arrangements that are the target of the accountability model ○ Accountability for local-system governance ○ Accountability for financing, funding and remunerating ○ Accountability for service planning ● Mechanisms used in the model to establish accountability ○ Formal mechanisms ▪ Legal instruments ▪ Economic instruments ▪ Voluntary instruments ▪ Information and education instruments	● The study reviews the almost decade of experience that the Centre for Medicare and Medicaid Innovation has in testing approaches to holding various actors accountable ● The CMMI has a range of levers of which value-based payment has been a key piece but the study notes that an aligned array of financial and non-financial incentives that touch multiple actors can promote joint accountability ● The study outlines a framework that includes levers for accountability, the actors to hold accountable, and the outcomes ● The five levers include: payment (applying upside and downside financial risk thought retrospective and prospective payments); measurement (tracking performance on specific outcome metrics over time or cross-sectionally); public reporting (making data on performance public); accreditation (requiring certain behaviours or actions to be certified as safe and of sufficient quality); and regulation (applying standards through federal regulation) ● These levers are applied to health providers, health plans, geographies, suppliers, government agencies and to consumers differently ● For accountable care organizations, CMMI combines levers including financial incentives such as applying prospective payments for defined populations to increase predictability for providers, evidence-based payments which engage procedure-oriented specialties, incorporate accountability for equity and require community representation on	Published June 2021

		governing boards as a condition of participation, and finally use full or partial primary care capitation to promote coordinated, population-based care at the front lines • Accountability for geographic models incorporates capitation or partial capitation of primary care providers plus additional incentives for critical services like care coordination and prevention • An additional level that hasn't been used but which could be pulled is to make participation in models mandatory and to work to include and align payment arrangements across public and private payers • Further, one future area of interest is in regards to accountability for racial equity which include directly paying providers for performance on equity outcomes, requiring the collection and public reporting of data by race/ethnicity, and requiring participating entities to create plans to reduce documented inequities Source	
	• 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	• Common understanding of accountability is one in which a governing body is in a position to mandate providers or organizations to meet certain goals or objectives and because of the authority or legitimacy of those bodies • An accountability relationship can be based on dialogue and does not need to be reduced to the application of formal controls • Three elements of an accountability regime include: the clear definition of a desirable goal or objective, the ability to measure or monitor the goal, and the set of consequences if achievements are not met • Literature on accountability remains in its infancy because identifying the right targets and establishing	Published September 2014

		the right mechanisms to account for the utilization of healthcare resources is a complex task Source	
	• 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	• The editorial describes two components of an accountability level that are needed, the first is to establish clear clinical and system leadership that crosses organizations and providers, while the second is to enable those leaders by tying the funding that is provided to organizations and providers for clinical activity to the quality of that activity according to standards that have been set Source	Published December 2015
	• Focus of the accountability model ○ Local-system entities ○ Teams of providers ○ Individual providers • Purpose of the accountability model ○ Improving performance • Health-system arrangements that are the target of the accountability model ○ Accountability for service planning and delivery • Mechanisms used in the model to establish accountability ○ Informal mechanisms ○ Formal mechanisms ▪ Voluntary instruments ▪ Information and education instruments • Factors enabling the accountability model ○ System-level factors	• Study described the Mayo Clinic Arizona's comprehensive approach to improve service quality, which includes accountability for service quality • Changes to accountability have included the robust collections of data on quality and its comparability across health systems including through patient satisfaction surveys as well as the development of cultures of accountability • The MCA establishes accountability through: ○ Collecting service related metrics in a department-level scorecard that is shared with both senior executives and front-line staff ○ Action plans are requested from underperforming parts of the system as well as progress reports that examine whether the gap between actual performance and target are being reduced ○ Established an operations coordination group which has the mandate to review each departments operation activities and co-develops improvement plans for each year ○ Education and training to make these improvements are provided • Lessons learned from the development of this approach include:	Published September 2014

		○ Accountability measures must all be interconnected ○ Leadership from all levels is needed to set the tone and leaders must demonstrate a genuine commitment to service excellence, model desired behaviour and communicate performance expectations ○ Data transparency creates a sense of urgency and accountability ○ Adding specific timelines and standardized processes to accountability and reporting processes Source	
	● Focus of the accountability model ○ Local-system entities ● Purpose of the accountability model ○ Aligning with underlying societal values ● Health-system arrangements that are the target of the accountability model ○ Accountability for service planning and delivery ● Mechanisms used in the model to establish accountability ○ Informal mechanisms ● Factors enabling the accountability model ○ Model/design-level factors (e.g., data availability)	● Performance intelligence of integrated networks of care is an essential tool to govern integrated delivery systems and is defined in the study as “the structured approach to acting on health policies, using knowledge and information generated by the application of scientific methods to comparable healthcare data to systematically measure indicators of health system performance” ● The study examines the Krijtolen Alliance which is a network of health and social care providers, all of whom remain separate entities but have the combined focus of referring patients to the right care at the right time ● Information is not readily available across the health and social care boundaries and quality and financial accountability remain organizationally based, however the alliance has been moving towards a more coordinated network with a focus on the population as a whole by pooling some finances of its members to organize multidisciplinary case managers and introduce select shared performance monitoring ● Participants in the study reported a need for insights into the efficacy and efficiency of	Published May 2021

		implemented multi-provider interventions both to generate a learning curve on the interventions but also to ensure accountability with financiers and patients • The study notes that the siloed data collection mirrors the siloed accountability and that governing to incentivize the triple aim requires an integrated data infrastructure that aligns with the governing structure • One solution to this could be the development of a performance intelligence dashboard as the existing information lacks actionability for the governance of integrated care networks • Two suggested measures include the per capita and per patient cost data integration that would allow combined accountability through aligning financial incentives to facilitate integrated care of financing and combined patient experience and outcome measures to reflect network quality of care and patient experience performance Source	
	• Focus of the accountability model ○ Local-system entities ○ Sector-specific partner organizations • Purpose of the accountability model ○ Improving performance • Health-system arrangements that are the target of the accountability model ○ Accountability for local-system governance ○ Accountability for service planning and delivery • Mechanisms used in the model to establish accountability ○ Voluntary instruments ○ Information and education • Factors enabling the accountability model	• The Swedish government has established Coordinated Elder Care which aims to create better forms of management and coordination for older adults through the implementation of quality records and the establishment of coordination bodies between municipalities, counties and representatives for private care providers • The study uses a theoretical framework on accountability issues in network governance to analyze the results of the Coordinated Elder Care initiative and present conclusions and policy implications for moving forward • The study defines governance networks as “a relatively stable horizontal articulation of interdependent but operationally autonomous	Published July 2019

	○ System-level factors ○ Organization-level factors	actors who interact through negotiations which take place within a regulative, normative, cognitive and imaginary framework that is self-regulating within limits set by external agencies and which contributes to the production of public purpose • Three dimensions of accountability of a governance network include inclusion (i.e., defining who is included within the accountability model), publicity (i.e., ensuring there is enough information available to hold the network to account) and responsiveness • The survey which was issued to the coordinating bodies found that the most important task was to discuss and solve problems occurring in the local coordinated care system and maintain an eye over quality reports • Coordinating bodies relied most heavily on joint written reports to judge how the health and social service organizations were performing • Managers of social services followed by managers of health organizations were seen to be the key reviewers of the coordinating body, with municipal representatives, county representatives and organizational managers perceiving themselves to have a strong mandate to enforce accountability • The study notes that the limited presence of external scrutiny and the presence of some uncertainty regarding who should be held responsible indicates the need for a more fulsome public debate on who actually holds responsibility for the care and services Source	
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	• Focus of the accountability model ○ Sector-specific partner organizations • Purpose of the accountability model ○ Improving performance • Health-system arrangements that are the target of the accountability model ○ Accountability for service planning and delivery • Mechanisms used in the model to establish accountability ○ Informal mechanisms • Factors enabling the accountability model ○ Provider level factors	• Case study focused the West-Friesland region in the Netherlands where there has been a proactive care model implemented among general practitioners, comprehensive case-management for people with dementia and their caregivers, and social community teams where municipalities collaborate with home care and social care organizations to delivery aid and social support • The case study focuses on documenting the improvement process and factors influencing it • Two improvement activities were undertaken ○ Intervision meetings which peer supervision and methodical discussions help participants to reflect on their personal and professional development and were aimed to stimulate reflection on their professional habits in relation to the older people they cared for ○ Second activity was workplace visits, whereby other professionals visited and shadowed each other during relevant parts of the day • These meetings were found to result in more understanding and trust, making it easier to collaborate further additional facilitators were found to be the motivation, commitment and multidisciplinary background of professionals participating in the improvement activities • Barriers to the success of the improvement activities were the lack of shared accountability across the collaborative partners, and indicated that they didn't feel ownership over the change process or their own tasks or responsibilities Source	Published March 2020
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	• Focus of the accountability model ○ Local-system entities • Purpose of the accountability model ○ Improving performance • Health-system arrangements that are the target of the accountability model ○ Accountability for financing, funding and delivery ○ Accountability for service planning and delivery • Mechanisms used in the model to establish accountability ○ Legal instruments ○ Economic instruments ○ Information and education instruments • Factors enabling the accountability model ○ System-level factors ○ Model/design-level factors	• Case study of the provision of six round 1 state innovation model awards to test how regulatory, policy, purchasing and other levers available to state governments could transform their health systems towards value-based payment and better align state systems with multipayers • States were given between 25 and 45 million dollars • The funding opportunity announcement required states to propose: ○ new payment and service delivery models ○ use of policy, regulatory, or legislative authorities to delivery broad-based accountability for high value outcomes and include multi-payer alignment ○ transition a preponderance of providers into a value-based clinical and business model increasing provider accountability for patient outcomes • States sought to increase participation in these models by financially supporting health IT, data analytics, technical assistance and workforce development • States used the funds to design or enhance ACO-type models with one-sided risk, while two groups created two-sided risk, while a bundled payment model with retrospective calculation of shared savings and losses • States also focused on establishing health IT and data analytics which were seen as critical elements to enable the value-based payment design • Finally, some funds were used to convene stakeholders for the purposes of encouraging voluntary collaboration, participating in the initiatives' governance, or soliciting advisory guidance	Published June 2019
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		• Factors that contributed to state's progress in multipayer alignment on value-based payment models include: preexisting experience and capacity with payment models supported by multiple payers; the use of state law to compel participation in the initiative (for those receiving Medicaid funds) • The initiative helped state to increase state and provider accountability for patient outcomes by expanding value-based payment model participation and by growing the degree of risk offered to providers under that model • All states used flexibility within the payment model design and new data availability to attract new providers, this included choice in the level of financial risk and in the quality measures for which they were held accountable for • Further, they were supported by investments in data analytics resources such as feedback reports to providers and grants or technical assistance to help providers use data • In one of the states, participation in the model was created through engagement between the government and those expected to participate in the model Source	
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	• Focus of the accountability model ○ Sector-specific partner organizations • Purpose of the accountability model ○ Improving performance • Health-system arrangements that are the target of the accountability model ○ Accountability for service planning and delivery • Mechanisms used in the model to establish accountability ○ Informal mechanisms • Factors enabling the accountability model ○ System-level factors ○ Model/design-level factors	• Multiple case study to understand the role coordination mechanisms play in how primary care medical homes can accomplish coordination in their medical neighbourhoods • The study identified four mechanisms that are used within networks to build ‘medical neighbourhoods’ including interorganizational routines, information connectivity, boundary spanners and communication, negotiation and decision mechanisms • Other mechanisms include incentive systems, control systems (e.g., norms and reputation) and selection systems such as hiring people with collaborative competencies • Organization must search for partners and reach agreements about how they will perform their joint work and repeated interactions can reduce transaction costs by promoting trust and reinforcing a sense of obligation towards one another • A care compact is used to articulate this agreement and make explicit the mutual responsibilities for communicating and coordinating shared patient care as well as addressing areas such as the roles of different providers for different types of referrals, information, access for routine versus priority referrals and how secondary referrals will be handled • Accountability measures were implemented for the compact by measuring and communicating specialist performance including report cards, patient surveys of specialist care and real-time feedback • In general, primary care medical homes used different coordinating mechanisms for different tasks and facilitators were found to include a supportive policy environment including payment	
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		models that promote shared accountability, interoperable information systems and incentives to facilitate the shift from independent to interdependent roles Source	
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