Achieving Accountability

Sarah Kramer, Rachel Solomon and Chris Dingman

Introduction

The word and concept of "accountability" is used broadly and frequently in healthcare – often seen as the key to success change initiatives. But what accountability means and how it is applied can vary significantly. Policy-makers, managers, researchers and healthcare providers use the term in relation to everything from the quality of our relationships with and expectations of one another, to our requirements for more transparency in how resources are used, to our diagnosis of problems and remedies for improving the healthcare system (Brown et al. 2006.)

For the purposes of the Wait Time Information System (WTIS) project, achieving accountability meant responsibility for not only deploying the WTIS, but evolving the system and using its data to reduce wait times and improve access to care. Success would mean shifting from a healthcare environment where few individuals were accountable for achieving a core set of results, to an environment where multiple levels and types of individuals would be accountable for achieving a wide range of results (Trypuc et al. 2007). That meant overcoming loyalties to existing systems and convincing many skeptics that the urgency with which the WTIS would be deployed was indeed real, and that data from the system could and would be meaningful in measuring and monitoring performance.

Although accountability is highly desirable, achieving it can be somewhat elusive, as solutions need to be customized to suite all the unique individuals and organizations involved. Success also requires overcoming the fear associated with accountability in healthcare, where who is accountable has also come to mean who will be blamed or penalized if things go wrong. (Harber and Ball 2003.)

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With the mandate to develop and deploy the WTIS on behalf of the Ministry of Health and Long-Term Care (MOHLTC), Cancer Care Ontario (CCO) set out to change this unconstructive view and establish a culture of accountability based on support, trust and collaboration. On a philosophical level it is easy to understand the importance of providing support, building trust and establishing collaboration. On a practical level these notions can be challenging to carry out.

CCO's approach, guided by the overall Wait Time Strategy, ensured the following were met:

- accountability was aligned at all levels;
- participants clearly understood their specific accountabilities; and
- participants were equipped to deliver on their accountabilities.

This article shares the approach and steps CCO took to achieve accountability for the WTIS project. The information will be of interest to healthcare policy makers, thought leaders and decision-makers working to deliver and sustain significant change within a healthcare environment.

Ensuring Accountability is Aligned at All Levels

Though a provincial initiative, an important element of the WTIS project was that it was led from the field, not by government. The massive and far-reaching undertaking meant that individuals at all levels and across all parts of the healthcare system would need to work together toward the same, clearly defined goals. To ensure this program worked, a new governance model was instituted and clear lines of accountability established at varying levels.

Backed by Premier Dalton McGuinty, support was first garnered within the MOHLTC, the largest ministry in Ontario's public sector, to create one of the most streamlined governance frameworks to be used for a provincial project. Leadership and the ultimate point of accountability for the WTIS project rested with CCO under its former Chief Information Officer, Sarah Kramer, Lead of the Wait Time Information Strategy. The framework was designed in a way that would allow decisions to be made in a timely manner and consistent with the strategic goals. The Wait Time Information Strategy Lead relied heavily on the WTIS Project Steering Committee and Clinical Expert Panels to ensure decisions made both clinical and business sense.

The governance model (outlined in Figure 1) allowed the WTIS project to maintain close working relationships with each of the various stakeholder groups – clinicians, hospitals, the newly established Local Health Integration Networks (LHINs), and the MOHLTC – as well as e-Health partners such as Canada Health Infoway, the Cardiac Care Network of Ontario, Smart Systems for Health Agency (now part of e-Health Ontario), the Canadian Institute for Health Informatics and the Institute for Clinical Evaluative Sciences. By drawing on a wide range of expertise, the project team was able to resolve issues efficiently, sometimes within hours, to keep disruptions to a minimum, and to establish the WTIS as a priority healthcare project.

With the governance structure in place, clear lines of accountability were established at multiple levels of the health system (Figure 1). This underscored the immensity of the project, but also showed stakeholders that they were part of a bigger picture and established a commitment to work together to achieve the challenging yet attainable goals. Perhaps more importantly, clear and multiple lines of accountability, culminating at an ultimate point, helped to reassure stakeholders that they would not be alone in the risks they assumed and would be supported in the efforts they undertook.

The WTIS team solicited input from across the health system at the onset of the project and throughout the initiative. This provided the opportunity for all stakeholders shaping and refining the overall strategy, as well as in the development and deployment of the WTIS. As an example, though LHINs had just been newly established and were still defining their mandates, their representation on the project's Steering Committee became a win–win situation – the project team was able to get valuable support and insight from the regions, and LHINs were able to align the requirements of the provincial initiative to regional efforts and long-term objectives. Early and regular input from stakeholders also allowed the project to benefit through a cycle of continuous improvement over its duration.

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Another important component of achieving accountability was transparency of the process and of the results. The government's commitment to publicly report wait time results established expectations from the healthcare system at a provincial level and helped focus efforts to improve performance. Open reporting of wait time data meant that service comparisons could now be made across LHINs and hospitals, highlighting regional and local trends. In some cases, this transparency in reporting spurred healthy competition and a greater sense of accountability among LHINs and hospitals to drive improvements.

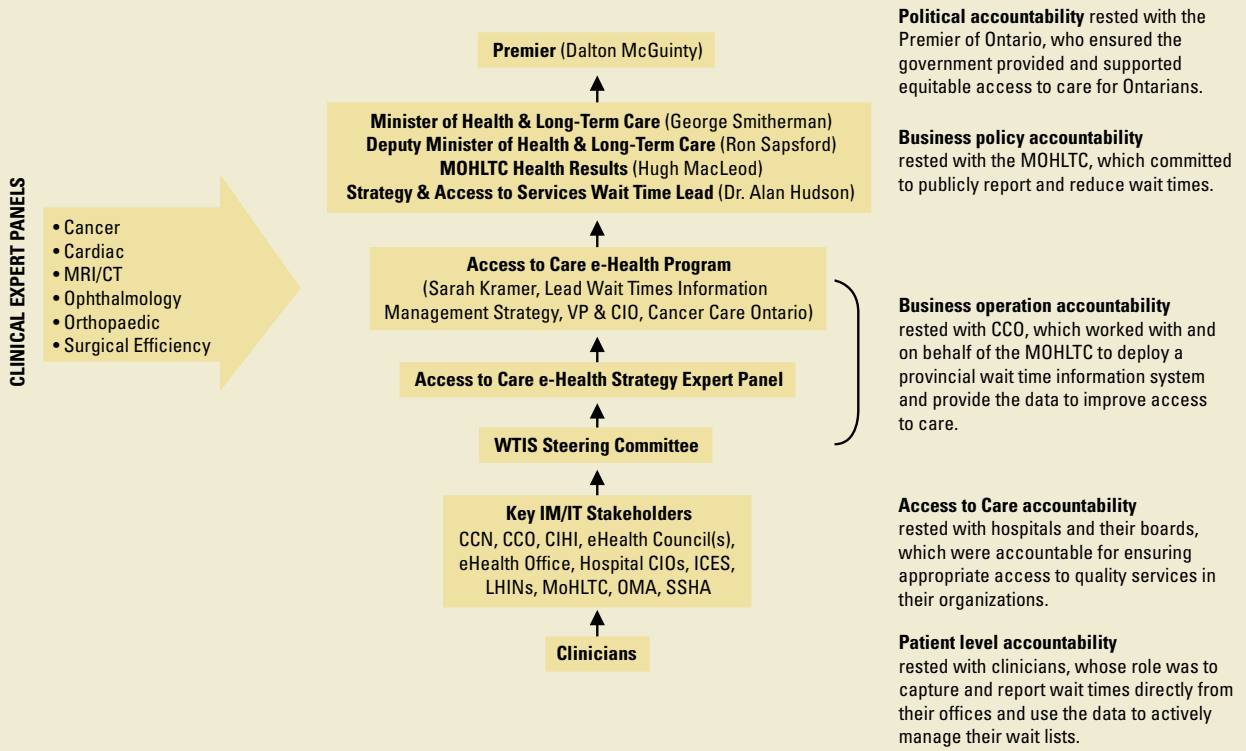
Making Sure Participants Understand Their Accountabilities

Along with a strong governance and support network, the burden of accountability should always go hand-in-hand with clear goals and objectives. Individuals and groups should know definitively what specifically they are accountable for.

By establishing a clear value proposition, the question on everyone's mind – "What's in it for me?" – was answered. It was particularly important that the value proposition be clear and repeated not only by those working on the WTIS project, but also across the strategy and the broader MOHLTC.

Under Ontario's Wait Time Strategy (Trypuc et al, 2007) objectives were clearly articulated, as was who was accountable

Figure 1. Governance structure and levels of accountability for Ontario's Wait Time Strategy and WTIS project (as of Jun. 2007)



for achieving them, and the results it was striving for. Working against notions that government strategies are often developed and rarely effectively applied, the strategy was widely disseminated, made available to the public and used guidance from industry experts to refine it along the way. The commitment was clear. The accountability to fulfill it was set.

Up until this point, it had been unclear where within the health system accountability for managing quality access to care, or specifically how long a patient waits for care, lay. The new governance model introduced for the Wait Time Strategy put this charge to the hospital CEO and board chair, making these individuals accountable for managing access and wait times in their organization (Trypuc et al., 2007). This was enforced through Hospital Accountability Agreements, which outlined accompanying requirements, including conditions for wait time funding and expectations for WTIS deployment and clinical adoption. A nested hierarchy of accountability agreements from the ministry, to the hospital CEO, to hospital operating units, instilled commitment at all levels of the industry to strive toward shared goals.

Hospital accountabilities and the accompanying processes they needed to adhere to were clearly documented. Hospitals had access to the WTIS project team and received frequent communications, as well as opportunities to seek clarification through regular teleconference sessions. Hospital coordinators and clinical leaders working with the project team were accountable for disseminating WTIS-related information to the field. A highly orchestrated communications program ensured information was coordinated and consistent, no matter who was delivering the message, thus helping to minimize misinterpretation or misinformation while reinforcing accountability.

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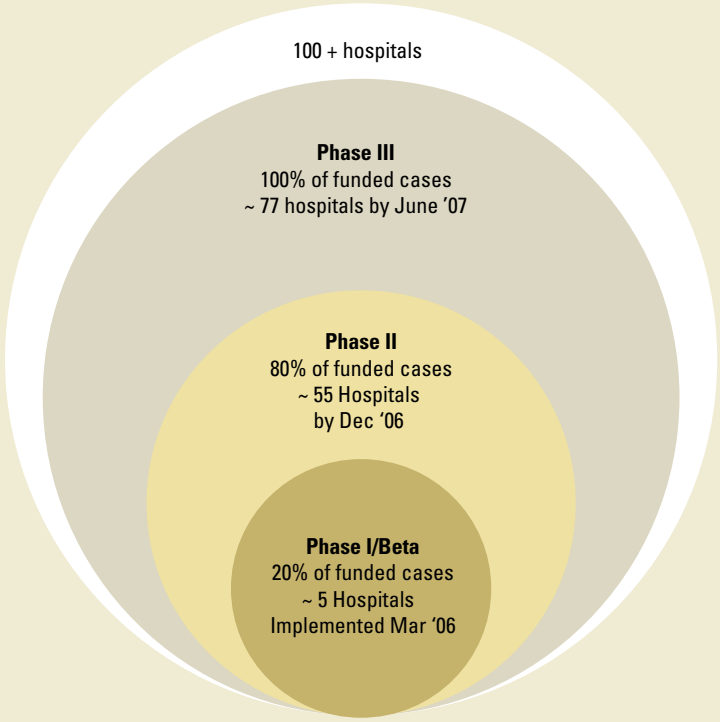
Through the Wait Time Strategy, the government established clear objectives and expectations for the WTIS project, beginning with a commitment to publicly report wait time data collected through the system. By posting wait time results on the provincial website, the government was also being held to account for improvements in access to care by the citizens

of Ontario. The initial objectives (outlined in Figure 2) were specific to five priority areas of care: cancer surgery, cardiac procedures, cataract surgery, hip and knee replacement surgery and MRI and CT scans.

At the execution level, deployment of the WTIS relied heavily on the efforts of hospitals, which were accountable for meeting numerous project milestones in the midst of a number of other initiatives already underway. Input from the field, channeled through the WTIS Project Steering Committee, was factored into deployment planning and, to a certain extent, timing, so that hospital activities and resources could be coordinated. Although timelines remained aggressive, these early consultations allowed the WTIS project team to establish clear expectations and milestones from the start. Hospitals were provided guidance on anticipated work efforts so that they could align resources early, along with tools to help them keep an eye on upcoming activities and track their progress. These processes and tools are further discussed in the article "Taking It to the Streets: Delivering on Deployment," page 30.

Figure 2. Objectives for Phases I, II and III of the WTIS project



Individual clinicians also had accountabilities in the deployment of the WTIS. Clinicians, who had so far been maintaining individual wait lists, were now required to centrally report wait time data from their offices, and do so within two business days. As relationships and work processes between hospitals and clinicians vary, significant effort was required on the part of hospitals to ensure clinicians understood and were able to fulfill their responsibilities. The WTIS project team ensured hospital teams were fully supported in anticipation of the challenges they would face in getting clinicians engaged. Along with extensive customizable communications materials, hospitals found the opportunity to draw on the advice and support of clinician champions and clinical leaders within their organization particularly helpful in helping clinicians understand the implications and anticipated benefits of the WTIS.

Ensuring Participants Are Equipped to Deliver on their Accountability

Not only must individuals understand what is expected of them and why, they must also be willing and have the ability (resources, conditions and skills) to achieve the outcomes for which they are being held accountable.

As is the case for all successful initiatives, leadership plays a critical role in actively supporting participants as they strive to fulfill their accountabilities. Leadership support came from all levels, including the Premier, who raised the project's profile with healthcare providers and demonstrated a willingness to accept risk, proving that the government was serious about making a change. This example of leadership that "walked the talk" filtered down throughout the project structure. The Access to Services and Wait Times Lead and the Wait Time Information Strategy Lead, along with many other healthcare leaders, rose to the challenge by participating in expert panels and steering committees guiding the project. Leadership support was demonstrated in many forms – through executives and clinical leaders participating in hospital meetings to endorse the project, provision of resources such as computers to clinician offices and in ongoing input. In many ways, this role modelling on the part of leadership resulted in LHINs, hospitals and clinicians increasingly working together to share knowledge, and in some cases, resources, to support one another.

With the accountability to improve access to care and reduce waits, hospitals participating in the WTIS project received financial support from the MOHLTC to fund more operating room time so that more surgeries could be performed. This government investment resulted in unprecedented increases to surgical capacity for selected services. As mentioned previously, Accountability Agreements made with hospitals required strict

Lessons Learned

1. **Clearly define objectives and outcomes** – Individuals cannot be expected to be accountable if they do not know or understand what exactly it is they need to achieve.
2. **Establish a clear and streamlined accountability structure** – Well-rounded business and clinical input is important and must be solicited to guide the development and deployment process, but accountability for the final decisions and answers should rest with one designated leader.
3. **Use leaders as role models** – Leaders must be willing to set an example for others and be clear on all participant roles and responsibilities.
4. **Communicate regularly and consistently** – Do not assume people remember, understand or accept their accountabilities after hearing it once. Provide plenty of opportunities for repeating messages and for people to seek clarification through various channels and project champions.
5. **Identify the value proposition for all participants** – Accountability cannot be achieved through a one-size-fits-all approach; needs and challenges will vary by stakeholder.
6. **Ensure individuals have some control over their accountabilities** – To take on accountability, individuals must have the flexibility to make adjustments to their unique circumstances and be given opportunities to use personal judgment and discretion, with strategic guidance provided.
7. **Enable individuals and organizations to be accountable** – Provide appropriate levels of support but balance central control with local ownership for activities.
8. **Be open to feedback and changes** – Regularly ask for feedback, and have processes in place to refine accountabilities as situations change and needs arise. Most importantly, act on the feedback provided.
9. **Follow through on commitments with fair repercussions** – Accountability cannot be enforced if there are too many exceptions to the rule.

funding conditions to be met, including reporting wait time data through the WTIS and ensuring that incremental cases performed for the five priority wait time service areas would not be at the expense of other non-priority areas.

Hospitals were also accountable for preparing their organizations for the implementation of the WTIS. Large-scale initiatives have been known to take a one-size-fits-all approach, unintentionally undermining local engagement. With 80+ participating hospitals, the WTIS project team let local expertise drive problem-solving and preparation for deployment at the hospital level. Hospital teams were given access to Steering Committee members and Clinical Expert Panel chairs so that local needs could be factored into deployment strategy and approach, and assigned single points of contact on the WTIS project team to provide dedicated support and assistance. This allowed the local level to apply a home-grown methodology for the provincial initiative, which became critical to the success of the overall deployment. Specific details on how hospitals were supported can be found in the "Taking It to the Streets: Delivering on Deployment" on page 30.

Clinicians were accountable for providing the necessary patient information to hospitals so that surgeries could be booked appropriately, wait times tracked and potential problems addressed. They were required to use wait list data to better manage their wait lists. This was an entirely new way of working for clinicians who were concerned about losing autonomy over their private operations. Through the WTIS project, clinicians were provided much support to prepare for the deployment and use of the WTIS and reports. For those who needed it, hospitals made the investment in computer equipment and Internet connections in clinician offices so that the web-based application could be directly accessed. All clinicians received training on the use of the system and, importantly, how the data could be used to make the case for more OR time for their patients. And, they were supplied with the necessary tools to support standardized prioritization of patients and accurate data entry.

Despite best efforts, some hospitals were initially unable to meet all conditions of wait time funding, sometimes due to a disconnect with clinicians or difficulty in enforcing wait time reporting requirements. In later phases of the project, anticipating this resistance, some hospitals instituted their own policies that required clinicians to report wait time data in the WTIS before they were granted access to operating room time.

Along with accepting accountability, individuals must be prepared to face the consequences of not meeting commitments. At the same time, these consequences must be fair and appropriate. Hospitals faced the real possibility of having wait time funding reclaimed by the MOHLTC if conditions set out in the Hospital Accountability Agreements were not met. As well, hospitals who did not submit wait time data according to requirements were informed that they would be noted on the Wait Times website as "non-compliant", creating negative perceptions in their local communities. All stakeholders were advised of these potential ramifications before hospitals signed their accountability agreements, ensuring they were understood by everyone. Early on, there was some skepticism about whether consequences would be enforced; however, the seriousness of the accountability model became clear through repeated messages and as consequences indeed ensued for hospitals that failed to meet their commitments.

Identifying and Addressing Obstacles

Effectively supporting stakeholders in achieving accountabilities also means removing obstacles standing in the way of progress. Privacy of personal health information that would be collected and disclosed through the WTIS, as an example, was a particular concern raised by all levels of healthcare. The project team took steps to complete a privacy impact assessment and developed a comprehensive strategy and independent governance framework to address and mitigate these concerns. CCO also liaised with the Information and Privacy Commissioner for Ontario to ensure the assessment results and the privacy governance structure aligned with provincial privacy best practices.

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Once a project is implemented, the initial momentum and motivation can dissipate quickly. To ensure new behaviours and results are sustainable, participants must have some control over what their accountabilities are and how they achieve them thereby by creating a culture of reinforcement and enforcement. Comparative reporting used throughout the WTIS project phase continues today in day-to-day operations. Monthly public reporting of wait time results via the provincial website and hospital compliance reporting on funding conditions keep the spotlight on performance management and stakeholder accountabilities in reducing wait times. As clinicians, hospitals, LHINs and the government compare and monitor their progress, new levels of collaboration and best practice sharing are taking place and continuing to drive the initiative forward. Hospital Accountability Agreements are being updated annually to reflect the expanding use of the WTIS and data, with more sophisticated criteria and parameters to incent continuous improvement.

Conclusion

Much has changed since Ontario's Wait Time Strategy and the WTIS was launched. Today hospital CEOs are using information collected through the system to manage access to care, waits for services, and patient flow within their organizations. Clinicians are providing the necessary patient information to hospitals so that surgeries can be booked, wait times tracked and potential problems addressed. Hospitals are being regularly audited to determine whether they are meeting the terms of their accountability agreements. With few exceptions, hospitals are fulfilling funding conditions, which continue to evolve to include more performance and efficiency factors.

The accountability model used by the WTIS project now serves as a benchmark to which other provincial initiatives are compared. Adjustments to the model will continue to be required to ensure accountabilities are sustained as the healthcare landscape changes, particularly in relation to the evolving role of the LHINs. It is anticipated that more government healthcare initiatives will follow a similar philosophy of accountability based on collaboration, trust and support so that accountability is welcomed and becomes the new norm within healthcare.

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About the Authors

Sarah Kramer is President and CEO of eHealth Ontario. Previously Sarah served as the Vice-President and Chief Information Officer with Cancer Care Ontario, as well as the Lead for the Ontario's Wait Time Information Management Strategy.

Rachel Solomon is a Director at the Toronto Central Local Health Integration Network. Previously, she was the Project Manager for the Ontario Wait Time Strategy from 2004 through 2006.

Chris Dingman is a consultant specializing in leading and advising on complex transformation programs in health care, financial services and the public sector. As Project Director, she led the successful development and implementation of the WTIS and Enterprise Master Patient Index projects.