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Ontario Node Case Study Final Report

The Role of Leadership in the Development of Family Health Teams and Nurse Practitioner Led Clinics in Ontario

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Table of Contents

1.0 Executive Summary

In Ontario, the provincial government introduced two new primary care innovations to renew the primary care sector. In 2004, the Family Health Teams were instigated in the province to improve access and to promote the health and wellness of communities. In 2008, Nurse Practitioner Led Clinics were introduced to reduce the number of people without a primary care provider and to improve comprehensiveness and integration of care.

To date, several evaluations are underway across the country to examine how newly introduced primary care models impact outcomes. However, these evaluations and frameworks have not yet comprehensively addressed the systematic and organizational processes that facilitate the implementation of primary care models and how these opportunities can translate into better results. In Ontario, new primary care models have created new expectations and new levels of performance for primary care leaders, both at the systematic (provincial) and organizational (local) level. The objective of this study was to examine the roles, actions, and leadership capabilities of provincial and local leaders in the creation, implementation and sustainment of Family Health Teams and Nurse Practitioner Led Clinics as well as the contextual factors that shaped or impeded the ability of these leaders to create, implement, and sustain primary care innovation over time.

This research study involved two research cycles. The first research cycle focused on the role of provincial and local leaders in the creation and implementation of Family Health Teams and Nurse Practitioner Led Clinics. The method that was used to collect data for this phase of research included: 1) Review of the literature; 2) Semi-structured interviews with policymakers, stakeholders and experts involved in creating policy and influencing the environment where primary care organizations emerged; 3) Case selection of three high performing Family Health Teams and one Nurse Practitioner Led Clinic in which semi-structured interviews were conducted with internal and external members for each case site. In total, 16 interviews were completed with provincial decision-makers and 44 interviews were completed with local members of Family Health Teams and the Nurse Practitioner Led Clinic. The second research cycle focused on changes within these organizations over time and the roles and actions of local leaders in these changes. During this phase, eight interviews were held with the same local leaders.

The findings of the first research cycle indicate that the impetus for creating the Family Health Team model was influenced by leadership at both the systematic and organizational level. At the systematic level, the provincial government created a model that was voluntary, lucrative and attractive. At the organizational level, there was substantial demand by clinical leaders for a lucrative model that also allowed for facilitation of change within their community. The experience was different for the Nurse Practitioner Led Model, which was driven by front line nurse practitioners with support from key decision makers and stakeholders.

At the systematic level, the Ontario Minister of Health and Long Term Care and a physician champion played an important role in the development of the vision for the Family Health Team model whereas the leadership of the Ontario College of Family Physicians played a role in supporting its implementation. The development of the Nurse Practitioner Led Model was driven primarily by local nurse practitioners in Sudbury. The leadership of the Registered Nurses' Association of Ontario played an instrumental role in the expansion of the model and the Nurse Practitioners' Association of Ontario played an important role during its implementation. At the organizational level, the desire to create a Family Health Team and Nurse Practitioner Led Clinic was motivated by the vision of physician and nurse leaders who engaged and convinced other team members to participate in the model. During implementation, administrative leaders were instrumental to the management of implementation activities. In all four case sites, leadership was distributed throughout the organization and exercised by different individuals at varying levels. At systematic level, creation of incremental group models, strong vision of provincial leaders, investment of substantial financial resources, employment of physician champions, and creation of a voluntary application process were key enablers for the creation and implementation of Family Health Teams. Challenges included resistance from the provincial professional organization for physicians. For the Nurse Practitioner Led Clinics, funding from the provincial government, perceived access crisis in Sudbury, leadership of two local nurse leaders, crucial support from provincial leaders, and the role of the media enabled the creation of Nurse Practitioner Led Clinics. Challenges included professional interest groups and government bureaucracy. At the organizational level, dedicated leadership from the clinical and administrative leaders and the establishment of a collaborative and complementary relationship between them were essential for the implementation of all primary care organizations. In all four case sites, the

most significant challenges were the lack of government support for organizational development activities and contract negotiations. The Nurse Practitioner Led Clinic faced the additional challenge of negative public campaigns by the provincial professional organization for physicians.

In all four case sites, the leadership capacities and practices of leaders in Ontario at both the systematic and organizational level were consistent with the elements of the LEADS framework. The framework can be augmented by inclusion of following qualities: respect, credibility, approachability, commitment, perseverance, trustworthiness, creation of an environment of transparency, and advocating and mentoring team members.

In the second research cycle, the most common change in all four primary care organizations was the development of the government mandated quality improvement plans. In the Family Health Teams, the most significant change consuming the time of physician leaders and executive directors was the implementation of the Health Links initiative in their respective Local Health Integration Network. In the Nurse Practitioner Led Clinic, a major initiative underway was the development of a board quality improvement committee. Leaders identified the following challenges to the sustainment of change: recruitment and retention of non-physician professional health care providers; adequate government funding; obtaining buy-in of physicians; succession planning; insufficient resources for quality improvement initiatives; and cultural and turf issues.

Strategies for effective development and sustainment of performance for primary care organizations include: building a collaborative relationship between the administrative and clinical leaders; establishing a balance of administration in the organization that is capable of managing the organization without stifling innovation; continuous engagement of all staff members; providing team members with the autonomy to be innovative and creating a culture in which “we learn from our mistakes”; and developing strong partnerships with other primary care and community organizations.

Strategies to build more leadership in the primary care sector include: financial rewards to primary care organizations that are leaders and can demonstrate high performance; governance training for board members; funding leadership and organizational development through in-

person peer to peer mentoring and formal education of physician leaders and executive directors; and funding organizations to support mentorship, professional development and training for staff at the ground level.

2.0 Research Cycle 1

2.1 Introduction and Context

The PHSI (Partnership for Health System Improvement) Leadership project is an initiative aimed at informing the development of leadership capacity in the Canadian health system through applied research and knowledge translation. Specific objectives for the project include creating an evidence-base of the qualities that leaders use to address critical health challenges successfully; translating existing and new knowledge of effective leadership in different organizational contexts into improved leadership development approaches; exploring effective means to develop and sustain leaders at all stages of their career; and developing national standards for leadership.

The goal of the Ontario node research study is to examine leadership dynamics in the context of primary care reform efforts in Ontario. More specifically, the case study examines the roles and actions of provincial and local leaders in the creation and implementation of Family Health Teams (FHTs) and Nurse Practitioner Led Clinics (NPLCs) in Ontario in the early 2000s. FHTs and NPLCs are primary care reform models that consist of inter-professional teams of primary care providers that deliver a comprehensive array of services to patients. The key difference between the FHT and NPLC models is that the NPLC model shifts the focus from family physicians as the primary contact for patients within the health care system to nurse practitioners. In this model, nurse practitioners exercise leadership at all levels of the organization (e.g., governance, clinical practice and day-to-day operations).

This study will also compare the emergence and development of the FHT model in Ontario with the FMG (Family Medicine Group) model in Quebec. The comparative analysis will examine the role of leadership in high-performing FHTs and FMGs in the context of the broader policy environment that helped to create these primary care models.

In examining the leadership dynamics that facilitated the creation and implementation of FHTs and NPLCs at the provincial and local level and to compare FHTs to FMGs, this study will align with the Quebec case study in addressing the following research questions:

1. Where did this impetus for change come from, internal or external? Bottom up versus top down?
2. What external and internal factors influenced leadership across and between levels of the health system in order to achieve sustained, meaningful change?
3. Who was effective in exercising leadership in support of change, and what roles did they play, and what did they do?
4. What leadership capabilities do leaders need in order to initiate and implement change?
5. How does leadership at different contextual levels of the health system affect change?
6. What learning opportunities will maximize the potential of leaders in the Canadian health system to sustain long-term health system transformation?

The first cycle of this research involved the completion of a literature review and key informant interviews with provincial leaders (e.g., decision-makers, experts) and local leaders (e.g., clinicians, executives and administrative staff). To date, the research team has collected and analyzed data for interviews with provincial leaders and local leaders in three high-performing FHTs and one NPLC.

A participatory action research (PAR) approach was used for this study and has been embedded in the research. A variety of decision-makers from the Ontario government have been involved in this study. These decision-makers have assisted with identifying the individuals that were involved in the creation and implementation of FHTs and NPLCs. They have also participated in key informant interviews and nominated high performing FHTs and NPLCs in Ontario.
At the completion of the first cycle of interviews with FHT and NPLC leaders, a summary of key findings was distributed to study participants. The goal of this knowledge transfer was to offer provincial and local leaders an analysis of the factors that serve as facilitators or impediments to change; the roles and actions of leaders in system transformation; and lessons learned in this change effort. This process also provided the research team with an opportunity to obtain feedback from participants in preparation for the second cycle of interviews. The second cycle of

this research study consisted of follow-up interviews with some of the participants in the original high-performing FHTs and NPLCs to assess issues identified in the first cycle, the roles and activities of leaders in addressing these issues, and the strategies for moving forward. A final report summarizing the finding of both cycles will be disseminated to all participants.

3.0 The Role of Leadership in the Development of Family Health Teams and Nurse Practitioner Led Clinics in Ontario

3.1 Background

High-performing primary care is widely recognized as the building block of an effective and efficient health care system (Aggarwal & Hutchison 2012). Countries with a strong primary care sector achieve superior health outcomes at lower cost. Since the late 1990s, there has been some, albeit slow, progress in various Canadian provinces and territories in creating new models of primary care that include multi-disciplinary teams, alternative payment regimes, implementation of information technology and quality improvement initiatives to improve access and outcomes (Aggarwal & Hutchison, 2012).

In Ontario, primary care reform is not a new phenomenon. The history of reform efforts is well documented (Aggarwal, 2009). Since the mid-1990s, the Ontario government has introduced a series of primary care reform models that focused on shifting family physicians from a solo practice fee-for-service model of care to a model that is based on a group model of blended payment. This history includes the introduction of a variety of new care models, including Primary Care Networks (PCNs), Family Health Networks (FHNs), Family Health Groups (FHGs), Comprehensive Care Models (CCM), Rural and Northern Physician Group Agreement (RNPGA), Family Health Teams, Family Health Organizations (FHOs) and Nurse Practitioner Led Clinics.

The Ontario Liberal Government of Dalton McGuinty introduced the FHT model and in December of 2004, the Ontario Minister of Health announced the creation of 150 FHTs for 2.5 million Ontarians by 2007–2008 (Aggarwal, 2009). The primary objectives of the FHT model were to improve access to primary health care through the implementation of interdisciplinary

teams and to promote the health and wellness of the communities that they serve. In February of 2008, the Ontario Premier and Minister of Health announced the implementation of 25 NPLCs. The primary objectives of the NPLCs were to reduce the number of people without a primary care provider and to improve comprehensiveness and integration of care (PRA Inc., 2009). In parallel developments in Quebec, the FMG model has been introduced to create a more responsive and accessible primary care system. It is a group-based primary care model in which a variety of providers deliver a comprehensive array of services to patients.

As of August 2011, there were 200 FHTs with 2,000 physicians and over 1,500 inter-professional health care providers serving 2.5 million enrolled patients (Ontario Primary Healthcare Planning Group, 2011). In addition, there were eight operational NPLCs and an additional 18 clinics being implemented. Over 5,000 Ontario residents were registered with a NPLC (Ontario Primary Healthcare Planning Group, 2011).

To date, several evaluations are underway across the country to examine how newly introduced primary care models impact outcomes and to examine the policy frameworks that create the context for change. However, these evaluations and frameworks have not yet addressed the team and organizational processes that facilitate the implementation of primary care models and how these opportunities can translate into better results. Primary care leaders, both at the provincial and local (team) level, have been involved in creating new expectations and new levels of performance in primary care. As indicated by Weberg (2009; 232), "innovation does not just happen; is the result of a perfect storm of leadership, financial, idea, teamwork, culture and demand factors".

FHTs and NPLCs are selected for this study since they represent an important health system innovation that emerged in Ontario (and Quebec) after long efforts to create a more responsive and integrated primary care system. Both models offer a broader range of services by a collaborative team of multi-disciplinary professional health care providers and are integrated with other health care sectors. There is growing interest in FHTs and NPLCs by provincial and regional governments across the country and internationally which makes understanding the factors in their implementation even more important. Furthermore, analysis of the FHT model allows for comparison with the FMGs in Quebec, a model that also consists of a team of primary

care providers. The only limitation of this study is that available resources did not allow detailed examination and comparison of these models with the Community Health Centre (CHC) model in Ontario, another model that is considered to be an innovative high-performing primary care model.

3.2 Overview of Ontario Study

This study examines the roles and actions of physician leaders and other key actors in the emergence of new primary care models. The project examines leadership dynamics at two levels: the provincial level and a more local practice level in the creation and implementation of FHTs and NPLCs. The local analysis will be conducted in the context of the broader policy environment that facilitated and/or impeded the creation and implementation of these models. The inclusion of a macro-system and policy level analysis is based on the assumption that changes in the provincial political, economic and healthcare contexts created an opportunity for change that had not previously existed. Leadership dynamics at the local (i.e., group practice) level were shaped by changes in the broader provincial context.
Overall, the key objectives of the Ontario case study are to:

1. Analyze the system factors, policy levers and other contextual factors that facilitated or impeded the development of FHTs and NPLCs and to identify the roles of leaders at the provincial level;
2. Examine the roles of leaders, in particular the role of physician leaders, executive directors and other key personnel, in FHTs and NPLCs in establishing and developing these teams in the context of the health networks and policy frameworks in Ontario and;
3. Identify how leaders at both the provincial and local levels are expanding and spreading FHTs and NPLCs to extend their impact, recruit other primary care providers and improve services in Ontario.

During the first cycle of the research study, the literature was reviewed (e.g., key policy documents and reports, academic literature, evaluations, legal documents) to examine the characteristics of these models, their history, development and performance. The research team then proceeded to select and interview 16 policymakers, stakeholders and experts involved in

creating the policy and influencing the environment where the FHTs and NPLCs emerged. Selection of these respondents was guided by consultations with key decision-makers and study participants. Data collection and analysis has been completed for this stage of the study using N-Vivo (9) software.

Based on the experience and knowledge of experts and decision-makers, three high performing FHTs and one high-performing NPLC in Ontario were selected as case study sites. During the policy level interviews, experts and decision-makers were asked to identify the attributes of a high-performing FHT and NPLC. These individuals were also asked to identify high-performing sites in Ontario. Two lists were generated to record the number of times a high-performing attribute was mentioned and to list the identified sites. Both lists were reviewed to derive a short-list of high-performing FHTs. Only one NPLC stood out from the comparative list. The criteria for selecting the final three FHTs among those nominated (in addition to their nomination as high performing) were the size of the group, distribution of cases among urban and rural areas and affiliation with a university or not. The three FHTs include:

- One large urban, university-affiliated FHT
- One medium-sized urban, non university-affiliated FHT
- One small rural, non university-affiliated FHT

The selected NPLC is a small rural, non-university-affiliated organization.

In the second phase of the study, data for each nominated high performing organization was collected by reviewing publications and data available from the Internet. Between December of 2012 and February of 2013, researchers visited four primary care sites. In advance of these meetings, researchers reviewed a range of material provided by each site including business plans, strategic plans, terms of reference for boards and committees, annual and quarterly reports, legal documentation, human resource policies, performance reports, program information, and results from patient and provider surveys. During each site visit, 60 minute interviews were completed with physician/nurse practitioner lead, executive director, physicians, nurses, allied providers and administrative staff. Approximately, 8-10 interviews were conducted per site. In addition, two interviews were completed with informed non-FHT/NPLC members who could provide external views on the development of the team and leadership in each site.

All interviews were audiotaped with the informed consent of interviewees. Interview questions focused on: a description of the content and process of change during the development of the vision, creation of the primary care organization (contract completion) and implementation; enablers and barriers to change; characteristics of the formal and informal leader(s); description of the attributes of high-performance in primary care; and strengths and weaknesses with respect to these attributes. In total, 44 interviews were completed in the 4 case study sites. The interviews and other materials from the case study were analyzed to identify key themes using a constant comparative method (Miles and Huberman, 1994; Boeije, 2002). The findings of this case study are based on thematic analysis of detailed interview notes. A final summary report was written and shared with local leaders.

A second set of interviews (with fewer individuals) was held with local leaders of the same FHTs and NPLC. These interviews addressed changes within the FHTs and NPLC over time and the roles and actions of leaders in these changes. A final report will be written and shared with all participants.

A comparative analysis will also be done between FHTs in Ontario and FMGs in Quebec to examine the role of leadership in high-performing teams. The cross case analysis will be done collaboratively between researchers and decision-makers in both provinces. Results of the case studies will be reviewed with a panel of decision-makers and experts and an inter-provincial group of decision-makers. This will be used to provide a dynamic assessment from multiple stakeholders, including researchers and decision-makers, and to share results that may influence the design of policy options and organizational strategies.

3.3 Research Findings

The Ontario research team has collected and analyzed data from interviews with 16 key informants consisting of provincial leaders (e.g., government officials, experts, stakeholders) and 44 respondents in four primary care organizations. Research findings from both phases of the first cycle are presented for five of the six common research questions[1]. Findings are presented

1. The question "How does leadership at different contextual levels of the health system affect change?" will be addressed at the completion of the first cycle.

separately for the FHT and NPLC case studies. A paper that incorporates interview quotations and further analysis is underdevelopment.

3.3.1 Where did the impetus for change come from, internal vs. external? Bottom vs. top down?

Family Health Teams

Systematic Level Findings

From the perspective of a broad range of provincial decision-makers, the impetus for change for the primary care sector in Ontario came from the context that was created by the Ontario government leadership. The initial planning of the FHT model began when Dalton McGuinty, who later became the Ontario Premier, was the leader of the Ontario opposition. In 2002, McGuinty brought together representatives from across the province to discuss primary care models. These discussions focused on expanding Community Health Centres (CHCs) or introducing a new primary care model that would be more acceptable to family physicians than the new models that were then being implemented. The Liberal Government campaigned on the introduction of a new primary care model. The issue of access to primary care physicians had become an important political issue in Ontario and in 2002 it was estimated that nearly 1 million of 11 million Ontario residents could not find a family doctor[2].

After the Liberal government was elected in 2003, George Smitherman became the new Ontario Minister of Health and was instrumental in creating and implementing the FHT model (Refer to Section 3C). He executed provincial consultations with 273 local providers through expert panels to build consensus on the key attributes of the FHT model. Once the model was established, the Ontario government invested substantial resources to encourage family physicians to participate in the model. This investment included increases in physician compensation and additional funding for a variety of non-physician professional health care providers (e.g., registered nurses, nurse practitioners, dietitians, pharmacists, mental health workers, social workers, patient educators, chiropodists, etc.), operation and capital (e.g., office space). Although participation in the FHT initiative was voluntary for family physicians, the significant investment in resources

2. Vanessa Lu and Karen Palmer, "No end in sight for family doctor shortage: A million Ontarians suffer as family practice loses luster" Toronto Star, 15 June 2002, p. A23;

and increases in physician compensation resulted in extensive demand for the FHT model. This was the first time in Ontario's long history of primary care reform efforts that the demand for the new model was greater then its supply.

Organizational Level

At the organizational level, based on our interviews and document analysis, the desire for the changes that were possible in FHTs was motivated by the vision of the lead physician. In one FHT, the impetus for change came from the context that was created by the Ontario government. The introduction of the FHT model by the provincial government offered family physicians a significant amount of resources for non-physician professional providers, operations and capital and increases in physician compensation. In the two FHTs, the impetus for change came from a more general desire to be innovative and excel in their community. Lead physicians in these organizations recognized that there was a gap in providing specialized primary care services in their communities and in teaching and research. For these reasons, lead physicians engaged and convinced other family physicians to participate in the FHT model.

Together, these findings suggest that the impetus for change was influenced from the top and the bottom. At the top, the provincial government created a model that was both lucrative and attractive that created substantial demand from front line practitioners.

Nurse Practitioner Led Clinics

Systematic Level

The impetus to create the NPLC model initially emerged at the local (bottom) level. Marilyn Butcher and Roberta Heale, two Nurse Practitioners (NPs) in Sudbury, Ontario were key leaders in the development of the NPLC model. These NPs had been involved in a number of leadership roles at both the administrative and clinical level (Heale & Butcher, 2010). Both served on the board of directors of the Nurse Practitioner Association of Ontario (NPAO). One had formed strong networks with community members through her clinical experience while the other had served on committees at the municipal, provincial and federal level and is an academic researcher.

The impetus for this change originated from concerns of a crisis in access to family physicians by patients in the Sudbury community. In addition, there were several unemployed and underutilized NPs in this area. In response to these concerns, Heale and Butcher submitted a business case to the Ontario Ministry of Health and Long Term Care (MOHLTC) for funding of an NPLC through the Family Health Team request for proposals. Their proposal was rejected by the MOHLTC. Two additional attempts were made to have the model funded with no success.

Following up on these efforts, the NPs wrote letters to a variety of stakeholders including the provincial nursing leadership organizations (Registered Nurses Association of Ontario (RNAO), Nurse Practitioner Association of Ontario (NPAO)), provincial leaders (Ontario Minister of Health), local politicians (MPPs in the opposition party and the local municipal government), and the media to bring attention to the issues in Sudbury. Heale and Butcher also solicited unemployed NPs in the community, encouraging them to write stories about their experiences in acquiring higher education and still being unemployed in a underserved community. Patients responded to the media coverage by voluntarily participating in video productions that expressed their concerns and stories about their journeys through the system. In 2006, the NPs presented their proposal at a Greater City of Sudbury Council meeting at which 25 NPs in the community attended. Together, this effort stimulated interest by local and provincial leaders. In particular, it caught the attention of Doris Grinspun, the Executive Director of the RNAO, who became instrumental in lobbying and selling the model to Ontario Minister of Health (Refer to Section 3B).

Organizational Level

At the organization (clinic) level the impetus to create the NPLC emerged from the vision of a group of experienced and committed nurse practitioners in the community. These nurse practitioners were concerned of a crisis in access in primary care services by patients in their community and by the unemployment rates of local nurse practitioners. These nurse practitioners grasped the opportunity to become an NPLC when the provincial government announced funding for the initiative.

Together, these findings suggest that the impetus for creating and implementing the NPLC model was driven largely by front line practitioners with support from key decision makers and stakeholders. Unlike the creation of the Family Health Team model, the Nurse Practitioner Led Clinics emerged as a contested alternative that drew criticism from a number of key stakeholders, including the Ontario Medical Association, but was able to create effective political pressures and to convince the Minister of Health that the model was a viable option to improve access to primary care.

3.3.2 Who was effective in exercising leadership in support of change, and what roles did they play, and what did they do?

Family Health Teams

Systematic Level

George Smitherman, the Ontario Minister of Health is described by many key stakeholders as being pivotal in the creation of the FHT model and its implementation across the province. Following his appointment in 2003, Minister Smitherman created the Health Results Team (HRT) to design and implement reforms in a number of key areas, including primary care. Minister Smitherman appointed a well-known physician champion as the Primary Care Lead in the HRT. Dr. James MacLean was a high profile physician and former hospital CEO. In his role as Primary Care Lead he helped to ensure that the new primary care model was a key agenda item for the Ministry of Health and Long Term Care, while also creating a credible and expert linkage to the family physician and broader medical community.

To select the key elements to be included in the FHT model, the Minister of Health decided to engage in direct discussions with local physicians rather than through the Ontario Medical Association (OMA). With the assistance of his Health Results Team, the Minister consulted with 273 local physicians through expert panels across the province. The large turnout of local physicians in this process was seen as a measure of interest in the new model. The detailed plans for FHT model emerged from these consultations.

Once the FHT model had been developed, the Minister of Health signaled his interest in investing substantial financial resources even though the OMA at the time was not supportive of this model. The Ministry of Health civil servants charged with implementation faced delays in delivering physician agreements due to ongoing changes in legal agreements suggested by OMA

staff. The OMA was also not supportive of Dr. MacLean. It was the first time that a local physician champion was responsible for leading an initiative at the Ministry who had not been elected or chosen by the OMA. The OMA launched a campaign to oppose the FHT model, which they claimed would create a "two-tiered system" in which enrolled patients in the FHT model would receive better care. The Ministry of Health did not back away from the new model. Indeed, when the provincial government introduced the FHT model through a call for proposals, the Ministry did not involve the OMA in the application and selection process. This strategy was a major break from prior primary care reform efforts that had been done in partnership with the OMA. Interviews with several key observers have suggested that these decisions were important to developing the FHT model and its implementation.

The appointment of Dr. James MacLean as Primary Care Lead by the Minister of Health was critical to the success of the model. He had established a reputation for being a well-respected family physician with credibility among his colleagues. He travelled around the province to engage his colleagues and marketed the benefits of the FHT model. He was able to alleviate their fears and concerns about government intrusion in family physicians' practices. By the time he completed travelling around the province, he had built trust and created a huge demand for the FHT model.

Jan Kasperski, the Chief Executive Officer of the Ontario College of Family Physicians (OCFP), also played a key role in assisting family physicians during the application process. The OCFP provided support to family physicians by recommending consulting firms for business case development, and directly addressing physicians' issues and concerns with the MOHLTC.

Organizational Level

The development of the vision and drive to create the three FHTs selected for detailed case study was driven by the lead physician in all three FHTs. Lead physicians in these organizations were champions for the initiative and instrumental in actively and strategically engaging colleagues in discussions about forming a FHT. In one FHT, the lead physician engaged like-minded physicians to consider the possibility of forming a group practice. In two FHTs, the lead physicians engaged physicians in their existing group practices. These physicians were

instrumental in explaining the benefits of the model (resources, financial gains) to their colleagues and creating support for their proposals.

The primary care organizations that applied to become Family Health Teams were reviewed by a Ministry of Health committee. Those who received approval from the Ministry to develop a business case then hired a consultant with government funding to assist with the detailed planning. Lead physicians used different strategies to develop their business cases. One lead physician created a steering committee to engage a variety of community partners (including members of the team, hospital and municipality) while the other two leaders set-up regular meetings with interested colleagues. During the creation of the FHTs, lead physicians in two organizations also played an important role in contract negotiations with their colleagues and the Ministry. In the other primary care organization, the consultant assumed this role.

In all three FHTs, the executive director was instrumental to the management of implementation activities. These individuals were involved in securing the location of the organization, developing employee contracts addressing financial and administrative issues, developing by-laws, policies, procedures, protocols, supporting the development of chronic disease and prevention programs, hiring non-physician professional staff (with input from the lead physician), integrating the staff of two organizations (physician were paid as members of FHN/FHO while other providers were funded through the FHT); and developing medical directives for primary care providers. These were complex (and, in some cases, new) tasks for these organizations. In all three organizations, the executive director tried to provide individual staff the autonomy to develop their ideas without introducing a large amount of bureaucracy for their implementation.

In all three FHTs, leaders did not just emerge at the executive level. Instead leadership was distributed throughout the organization and exercised by different individuals at varying levels. In one case site, family physicians were extraordinary champions for the development and implementation of chronic disease and prevention programs the promotion of the role of non-physician providers and the implementation of information technology. In another primary care organization, a physician and administrative assistant became the champions for the

implementation of advanced access and information technology. The physician was able to attain the buy-in of other physicians in the practice by demonstrating its benefits through its successful implementation in her practice, arranging quality improvement training and support, and educational sessions for the other physicians and team members.

In two FHTs, nurses and other non-physician professional health care providers emerged as leaders in their disciplines or in the development of innovative chronic disease management and prevention programs. These individuals worked hard to achieve the buy-in and trust of their colleagues with respect to their skills and to demonstrate the benefits of their programs. In one FHT, the registered nurse and dietitian were considered champions in program implementation. In another FHT, the registered nurse, geriatric nurse, and social worker were identified as leaders.

Nurse Practitioner Led Clinics

Systematic Level

The leadership and actions of Marilyn Butcher and Roberta Heale, the two Sudbury NPs, were instrumental in creating the impetus for change and the vision for the NPLC model. Their roles and actions are described in section 3C.

Doris Grinspun, the Executive Director of the RNAO, was influential in actively lobbying the Ontario Minister of Health and persuading him of the need for the NPLC model. Minister Smitherman announced the implementation of the first NPLC pilot in Sudbury in November of 2006 and was present on August 30th, 2007 for its grand opening. The first NPLC consisted of six full-time nurse practitioners and two consulting physicians who worked five half-days a week (Dicenso and Wyman, 2008). In April of 2008, Premier Dalton McGuinty visited the Sudbury NPLC. Shortly after this visit, 25 additional NPLCs were announced for the province.

Minister Smitherman's leadership during the development of the NPLC model of primary care was pivotal. He faced two sources of resistance to the model – from the OMA and his bureaucracy in the Ministry of Health and Long Term Care. The Minister of Health had anticipated that the OMA would become a significant barrier to moving the NPLC initiative

forward. For this reason, he strategically kept the OMA out of any discussions or decisions about the NPLC model. As expected, the OMA actively opposed the introduction of the model during both the implementation of the first pilot and the expansion of the NPLCs. Communications were sent from the OMA to the Minister of Health, newspaper editors and mayors across Ontario designed to created opposition to the new model and containing incorrect information about the model design (e.g., stating that the clinics would not include participation by family physicians). The intent of this campaign was to create fear and prevent the implementation of NPLCs.

In addition to external resistance, there was internal resistance to the model from a number of civil servants in the Ministry of Health bureaucracy. The civil servants favored implementing the physician driven FHT model and paid less attention to the development of NPLCs. NPLCs struggled to receive the same incentives in the FHT model including adequate resources, access to the electronic medical record (funded by the Ministry as part of the FHT agreements) and fair compensation for the physicians who practiced in NPLCs. Some observers speculated that the bureaucrats were providing information to the OMA about the development of NPLCs, supporting the OMA's campaign to prevent the implementation of NPLCs. Over time, the initiative's development was moved from the Primary Care Branch at the Ministry to the Nursing Secretariat. There was more support in the Nursing Secretariat for the initiative but less staff expertise and continuing staff turnover. Despite this resistance, the Minister of Health remained committed to the NPLC initiative and was able to stand his ground in the midst of efforts to slow or stop the development of this new primary care model.

Paula Carere, the President of the Nurse Practitioner Association of Ontario (NPAO), also provided support to the NPLC initiative during its operationalization. She instigated a series of teleconferences with NPLCs so that NPs across the province could provide support to each other on implementation issues such as capital planning, purchasing and insurance. She also worked with various stakeholders to address the concerns and needs of NPLCs. For example, she worked with Health Quality Ontario to ensure that NPLCs had the same access to quality improvement training as providers in FHTs. And she worked with the Association of Ontario Health Centres (AOHC), Ontario MD and eHealth Ontario to establish the processes by which NPLCs could receive funding for an electronic medical record and to build consensus on a common vendor.

Organizational Level

In the case study of the NPLC, a group of four nurse practitioners were the drivers for the creation of the NPLC. These NPs successfully engaged and organized 15 nurse practitioners in their community who unanimously agreed on the benefits of creating the model for their community. During this process, a business case was developed and a nurse practitioner was nominated by colleagues to be the lead for the initiative. She negotiated the contract for the organization.

During the implementation of the organization, a group of three NPs formed the board of the organization and were actively involved in negotiating the architecture and lease for the organization, addressing legal and financial matters, liaising with the Ministry, developing the organizational chart for the organization, hiring staff and selecting the vendor for the electronic medical record. The administrator lead was hired to oversee construction of the building, develop administrative policies and procedures and promote the recruitment of patients. Currently, a new administrative and clinical lead are involved in planning, and day-to-day operations of the clinic. The administrative lead is involved in organizational development and reporting and the clinical lead is responsible for the management of the clinical team. The administrative and clinical leaders both provide a significant amount of autonomy to their team.

This organization also has leadership distributed throughout the organization. For example, a nurse practitioner was identified as a leader and advocate of chronic disease and prevention management initiatives. An administrative staff member was identified as the champion for quality improvement initiatives.

3.3.3 What capabilities do leaders need in order to initiate and implement change?

Family Health Teams

Systematic Level

Minister Smitherman had a deep appreciation of the critical role of primary care and decided that its revitalization would be his legacy. Key informants describe him as a strong-minded leader who has high self-awareness and unwavering determination to achieve his goals. He is an individual who is clear about his own values and principles and is not afraid to take action even in the face of opposition. He was also considered to be honest, confident and resilient in the face of adversity.

The Minister of Health was also viewed as a leader who continuously challenged the status quo and was constantly seeking out new ideas, innovations and solutions to complex problems. He had substantial prior experience with the CHC model in Ontario and was an advocate of a strong primary care system that is comprehensive, accessible, responsive, and fosters egalitarianism amongst citizens and professions. He created a coalition of internal and external stakeholders to help champion and execute a common vision and deliver on the government's commitment to reform primary care. He championed the new FHT model and engaged Ontario physicians in a consultation process on its development. This provided an opportunity to build consensus and to create a broad based vision for primary care. His approach allowed for open discussions and the establishment of mutual trust between key players.

In the implementation of the FHT model in Ontario, Minister Smitherman demonstrated substantial leadership capabilities including: the political intelligence to know when to act and when not to; how to negotiate through conflict and mobilize support; and the confidence and courage to persevere in the face of resistance. Moreover, although the Ontario Minister spoke as a "revolutionary", he could be an "incrementalist" who knew when to compromise. For example, Minister Smitherman recognized that in order to foster the development of FHTs and NPLCs, he could not simultaneously transfer responsibility for primary care to the new Local Health Integration Networks (LHINs) in Ontario despite the urging of many. This was a key concession he made to the OMA.

The leadership capabilities of Dr. James MacLean, the Health Reform Primary Care Lead, were demonstrated in his effective engagement of family physicians in Ontario. Dr. MacLean focused on developing and communicating a vision for primary care, and tirelessly championed the potential value and impact of the FHT model to his colleagues while listening to and responding to their concerns. He was able to empower his colleagues to act on the vision by relieving their fears of government intrusion into professional practice and the scale of the proposed changes. He is a leader who is described as having charisma, credibility and the ability to establish trust.

Organizational Level

Physician leaders who were involved in creating their new family health teams were and are actively involved in activities within their organization and in the community. All these physician leaders participate on the board. In three primary care organizations, the lead is actively involved in internal quality improvement committees. Leaders in all three organizations are described as: visionary, innovative, respected, credible, supportive, approachable, self-aware, committed, problem-solvers, and connected to partners in the community.

During the phase of identification and recognition of the need for change, physician leaders were able to effectively engage colleagues and develop coalitions with external stakeholders. These leaders were able to obtain the buy-in and trust of their colleagues and external partners by: facilitating meetings that allowed for open dialogue and communication; sharing information on the initiative; inspiring and creating a shared commitment on the vision of the organization; and negotiating to resolve conflicts. During negotiations for their contracts and the creation of the primary care organizations, leaders were able to navigate the political environment by being politically astute.

The executive directors of these organizations were described as visionary, respected, knowledgeable, strategic thinkers, mentors, problem-solvers and self-aware. These leaders were able to build cohesive inter-professional teams by fostering a culture of innovation and excellence and an environment in which there is a sense of respect, belonging, trust, transparency, collaboration and cooperation. The executive directors were effective at: communicating the vision of the organization to staff and setting clear and meaningful expectations of the team; facilitating avenues for staff to contribute to team discussions; advocating, engaging and empowering staff to pursue their ideas; supporting the professional and personal goals of staff; being responsive to ongoing issues and resolving conflicts.

Leaders that emerged at the staff level were described as passionate, respected, knowledgeable, competent, dedicated, risk takers, and creative. These individuals were also known to have integrity and courage and possessed the following leadership capabilities: self-awareness, self-development of skills and knowledge, taking action to implement ideas, engaging team members

and communicating with providers to build buy-in for skills and programs, and building relationships in the community.

Nurse Practitioner Led Clinics

Systematic Level

Marilyn Butcher and Roberta Heale, the two local NPs in Sudbury had a personal vision of effective primary care that could meet the needs of their community. This vision was that all primary care providers would be utilized to their full potential and that all patients would have access to a primary care provider. This vision drove the conceptualization of a unique and innovative model – the Nurse Practitioner Led Clinic. The leadership capacities that made these NPs effective included their ability to build coalitions, develop a strong positive public profile for their concerns, and engage the appropriate local and provincial stakeholders. They were effective in communicating their vision to the public through the media and empowering unemployed NPs and others to act on their vision.

Another key player in the NPLC initiative was Doris Grinspun, the Executive Director of the RNAO, who has a reputation for being direct, outspoken, fearless and politically connected. She is a strong advocate for the nursing role and she used the crisis in Sudbury as an opportunity to enhance the role of the NP. During the marketing of the NPLC model, her leadership capabilities included the ability to negotiate and persuade powerful and influential leaders, including Minister Smitherman, to support her vision and the persistence to follow it through.

Paula Carere, the President of the NPAO demonstrated substantial leadership in her effective engagement of local nurse leaders from the NPLC and the establishment of mutual trust. The President also built strong relationships with various provincial leaders, which allowed her to communicate the concerns of NPLCs and successfully negotiate resources for them.

The leadership capabilities of the Ontario Minister have been described in this section under the "Family Health Team".

Organizational Level

In the NPLC, the nurse practitioner that led the initiative is a board member. She is described as a well-respected primary care provider who has strong connections in the community and is self-aware, determined, supportive, and approachable.

During the phase of identification and recognition of the need for change, nurse leaders had the capability to effectively engage colleagues and develop coalitions with external stakeholders. These leaders were able to obtain the buy-in and trust of their colleagues and external partners by facilitating meetings that allowed for open dialogue and communication and building support and consensus on the vision of the organization. During their negotiation of the contract with the Ministry of Health, the nurse leader was able to navigate the political environment by being politically astute.

The group of nurse practitioners that facilitated the initial implementation of the clinic had the self-awareness to understand that they did not possess the skills needed for organizational development (e.g., for incorporation, legal, financial). As a result, these nurse practitioners leveraged the skills of experts and undertook personal learning to effectively managing these changes. The current nurse and administrative leads have been instrumental in the development of the inter-professional team. Together, these leaders have created a culture of innovation and excellence and an environment in which team members feel respected and heard. Leaders have facilitated ongoing collaboration and cooperation between team members by facilitating formal meetings that provide opportunities for team discussions and advocating, engaging and empowering staff to pursue their ideas. The physician that was hired was someone they knew and an innovative and respected doctor in the community. He also worked at the FHT. His presence and role helped establish the clinic's credibility in the community.

At the staff level, local leaders were described as respected, knowledgeable, competent, and dedicated. These individuals demonstrated leadership by effectively engaging team members and community members in discussions about the needs of the community and obtaining buy-in for chronic disease and management programs.

3.3.4 What external and internal factors influenced leadership across and between levels of health system in order to achieve sustained, meaningful change?

Family Health Teams

Systematic Level

The primary motivation of the Ontario government in creating the FHT model was to address the concern for patients who had no access to a primary care practitioner in Ontario. In the same year, the First Ministers' Accord had increased funding to provincial and territorial governments by $16 billion and made a commitment that at least half of provincial residents/potential users would have access to an appropriate provider 24/7 by 2011 and that users would routinely receive needed care from multidisciplinary primary care organizations or teams (Aggarwal, 2009).

Several factors were imperative in facilitating the spread of FHTs and enabling leaders of the Ontario government to promote this model to physicians. The first factor was Ontario's prior history of introducing a variety of primary care reform models that involved shifting family physicians from a solo fee for service model to a group model with blended payment. This history includes the introduction of Primary Care Networks (PCNs) in 1997, Family Health Networks (FHNs) in 2001, Family Health Groups (FHGs) and Comprehensive Care Models (CCM) in 2003, the Rural and Northern Physician Group Agreement (RNPGA and Family Health Teams (FHTs) in 2004 and Family Health Organizations (FHOs) in 2007 (Aggarwal, 2009). The participation of local family physicians in these primary care models helped facilitate a significant, evolving culture change for these professionals since it provided insights and experience for family physicians on the benefits of working with other providers (e.g., in sharing coverage). It also stabilized the income of family physicians. These incremental changes and the experience of a growing number of primary care physicians with the new models allowed for easier adoption of the FHT model when it was promulgated.

Another factor that facilitated the adoption of FHTs by local family physicians was the significant financial investment in the model by the Ontario government. This investment included substantial increases in family physician compensation and funding for non-physician professional health care providers, operation and capital. In 2008, the Health Service Organization (HSO) and Primary Care Network (PCN) models were harmonized and

transformed into the FHO model. This model was similar to the FHN model except that the basket of services was structured in a manner that made physician compensation more lucrative (e.g., immunizations were removed from the basket of services allowing physicians to charge for this activity). The FHO model resulted in additional increases in physician compensation and more demand for the FHT model by family physicians.

The process by which the Ontario government engaged family physicians in the FHT initiative was a less obvious, but powerful, enabler of the implementation. The approach taken by leaders at the Ontario government to engage family physicians in bidding for Family Health teams differed from that used by previous governments. Instead of allowing all family physicians to participate in the model, the Liberal government created an application process in which interested physicians had to submit business cases and compete for FHT funding. The limitations on the new Family Health Team funding and the enriched funding package and compensation in the FHT model stimulated interest among primary care physicians who wanted to gain access to the opportunity.

The implementation of Family Health Teams was also a more prominent part of the government's healthcare strategy than prior efforts to introduce new models. The Ontario government made primary care reform a critical element of its healthcare transformation agenda and appointed Dr. James MacLean, a high profile family physician as its Primary Care Lead in what was termed the Health Results Team. Dr. MacLean was responsible for addressing implementation issues for the FHT model, developing the criteria for the evaluation of business cases from interested family physicians and coordinating the FHT implementation with other health reform issues. In every wave of the call for proposals, an overwhelming number of applications were submitted. The application process proved to be a powerful strategy since it signaled to family physicians that it was a competition with clear deadlines and limited resources.

Organizational Level

During the early phases where family health teams were recognizing the need for change, the commitment of lead physicians to improve the accessibility and the quality of care delivered to

their community and their ability to persuade colleagues of the benefits of the FHT model instigated and sustained change (Refer to Section 3A). An external factor that significantly enabled change was the establishment of a FHO/FHN contractual agreement between local physicians (with existing business and family relationships) and the Ministry, prior to the announcement of the FHT. The creation of a group model with shared coverage facilitated a significant, evolving culture change for professionals since it provided a clear understanding and concrete experience for many family physicians on the benefits of working with other providers. Change was also facilitated by the efforts of local leaders to build relationships in the community (with universities, municipalities, hospital, specialists, primary care providers) to achieve their commitment for the implementation of the model. During the creation of the FHT, the Ministry of Health provided funds for embryonic family health teams to use consultants who assisted these organizations in the development of their business plans, which outlined the vision of the organization, and its strategic priorities. Two of the FHT organizations that were studied in depth indicated that their most significant challenge during this stage was contract disputes with the Ministry on the resources the FHTS needed to operate effectively.

During the implementation of these FHTs, collaborative relationships between the executive directors and lead physicians facilitated their implementation of an inter-professional team and the successful management of the complex changes required. In all three FHTs, executive directors and lead physicians had complementary skills that allowed them to work together effectively. Physician leaders focused on driving the vision of the organization, influencing internal and external colleagues while executive directors focused on managing and implementing this vision by empowering staff to act on initiatives that met the organization's strategic objectives.

FHTs had to recruit effective competent and skilled team members who were independent but also worked well together to create an effective team and learn to work together over time. The lead physicians in all three organizations were involved in the hiring process and tended to focus more on the practice philosophy of individuals and their interpersonal skills, rather than just their technical competencies. This approach was seen as important to the employment of a cohesive

team of like-minded team members. One organization used a competency model (knowledge, skill, attitude framework) to recruit staff with an emphasis on the attitudes of these individuals.

FHT leaders have been able to sustain change by creating new structures and work processes: implementing committee structures, medical directives, using an electronic medical record, and instituting formal and informal team meetings. The most significant challenge for these organizations has been the lack of government support for initial organizational development activities, particularly around the development of effective governance, and the development of key support services (e.g., legal, human resources, finances etc.).

Nurse Practitioner Led Clinics

Systematic Level

The initial NPLC flourished in a the community of Sudbury which was experiencing difficulties in providing access to primary care providers due to a shortage of family physicians. At one time there were 30,000 Sudbury residents without a primary care provider despite the presence of eight unemployed NPs (Butcher, 2011). Moreover, while the MOHLTC had funded a new Sudbury FHT this practice experienced problems in expanding its operations. The two local nurse leaders recognized the needs of their community and designed their solution to address these demands for access to primary care. Local media played a significant role in publishing and distributing information about the crisis and lobbying for the implementation of the NPLC model. After the key Sudbury City Council meeting in 2006, the local newspaper interviewed NPs for television, newspapers and radio stories which successfully caught the attention of the public as well as local and provincial leaders.

Funding from the provincial government for the NPLC initiative enabled the implementation of the pilot in Sudbury and its later expansion. This funding provided support for the implementation of an inter-professional team (e.g., consulting physicians, clerical staff, inter-professional health care providers and a clinic director), capital, and operation. Over time, NPLCs were provided access to funding for the electronic medical record and quality improvement training through Health Quality Ontario (HQO).

The perceived access crisis in Sudbury, the outspoken leadership of two local nurse leaders,

crucial support from provincial leaders, and the role of the media influenced the government to act, creating dedicated funding support for the NPLC initiative that facilitated its spread throughout Ontario.

Organizational Level

The experience of the NPLC case site was similar to the FHTs. During the phase of identification and recognition for the need for change, the commitment of a group of nurse practitioners to improve the accessibility and the quality of care delivered to their community instigated and sustained change (Refer to Section 3A) as well as securing the support of community members, local providers, media, government officials and patients. During the creation of the NPLC, the most significant challenge for the organization was contract disputes with the Ministry and resistance to their implementation in the community because of a negative public campaign launched by the Ontario Medical Association.

The factors that facilitated implementation the new model and its development included collaborative relationships between the administrative lead and nurse lead and the effective recruitment of a cohesive team of providers. The most significant challenge for this organization was the lack of government support for implementation activities and continuous funding delays by the Ministry.

3.3.5 What learning opportunities will maximize the potential of leaders to sustain long-term health system transformation?

This multiple case study demonstrates the impact of strong leadership at the provincial and organizational level that allowed for the creation and implementation of innovative primary care reform models in Ontario. But these organizations, even those identified as high performing, have not full exploited their potential impact. Many FHTs and NPLCs have not fully implemented the programs and initiatives that will maximize their effectiveness, including open access scheduling, full use of the electronic medical record, closer ties to specialists, and improved chronic disease management and prevention programs. Primary care organizations would also benefit from training at all levels (board, executive, staff) on the role of leadership and how leadership can enable improved performance Board members and the executive team

would benefit from detailed knowledge on organizational development processes, including the legal components of incorporation, establishing effective governance structures and processes, implementing the electronic medical record and quality improvement initiatives and effective methods for team recruitment, team building and integration of all providers.

3.4 Ontario Node Analysis of Leadership of Change

3.4.1 What is working in terms of stimulating and supporting health system transformation and what contextual factors influence effective leadership action?

As discussed in section 3D, the breakthrough of reform outlined in this case included a number of key leadership elements. At both the systematic and organizational level, there was a strong vision of what was needed for effective primary care reform and a willingness to engage in an incremental change management process that helped to make this vision a reality. At the provincial level, leaders were engaged over a number of years with relevant stakeholders, but were not afraid to act against substantial opposition. The government signalled its willingness to invest major financial resources in primary care reform and a substantial amount of primary care physicians responded to this signal. The development and implementation of an application process to engage primary care providers helped to support the growing participation of primary care physicians, and by creating an impression of scarcity, both encouraged broader engagement while limiting opposition to the new model. At the organizational level, dedicated leadership from organizations that were focused on supporting and implementing these innovations was also critical to the successful operationalization of these innovative models. The leadership of administrative leaders and the establishment of a collaborative and complementary relationship with the clinical leaders were essential for the implementation of a high-functioning inter-professional team.

3.4.2 Where are the gaps between current practices of leadership and the expectations for leadership outlined in the emerging health leadership capability frameworks (e.g., LEADS)?

The practices of leadership that were observed by leaders in Ontario at both the systematic and organizational level are consistent with the elements of the LEADS framework. Provincial and local leaders focused on “systems transformation”, “engaged others”, “achieved results”, “developed coalitions” and “led self”. However, some characteristics of leadership emerged in

this case study, which are not explicitly articulated in the LEADS framework. For example, leaders were described as possessing the following qualities: "respect", "credibility" "approachability" "commitment" "perseverance" and "trustworthiness". These qualities could enhance the "Demonstrate Character" sub-theme within the "Leads Self" dimension. Creating an environment of "transparency" could be included as part of sub-theme "Contribute to the Creation of Health Organizations" in the "Engaging Others" dimension. Finally, "advocating for" and "mentoring" team members could be included in the sub-theme "Build Teams" within the "Engaging Others" dimension. The sub-theme "Assess and Evaluate" within the "Achieve Results" dimension did not emerge as part of leadership capabilities in this case study. This may be because leaders have not yet proceeded with formal evaluation in their organizations given the pressures of time, the lack of standardized data from information systems and limited resources for quality improvement initiatives.

Analysis of this case study also confirmed the importance of plural leadership (Denis, Langley and Sergi, 2012). Key leadership behaviors were not carried out by any one particular leader. Instead leadership was distributed amongst different individuals at different stages. Thus individual leaders possessed some but not all the leadership capabilities present in the LEADS framework. At the provincial level, the Minister of Health was instrumental in developing the vision for the primary care sector, developing coalitions and building consensus amongst internal and external stakeholders. Once the vision was embraced, leadership for the implementation of the initiative shifted to other individuals and external organizations. In the primary care organizations studied, each organization had a strong clinical and administrative leader that had complementary skills. Clinical leaders were instrumental in developing the vision for the organization and attaining the commitment of team members while the administrative leaders managed the process of change. Together, these individuals created a culture of innovation, which empowered other members of the team to emerge as leaders. At the front-line, physicians, nurses and non-physician professional providers became champions for the development of chronic disease and prevention programs, quality improvement programs, and implementation of information technology. Thus, groups of leaders combined their diverse expertise, skills, leadership qualities, authority and sources of legitimacy to enact meaningful change.

3.4.3 How can knowledge of effective leadership be translated and mobilized by the network into approaches, programs, tools and techniques to develop a culture of effective leadership?

There are a wide variety of leadership development programs already available to executives in public sector organizations and board members, executives and staff of primary care organizations. But these programs need to be more closely linked to the critical elements of high performing primary care organizations, including quality improvement skills, and linkages between these organizations and other elements of the health care system. These programs should provide training on the theory, methods and tools that foster innovation and effective change management. At the organizational level, this training should include a focus on: effective governance structures and processes; development of an integrated inter-professional team in which all team members are working to their full scope of practices; program development of chronic disease management and prevention programs; implementation of information technology that allows for accessing, analyzing and making decisions on standardized data; and clearly understanding of accountability, quality improvement and performance measurement mechanisms.

4.0 Research Cycle 2

4.1 Background

The objectives of the second cycle of this research study were to: present and validate the overall and case specific findings from the first cycle of research to local leaders in three Family Health Teams (FHTs) and one Nurse Practitioner Led Clinic (NPLC) in Ontario; examine organizational changes that have taken place in these organizations since the previous interviews, and the role(s) and action(s) of leaders in these changes; describe leadership challenges; and identify external and internal strategies that can cultivate more leadership in the primary care sector.

During September 2013, a second set of interviews was conducted with local leaders in three FHTs and the NPLC. These individuals were previously interviewed during the period of December 2012 to January 2013. In total, eight interviews were completed with the executive director and physician leader from the three FHTs and the clinical leader and administrative

leader of the NPLC. These individuals were selected for interviews since both leaders had an instrumental role in creating and implementing their organizations, all of which had been created since 2005. All participants validated the findings of the first cycle research findings, which resulted in minimal changes to the initial report. The purpose of this report is present findings for the following research questions:

1. What changes have been made in the FHTs and the NPLC over time? Which actor(s) have played an important role? What was their role(s)?
2. What organizational or leadership challenges do leaders face in the FHTs and the NPLC? How are leaders addressing these challenges?
3. What internal and external strategies can assist leaders in the effective development and sustaining of these high performing primary care organizations?
4. What strategies can enable more leadership across the primary care sector?

4.2 Research Findings

4.2.1 *What changes have been made in the FHTs and the NPLC over time? Which actor(s) have played an important role? What was their role(s)?*

In all four of these Ontario primary care organizations, the most common change affecting their performance has been the development and approval of formal ***quality improvement plans*** (QIP) by executive directors/administrative lead in alignment with the requirements of the Ontario provincial government and Health Quality Ontario (HQO). Of the four case sites, only one organization implemented a comprehensive QIP with quality indicators reflective of the strategic objectives of the organization. The executive director and lead physician drove this initiative. In the first research cycle, these leaders were key to the development of quality improvement committees. In three FHTs, the executive director and lead physician were actively involved in the development of quality priorities and associated indicators. When the announcement was made to submit QIPs, these leaders leveraged existing work to complete the requirement.

The NPLC had not yet implemented this governance structure. In the second cycle, the administrative lead at the NPLC indicated that a quality committee has been established "*as part of our quality improvement plan which was in large part from your feedback".* The Chair of the

Board (who is the founding nurse leader) is credited for leading the implementation of this initiative.

As part of their quality improvement initiatives, all these primary care organizations indicated progress has been made with respect to formal evaluation of a few or several chronic disease management and prevention programs. Team members who are champions for these initiatives are leading the implementation of these evaluations. In one organization, the quality committee has implemented a decision support team to assess whether chronic disease management and prevention program resources are being optimized. In two organizations, the administrative leads and staff have invested additional time and resources to increase patient uptake of programs by emailing and phoning patients, updating websites, and creating posters. Another change identified in three primary care organizations is the implementation of advanced access methodology (in some form) by all physicians in FHTs and nurse practitioners in NPLCs[3]. Other changes that are more specific to individual FHTs include development of formal governance policies and procedures and a monthly staff recognition program by the executive directors.

Another major change for all FHT case sites is their participation in the ***Health Links***[4] initiative. All three FHTs are the coordinating organization for a Health Links initiative in their respective Local Health Integration Network (LHIN). Health Links initiatives rely on collaboration and coordination between primary care providers and specialists, hospitals, long-term care, home care and other community supports to improve care and reduce the use of hospital services. FHT leaders indicate that this initiative has consumed a significant amount of their time over the last year. In two FHTs, the lead physician is spearheading the initiative while the executive director is the leader for the other FHT. These leaders have been actively involved in engaging, recruiting and building partnerships with several stakeholder groups and physicians in the community. A significant amount of time has been invested in developing and building consensus on their business case based to meet the requirements of the Ministry of Health and LHIN.

[3] Advanced access methods enable clinics to improve patient access to services by changing the booking procedures and reducing the backlog of patients waiting for appointments.

[4] *Health Links* is an Ontario Ministry of Health and Long Term care program that aims to improve the management of complex patients who are high users of services.

Currently, FHTs are at different stages with respect to the implementation of their Health Links initiatives. In one FHT, the lead physician has developed a Health Council with representation from patients, FHTs, CHCs, hospitals, solo primary care providers, community care access centres (CCAC), LHIN and other community partners. The Council has established Working Groups for each key objective of their Health Link. To engage the community, the lead physician has created a physician advisory group, a seniors' advisory group, a patient advisory group, a youth advisory group and a Chinese community focus group. To date, the FHT has established linkages between the CHCs and hospitals to attach complex patients; developed advanced care initiatives for complex patients; worked with community organizations and small practices to bridge their resources; and liaised with a seniors' group and at risk populations. The FHT is in the process of developing plans for physician follow-up of patients discharged from hospitals within 7 days and reducing avoidable emergency department visits as well as developing comprehensive care plans for chronic patients. In another FHT, the lead physician has leveraged existing partnerships with hospitals, CCACs and universities to enable better utilization of the Ontario Telemedicine Network service between family physicians and specialists (dermatologists, child psychiatry, psychiatry); to provide access to residents in the community to chronic disease management and prevention programs in the FHT; and to assess the integration of electronic records and the standardization of data. The last FHT is in the process of hiring a project coordinator for implementation of their Health Link initiative and is currently planning and developing a comprehensive care plan for complex patients who are in the top five percent of users. The FHT has established a links with the local hospital and CCAC to implement new screening tools that identify at risk patients and trigger an immediate assessment by CCAC case managers before the patient is hospitalized. The plan is to expand this as part of the Health Links initiative.

4.2.2 What organizational or leadership challenges do leaders face in FHTs and the NPLC? How are leaders addressing these challenges?

The most significant challenge that leaders face in all four primary care organizations is the recruitment and retention of non-physician professional health care providers. Currently, there are huge disparities in income for these providers relative to their potential earnings in the acute care sector. All leaders indicate that retaining their staff has been difficult. The provincial

government recently announced that wages for non-physicians providers will remain frozen and FHT budgets will be cut by 0.5%. The Ministry announced these changes despite numerous efforts by FHT leaders to reconcile the issue with Ministry staff. Another significant challenge for all leaders is the method by which the Ministry allocates resources. Decisions about human resource allocations do not take into consideration the needs of the community. For example, if a physician leaves a practice and de-rosters patients, resource allocations for non-professional health care providers in that practice are slashed. In the NPLC, the clinical lead is expected to service a full roster of patients and as well as complete her administrative work. The Ministry has not provided any resources or guidance on how the patients of the clinical lead should be allocated to other primary care providers in the organization.

Internally, the most significant challenge for all FHT leaders has been achieving the buy-in of a few outlier physicians who have not endorsed the vision of the FHT model and who rarely refer patients to non-physician professional providers or their programs. These physicians also tend to lag behind other providers on their use of the electronic medical record and in participating in meetings with the inter-professional team. The executive director and lead physicians in the three FHTs have tried multiple avenues (e.g., education, informal meetings, participation on committees and board, physician champions) to engage these physicians but the impact of these attempts has been limited. These leaders state that the only method to address the resistance of these physicians may be to remove them from the organization. This is a challenge since the organization's board of directors will not approve of this decision. To address this issue, one executive director is working on putting in place robust recruitment policies for new physicians, which will have contractual obligations stating the expectation of new physicians.

In another organization, the lead physician is facing challenges with respect to succession planning. He is currently in a conflict of interest position given his dual roles as both the chair of the board of directors and lead physician. As a leader, his challenge has been recruitment for one of his two positions and for replacing recently retired physicians. There is no interest from existing physicians to assume one of his leadership roles. The lead physician is planning to address this by efforts to groom someone to take on one of his roles over time.

In all four organizations, insufficient resources for the development, implementation and monitoring of quality improvement initiatives remains a challenge. The FHT leaders indicate that they are exploring whether they can access the resources the provincial government recently announced for this initiative. In one FHT, the executive director is exploring innovative avenues by which patients could complete patient surveys or do medication reconciliations on a tablet, which could automatically update patient information in the EMR and provide continuous results on patient satisfaction. Other challenges across all FHTs include addressing the issue of physicians who identify more with their FHO than the FHT, and turf issues between stakeholders with respect to the Health Links initiative. In the NPLC, obtaining discharge information from hospitals on patient encounters continues to remain a challenge.

4.2.3 What internal and external strategies can assist leaders in the effective development and sustainment of primary care organizations?

According to respondents, internal strategies for effective development and sustained performance for primary care organizations include:

- Building a strong collaborative relationship between the administrative and clinical leaders in which there is clear understanding of roles and responsibilities
- Establishing a proper balance of administration in the organization that is capable of managing the organization, but not stifling local innovation
- Continuous engagement of all staff members
- Providing team members with the autonomy to be innovative and creating a culture in which "we learn from our mistakes"
- Developing strong partnerships with other primary care and community organizations to build a continuum of care and examining opportunities for alignment of resources to improve capacity to serve patients, for example by sharing resources between FHTs.

Leaders indicate that the Ministry must provide a stronger leadership role in supporting primary care leaders by:

- Establishing a clear and concise vision for primary care in Ontario and remaining committed to its implementation
- Including additional remuneration for physicians in leadership roles

- Increasing the salary of executive directors in order to recruit and retain high-performing leaders
- Aligning the salaries of non-physician professional providers in primary care with other health care sectors
- Providing flexibility in how primary care organizations use their human resource budgets and consider the needs of the community in allocation decisions

4.2.4 What strategies can enable more leadership in the primary care sector?

To build more leadership in the primary care sector, respondents recommend that the Ministry could:

- Provide financial rewards to primary care organizations that are leaders and can demonstrate high performance
- Invest in funding for leadership (e.g., leadership training) and organizational development (e.g., legal, human resources, media, quality improvement) education and training through in-person peer to peer mentoring and formal education of physician leaders and executive directors. This can be done by providing recognized clinical and administrative leaders with incentive payments to mentor other primary care leaders
- Fund training and support for board members on effective governance and their role as leaders
- Allocate funding for mentorship, professional development and training for clinical and administrative leaders at the ground level

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6.0 Acronyms Used in this Report

AOHC	Association of Ontario Health Centres
CCM	Comprehensive Care Models
FHG	Family Health Groups
FHN	Family Health Networks
FHO	Family Health Organizations
FHT	Family Health Teams
FMG	Family Medicine Group – Group de médicine de famillle – in Quebec
HRT	Health Results Team (at Ontario Ministry of Health and Long Term Care)
LHIN	Local Health Integration Network
MOHLTC	Ontario Ministry of Health and Long Term Care
NPAO	Nurse Practitioner Association of Ontario
NPLC	Nurse Practitioner Led Clinics
OCFP	Ontario College of Family Physicians
OMA	Ontario Medical Association
PCN	Primary Care Networks
RNAO	Registered Nurses Association of Ontario
RNPGA	Rural and Northern Physician Group Agreement