



Partnerships for Health System Improvement (PHSI) Leadership and Health System Redesign

Quebec Node Case Study Final Report New Primary Care Models in Quebec: The challenges of creating family medicine groups



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December 2013

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Executive Summary

Background: In the early 2000, the Quebec government decided to support the implementation of new primary care services organizations: Family Medicine Groups (FMGs). This province-wide initiative was launched in order to improve the responsiveness and access to primary care and to integrate primary care more effectively in the health and social service networks of the province.

Objectives: The Quebec node case study proposed to examine leadership dynamics and process of change in the context of primary care reform, more specifically for the development of FMGs. We examined leadership roles and actions, leadership capacities and contextual factors that facilitated or impeded leadership in order to initiate and sustain primary care transformation.

Methods: A multiple case study was conducted. Three high performing FMGs were identified. Criteria for selection of cases included the size of the group, distribution of cases among urban and rural areas and affiliation with a university or not. Three cycles of research were conducted to identify the evolution of leadership roles and capacities through the change process. For each cycle, we conducted semi-structured interviews with physicians, nurses and managers within the three selected FMGs.

Results: The voluntary approach to physicians' involvement was an effective strategy to initiate change, since the government decided to invest substantial resources to encourage family physicians' participation in FMGs. At the organizational level, the desire for the changes was motivated by the vision of physician leaders who engaged and convinced other family physicians to participate in the FMGs. During the implementation of FMGs, physician leaders were the main drivers of change; they held a central coordinating position in FMGs management. A more distributed leadership was observed during the development of FMGs, across associate physicians, nurses and managers. At the systemic level (regional and provincial levels), there was a lack of overall vision of the development of FMGs.

Conclusion: There was a strong leadership for the transformation of primary care at the local level, coming from physician leaders of FMGs and local health services network, but a lack of vision and leadership at the systemic level, in terms of sustaining the development of FMGs by setting new directions.

Introduction

The Quebec node leadership case study untitled « New primary care models in Quebec: the challenges of creating Family medicine groups (FMGs, *Groupes de médecine de famille*), proposed to study leadership in the context of primary healthcare reform and more specifically, for the development of a new model of primary care delivery in the early 2000s. We decided to study the implementation of Family medicine groups (FMGs) in Quebec, as this primary care model represents a breakthrough in the organization of primary care in Quebec. FMGs are small multi-professional organizations composed of physicians and nurses with administrative support. This province-wide initiative emerged from long efforts to create a more accessible and responsive primary care system that offered a broader range of health services and was better integrated with secondary and other care services.

The main objective of this study is to examine leadership dynamics, as roles and actions of physician leaders and other key actors, in the emergence of a new primary care model. We examine the ways in which leaders contributed to these new clinical teams and the lessons learned in creating new multi-professional care teams in the context of efforts to reform primary care services. A multiple case study was conducted by including three FMGs organizations in that study.

Cycle 1: First Cycle of Research

Part 1: Introduction to Quebec node leadership case study in the context of the overall research study

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

The Quebec node case study proposes to examine leadership dynamics and process of change in the context of primary care reform, more specifically for the development of FMGs. All across Canada and abroad, a longstanding consensus among politicians, professionals, researchers and clinicians exists regarding the need to reform primary healthcare in order to improve the performance of healthcare systems. Reports on the Canadian health systems underline the need to renew and improve primary care to better serve Canadians and respond to their expectations regarding health care (Romanow 2002; Senate Standing Commission on Social Affairs, Science and Technology 2002). As the healthcare system main entry point, primary care services organization has consequences on accessibility, coordination and integration of care. In consequence, many provinces in Canada have undertaken to develop new primary care models, based on these common goals: improved access to primary care services; better coordination and integration of care and expansion of a team-based approach to clinical care (Hutchison 2011).

In Ontario and Quebec, similar primary care models have been implemented in the early 2000s. These models are based on interprofessional health teams composed of family physicians, registered nurses or nurse practitioners, and others health and social professionals, working in a collaborative environment. As these two models have similarities, leadership dynamics can be compared. A comparative case analysis will illustrate the role of leadership within selected FMGs in Quebec and Family Health Teams (FHTs) in Ontario. This comparative analysis will be conducted later in the context of the broader policy environment that helps create new primary care models.

In order to examine leadership dynamics, the following core questions were asked:

- What leadership capabilities do leaders need in order to initiate and implement change?
- How does leadership at different contextual levels of the health system affect change?
- Who was effective in exercising leadership in support of change, and what roles did they play, and what did they do?
- Where did this impetus for change come from, internal or external? Bottom up versus top down?
- What external and internal factors influenced leadership across and between levels of the health system in order to achieve sustained, meaningful change?

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

These common core questions will be used to compare leadership in the implementation of both FHT and FMG models.

The first cycle of our research process consisted of data collection and analysis. Results are synthesized in this first report. The second cycle of the process will consist of returning a brief synthesis of the main results to the participants (including physician leaders) in order to get their insights on leadership roles, activities and dynamics identified. Their feedback will enable to confirm, adjust or revise our analysis of leadership process. Further, a second round of interviews with participants will examine the evolution of leadership roles and activities, the new obstacles and challenges in exercising leadership and strategies used to solve these problems and challenges.

The approach used in our case study is based on participatory action research (PAR), since decision makers were involved in several steps of the research process. First, they participated in the selection of cases studies (our three high performing FMGs). Second, feedback from participant leaders will be collected on the first round of interviews. Finally, our results will be disseminated to health care decision makers, in order to translate knowledge and learning opportunities from the Quebec case study. The focus of our PAR approach is more observational and descriptive than prescriptive and interventionist, since we do not purposively attempt to influence decision makers beyond the recommendations that we will formulate.

Part 2: Situational analysis—Quebec node FMG case study

Our study of leadership process in the development of FMGs organizations appears particularly relevant, since this new primary care model represents a breakthrough in the organization of primary care in Quebec. In this regard, FMGs appear promising to address challenges facing primary care services, such as improving accessibility, coordination and integration of care. Nevertheless, the shared responsibility of FMGs and Health and social services centers (*Centres de santé et de services sociaux* (CSSS)) in delivering primary care services limits the potential of FMGs to solve alone primary care challenges in Quebec (Breton, Levesque and al. 2011).

This new model results from a province-wide initiative, launched in the early 2000s, in order to improve the responsiveness and access to primary care and to integrate primary care more effectively in the health and social service networks of the province. This initiative intended to facilitate better response (among other things) to the needs of vulnerable population, patients with chronic diseases and to improve access to primary care for the general population (Pomey and al. 2009). The government created a voluntary approach to physician's engagement. Consequently, physicians were free to implement their own FMGs with organizational support from government. In Quebec, the creation of FMGs was a recommendation of the «Clair Commission» in 2000. FMGs consists of six to ten physicians working with nurses and sometimes others providers to offer primary care services to registered patients on the basis of a contractual agreements with regional health authorities representing government (Hutchison and al. 2011). In 2001, Quebec government announced his financial and organizational support, regarding medical clinics which were developing their own FMG. In order to be accredited, FMGs had to meet some organizational criteria, such as extended opening hours, collaboration between family physicians and nurses integrated in the group, and services agreements between FMGs and their local health network (Health and social services centers: « *Centres de santé et des services sociaux* » (CSSS)). The first wave of FMGs was initiated in 2002. New FMGs are created every year since, and in November 2012 250 FMGs were accredited across Quebec (Ministry of health and social services 2012).

In the early 2000s, many provinces across Canada undertook initiatives for primary health care renewal, following the 2003 First Ministers Health Accord which targeted (among others priorities) primary health care change. These province-wide initiatives were addressing the same main issues as those faced by Quebec, such as access improvement to primary care services, coordination and integration of care within health care system networks. The same main components/strategies are used in primary health care change initiatives across provinces (Alberta, British Columbia, Ontario and Quebec). Similar components are: a voluntary approach of physicians' engagement, a team-based approach, and a population-based approach with a focus on prevention and management of chronic and complex illnesses (Hutchison 2011).

Yet, the characteristics of primary health care services organization in Quebec invited to examine leadership in that specific context. In order to analyze leadership in the development of FMGs in Quebec, the following node specific questions were asked:

- What are the role of leaders, in particular the role of physician leaders, executive directors and others key personnel in FMGs in establishing and developing these teams in the context of the health and social service networks in Quebec?
- What are the system factors, such as policy levers, the organizational factors and the cultural factors, such as professional cultures and practices that facilitated or impeded the development of leadership capacity for primary care renewal?
- What are the ways to strengthen leadership capacity and more specifically physician leadership for primary health care renewal to provide effective, accessible and integrated services in Quebec?

We feel that these specific research questions were adapted to the explanatory study on physician leadership and leadership capabilities in the context of FMGs in Quebec. They however were related to the broader core research questions of the overall PHSI project by paying attention to leadership in action and to the inter-relation between context and leadership capabilities and practices.

A multiple case study was conducted. Three high performing FMGs were identified by health care managers and decision-makers of our research team. Criteria for selection of cases included the size of the group, distribution of cases among urban and rural areas and affiliation with a university or not. The following FMGs were selected:

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

In two of the three FMGs, four personnel members were interviewed: the physician leader (or executive director), an associate physician, a nurse and an administrative officer. In the last FMG, five personnel members were interviewed: the executive director, two associate physicians, a nurse and the administrative officer.

The approach used in our case study was based on participatory action research approach (PAR). Decision makers and health care managers were involved in the first cycle of the research process, for the selection of case studies (high performing FMGs). In a second cycle, they will be asked to provide feedback on these results and an update on their leadership context, challenges and strategies. They will also get involved in the third cycle which will consist of knowledge translation. In that regard, a synthesis of the key results will be submitted to key policy makers, such as decision-makers within the Ministry of Health and Social Services and the president of the Quebec Federation of General Practitioners. Other health system decision-makers will be identified.

Finally, we plan to present our case study results during a conference of the « Association Francophone pour le Savoir » in May 2013.

Part 3: Situational analysis—Research results for project initiation

In order to identify leadership dynamics in the context of the development of FMGs, we used a conceptual framework which addresses leadership in contexts of organizational change. This framework presents three different leadership dynamics depending on the phases of organizational change. The first leadership dynamic involved before creating new organizations corresponds to the identification and recognition of the need for change. During the initiation/creation of new organizations, the second leadership dynamic involves the design of the strategic and shared vision for the new organization. Finally, the implementation of new organizations requires leadership to operationalize change by implementing new activities (Kotter 1995; Tichy and Devanna 1990). For each core questions, results are presented depending on these three main phases of change.

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

Since the government developed a voluntary approach to physician's involvement in the FMGs, the impetus for change came from medical clinics, specifically from physician leaders who had responsibilities and an important commitment towards the development of their clinics. Consequently, FMGs creation was started from bottom. Nevertheless, to get the physicians'

involvement, regional health authorities created incentives such as financial incentives, administrative support and the provision of nurses for clinical support.

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

During the first phase of change (i.e. before the creation of FMGs), physician leaders exerted an important leadership, by identifying the need for renewing their model of family practice by creating FMG. These physicians were clinical leaders of their group, who always had an important involvement and many responsibilities regarding the management and the development of their clinics. They played a strategic role in order to get the support of their associate physicians for creating a FMG. They explained to their associates the functioning of the new primary care organization model, with intensive communication. Further, physician leaders presented benefits of the new practice model underlying the FMGs, such as financial gains and administrative and clinical support.

« Before that, I organized meetings with the team to know if physicians were interested, meetings with all the family physicians of our clinic. I presented and described the model of practice ». (Physician executive director, FMG A).

In the creation phase of the FMGs, the role of physician leaders appeared once again particularly important. In all cases, these leaders became executive directors of their FMGs. First, they had to develop a contractual agreement with their associate physicians interested in creating FMGs, which established shared responsibilities of all physicians towards patients. Their role was also to develop and negotiate contractual agreements with regional health authorities, in order to be accredited. In this regard, they had to write a contract commitment which defined FMGs functioning according to the government criteria such as extended opening hours, care services without appointment, coordination with CSSS and collaboration with nurses. In that creation phase, external actors such as CSSS, « Département régional de médecine générale » (*Regional department of family medicine*) and projects managers dedicated to FMGs creation by regional health authorities, provided their support. They exercised a strategic leadership in supporting and negotiating the FMGs creation requests with regional health authorities.

« They had a certain influence on regional health authorities and they were supporting us. So they were influential people, they had influence on the government. There is the board of DRMG presidents in Quebec. So these people have worked hard to make our project a success ». (Physician executive director, FMG B).

Finally, during the implementation phase of FMGs, a more distributed leadership was identified. Depending on activities implemented, different internal and external leaders were identified. Nevertheless, in terms of FMGs management, executive directors remained in a central coordinating position. FMGs management involved many activities such as patients' registration, team members' integration (including nurses and administrative agents) and clinical management. To set up procedures for patients' registration, administrative agents were involved with the support of executive directors. Concerning integration of nurses in the FMGs, both physicians and nurses exerted leadership. Physician leaders and some associates physicians explained and promoted to the group the new role of nurses in the management of patients. Nurses promoted also their own role in communicating intensively with physicians.

« To integrate nurses, we made some contacts to make known the role of nurses within FMGs. I invited them in the group and encouraged them to describe their role». (Physician executive director, FMG B).

In terms of clinical management (organization and management of services supply), all physicians exercised leadership with the supervision of executive directors. Others activities were developed within FMGs, including elaboration of nursing care protocols, implementation of information systems, and the development of coordination between FMGs and health system networks. In the development of nursing care protocols the role of executive directors was central with important support from departments of nursing within the CSSS.

«We worked a lot together with departments of nursing to elaborate nursing protocols». (Physician executive director, FMG B).

The implementation of information systems involved all FMGs members (physicians, nurses, administrative agents) with supervision by different professionals depending on our three cases (executive director, associate physician or administrative agent). Finally, physician leaders with

support from their associate physicians had leadership in establishing shared care programs with others clinics, hospitals or local community services centers (*Centres locaux de services communautaires*) within their health system network (i.e. CSSS).

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

Depending on the phase of change, physician leaders mobilized different capabilities.

Capabilities associated with the phase of identification and recognition of the need for change were: intensive communication, attending associate physicians' expectations and fears regarding change, tact, diplomacy and the ability to bring associates together for the proposed creation of FMGs. This later ability was extremely related to leader charisma.

« My appreciation of leadership is (...) I find that there was lot of charisma...charm...it helped to move forward ». (Physician, FMG B).

« The leadership at the base is...to be able to convince a group to go in one direction ». (Physician, FMG C).

« Look, he has a style like his management style, very cooperative, absolutely not autocratic, and participatory ». (Physician, FMG A).

During the FMGs creation process, capacities of physician leaders were related to their ability to negotiate with regional health authorities (for contractual agreements) and their ability to convey to associate physicians a shared vision of the new organization (for shared responsibilities agreements).

Finally, during the process of FMGs implementation, different capabilities were observed depending on activities. Concerning patients' registration and team members' integration, executive directors mobilized their ability to empower and train staff (including nurses and administrative agents). This capacity was also found for the implementation of information systems within FMGs. With regard to clinical management, physician leaders were able to delegate the management of care services or programs to their associates.

« You need more doctors, captains who will manage small business. So you need a doctor who will handle all the mental health program (...). And after that, someone in charge of hypertension

and diabetes programs (...). Then someone for routine services, for walk-in clinic visits (...). So I need captains to help manage it ». (Physician executive director, FMG A).

Regarding development of nursing care protocols, executive directors mobilized their ability to seek support from other clinics or hospitals and from departments of nursing within CSSS.

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

During the phase of identification and recognition of the need for change, we identified two types of facilitating factors. The first one is related to the professional values of physicians. Willingness of physicians to improve accessibility and quality of family medicine services facilitated their involvement in the proposed creation of FMG.

« There were many patients that we called "orphans", i.e. without a doctor, and we had to find a way to change the way we practiced for better services, to increase accessibility ». (Physician executive director, FMG B).

Second, their involvement in that project was also facilitated by factors related to organizational structure, such as a cohesive team or a clinical structure (clinical functioning) close to that of FMGs.

Concerning the creation process of FMGs, factors were mostly external factors related to policy regulation. One major obstacle to FMGs accreditation was the rigidity of the criteria of the clinical model imposed on new FMGs by regional health authorities.

« But in the first model of FMGs....requirements were very large (...), criteria were too rigid, it didn't work ». (Physician executive director, FMG A).

Nevertheless, strategic political position of external actors supporting FMGs creation (such as executive directors of CSSS and influential members of DRMG) facilitated the negotiation between FMGs and regional health authorities concerning contract agreements.

Finally, an important internal factor was observed for management activities: the organization of the decision structure within FMGs. In fact, the centralization of power in the hands of executive directors facilitated the implementation of new activities.

« But in terms of communication with the CSSS, with nurses, for the implementation of new protocols (...) and discussions around any change we need, it is the doctor who is responsible for it. And I would say that it was facilitating ». (Physician executive director, FMG C).

Concerning the development of nursing care protocols and the implementation of information systems, policy factors were identified. The absence of standardized protocols (from regional health authorities) was an impeding factor. With regard to information systems, the lack of financial and organizational support from regional health authorities was a factor that impeded their implementation.

« Recently we talked about electronic medical records because we are in a long process of trying to implement it. And it's complicated because we are within a hospital and the ministry has frozen funds for a long time. And we felt isolated because the ministry imposed "You must choose such software and such company" ». (Physician executive director, FMG A).

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

The first learning opportunities are related to change management training of physician leaders within FMGs new primary care organizations. There is a need to develop training activities or programs in order to teach physicians to better manage change in their group. The second one is related to the resources committed by government for the implementation of information systems. A strong leadership is necessary from regional health authorities in order to give more financial resources and operational support to FMGs that are in the process of implementing such systems. Finally, leadership efforts have to be made in terms of nurses' integration within groups by developing new and standardized nursing protocols for all health problems, including for chronic and complex diseases.

Part 4: Situational analysis—Findings

The second round of our research consists of returning results to leaders (including physician leaders) and obtaining their insights regarding leadership, in order to adjust, add or correct our first results. Further, a second round of interviews with key leaders is also an opportunity to identify new problems and challenges facing FMGs, and new strategies used by these leaders to address these problems and challenges. These interviews are especially useful in order to clarify leadership dynamics regarding the development of coordination between FMGs and health system networks, since the three cases studied (FMG) were not yet well coordinated with other health care organizations. This second cycle of our research is planned for the fall 2012 (November to December).

Our Quebec node case study contributed to answer partly to the following three main questions.

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

The government voluntary approach to physicians' involvement with incentives (financial incentives, administrative support and clinical support) is an effective strategy to stimulate and get the support of physicians in the creation of FMGs. Furthermore, leadership from regional health authorities through the support of project managers dedicated to FMGs implementation was an effective way to help and foster the implementation of new organizing procedures and activities within FMGs. Finally, the fact that a physician leader (the executive director) supervises and coordinates team members' efforts to implement change activities was a real facilitating strategy.

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)?

Many practices of leadership observed in the FMGs studied here are consistent with the LEADS framework, especially around the components "Engage others", "Achieve results", "Develop coalitions" and "Systems transformations". However, while LEADS framework underlines leadership capabilities related to assessment and evaluation practices, leaders within FMGs were

not involved in the assessment of their clinical practices and processes regarding health outcomes. Since the implementation of clinical information systems is recent, physician leaders have not yet collected data and measured clinical outcomes of FMGs. In that regard, government has not developed benchmarks and incentive policies in order to enable and encourage local and regional efforts to evaluate FMGs' performance in terms of accessibility, coordination and integration of care within the health system network.

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?

In view of our Quebec case study on the development of FMGs, some knowledge could be mobilized by the health system network into approaches, programs and tools in order to develop a culture of effective leadership. Training programs for family physicians would be a learning opportunity in order to give them methods and tools to better manage change for the implementation and development of their new organizations. Further, a « frequently asked questions » document would be a useful tool in order to list common implementation problems and effective strategies used by FMGs to solve problems. Leadership efforts have to be made in terms of nurses' integration within FMGs by developing new and standardized nursing protocols for a wide range of health problems, including for chronic and complex diseases. Finally, incentive policies could be put in place in order to enable and stimulate regional and local efforts to evaluate FMGs' performance regarding accessibility, coordination and integration of care within health system network.

Cycle 2: Second Research Cycle in the Context of the Quebec Node Case Study

Part 1: Objectives of the second research cycle

The second cycle of the research consisted in returning a brief synthesis of the first cycle research results to the participants (including physician leaders) of our three Family Medicine Groups (FMGs), in order to get their insights on leadership roles, activities and dynamics that had been identified. Their feedback enabled to confirm our analysis of leadership process, since they had no specific comments to make on the synthesis (no changes/revisions or adjustments).

Further, a second round of interviews was conducted with some of the participants interviewed in the first round of the research. These participants were the key leaders involved in the creation and implementation of their FMG. In total, we interviewed six members of the three FMGs:

- FMG A: two physician leaders (same participants as in the first round);
- FMG B: one physician leader and one manager (same participants as in the first round);
- FMG C: one physician leader and one associate physician (same participants as in the first round).

This second round of interviews, conducted from February to April 2013 aimed at examining the evolution of leadership dynamic a year after our first round of interviews (January-March 2012). More specifically, we examined the evolution of leadership roles and activities, the new obstacles and challenges in exercising leadership and strategies used to solve these problems and challenges, in the context of FMGs' development after their implementation. Further, we observed the new leadership capabilities as well as the contextual factors that help or impede the development of FMGs in their local health networks (Health and social services centers - «Centres de santé et de services sociaux» CSSS).

In order to achieve these research objectives, three core questions were asked:

- 1. Who is effective in exercising leadership in support of the development of FMGs and have the key leaders changed and have their roles changed?*
- 2. What leadership capabilities do leaders need in order to sustain change and further development of FMGs? Have their capabilities changed?*
- 3. What external and internal factors influence leadership across and between levels of the health system in order to continue to sustain the development of FMGs?*

These questions are consistent with the core questions asked during the first cycle of the research in the context of the overall research study.

Part 2: Evolution of leadership—Results of the second round of interviews

1. Who is effective in exercising leadership in support of the development of FMGs and have the key leaders changed and have their roles changed?

Generally, physician leaders remain the main drivers/initiators of FMGs development and supervise the overall management of their FMG. Nevertheless, we observe a more shared or distributed leadership across all members of FMGs.

External actors [CSSS, Regional Health Authorities (RHA), consultants, Federation of general practitioners of Québec (FMOQ)], are still supporting FMGs in implementing new clinical activities, in management or funding, but more on an ad hoc basis, when FMGs' members consult them for advice and/or support. The evolution of the roles of the key leaders is presented according to the main activities exercised for the development of FMGs (the same main activities as in the first round interviews).

In terms of **clinical management/clinical development**, physician leaders/executive directors, keep key roles in elaborating general clinical guidelines and in coordinating overall clinical activities. However, more and more they delegate the initiatives of developing and managing new programs and new clinical activities. Indeed, associate physicians play an increasing role in clinical management: each physician contributes in initiating, developing and managing health programs; they are driving continuous clinical development of their group by proposing new ideas, new programs, etc. For the three studied FMGs, associate physicians are totally involved in managing their programs (monitoring targets, monitoring referral process to health professionals, supporting and training clinical staff, etc.).

«Physicians here are totally free to propose and develop new things, new care programs depending on their interests(...) I think it's very critical in order to continue to develop our FMG». (Physician, FMG B).

The role of the physician leader is to coordinate all care programs and ensure consistency in the provision of care depending on the overall needs of the registered patients.

Nurses working within FMGs are now fully integrated in clinical teams and have more leadership regarding monitoring patients, in collaboration with physicians. They are totally involved and jointly responsible of patients' management with physicians. Moreover in the three FMGs, they took more responsibility in diagnosing patients and in monitoring independently patients with chronic diseases. All physicians still support nurses in their clinical role and keep discussing clinical cases with them when needed.

«We delegate more to nurses, because we have implemented the Advance Access. That's a new concept...a new way of practicing medicine, you know? Currently, nurses are much more involved in monitoring patients. They see patients, prescribe medications, so they are doing a part of our work, it means that it saves time for physicians». (Physician, FMG B).

Concerning the introduction of new nursing care protocols, both physicians and nurses demonstrate leadership, with more and more support from the government (Ministry of health) which has recently developed standardized protocols or guidelines for a number of health problems.

Finally, external actors such as independent consultants or pharmaceutical companies (new actors) are supporting FMGs to elaborate new models of clinical management and development, in order to revise processes of care and care organization (as the advanced access within two FMGs).

Interprofessional collaboration (team work among physicians, nurses and others health professionals within FMGs) is now well developed within two FMGs and is going to be implemented in the coming months in the last FMG (the smallest one). Nutritionists, psychologists, social works have been employed and now work closely with medical teams. Physicians refer more patients to health professionals. Both physicians and managers play an increasing role in encouraging interprofessional collaboration by communicating intensively to all physicians the role of each health professional and supporting physicians with procedures of referring patients to these professionals.

External actors such as CSSS, RHA and pharmaceutical companies are supporting FMGs to develop interprofessional collaboration within FMGs, by linking physicians and health professionals and by funding the recruitment of new health professionals or nurses.

Daily management activities involve new patients' registration, human resources and budget management, support for the implementation of change activities, and supervision/coordination of work reorganization. The leadership for these activities is more and more delegated to non-clinician managers inside or outside FMGs (managers within CSSS or independent consultants). We observed a less central role for physician leaders (compared to the creation and implementation phase of FMGs). However, they are still supervising and supporting the team members when problems occur, but more on an ad hoc basis.

In terms of **developing new partnerships** with hospitals and clinics (for shared care programs or care services pathways/corridors) within their local health services network (CSSS), we observed more leadership from both executive physicians and associate physicians. Managers within CSSS provide their support in terms of organizing coordination, in order to facilitate the development of these new partnerships. The progressive development of partnerships leads to more integration and coordination of care between FMGs and CSSS for registered patients within FMGs.

«I think that it's now easier to develop partnerships. Now our FMG is well-known in our CSSS. Clinics or hospitals are more willing to develop care services pathways with us, sometimes they contact us directly. There is reciprocity in these partnerships, it's based on an exchange of services». (Executive Physician leader, FMG B).

2. What leadership capabilities do leaders need in order to sustain change and further development of FMGs? Have their capabilities changed?

We observe two types of **constant capabilities** still exerted by physician leaders within FMGs'. First, they had the ability to engage members, supporting and challenging them, creating engaging environment by sharing a personal vision and seeking to inspire a shared vision among FMGs' members.

«When we are implementing new things, I always have to share and sell a vision in terms of accessibility and quality improvements....that we want to increase our volume of activity in order to better serve our population; I'm always selling that vision». (Physician, FMG A).

Second, key leaders mobilized their capacity to align actions with collective vision, goals and mission of FMGs. Both types of capacities are mobilised especially when new clinical activities are implemented within FMGs, such as new care protocols, new care organization (like the advanced access), integration of new health professionals within teams, etc.

However, the continuous development of FMGs, especially because of the need for more interprofessional collaboration, led to **new or larger capacities** exerted by physician leaders. They have developed more skills in building teams, which means facilitating environments of collaboration and cooperation among team members to achieve results (to address patients 'needs). Further, they have increased capacities in building coalitions, which refers to purposefully building partnerships and networks to create results. They are exercising these capacities in order to create connections with hospitals and others clinics and create trust and shared meaning among all their clinical partners.

«The other thing is.., in the organization, I have to work a lot with physicians and other health professionals, to ensure that they develop a sense of belonging, to ensure that they feel they work together for the same purpose: the well-being of our patients». (Physician executive director, FMG A).

3. What external and internal factors influence leadership across and between levels of the health system in order to continue to sustain the development of FMGs?

We observed a major facilitating factor which is increasingly supporting the continuous development of FMGs. It is related to the shared vision within local health network (i.e. within CSSS, *Health and social services centers*) regarding FMGs values, goals and mission. CSSS now better recognize FMGs' contribution in terms of care accessibility. This shared vision or recognition facilitates the support from CSSS to provide more expertise for various activities: development of new clinical partnerships, implementation of new care organization, daily management activities, etc.

«I think that there is a huge recognition of our FMG, of our clinical work, in terms of services that we offer to our population, in terms of accessibility and quality improvements. The CSSS recognizes us as an integral part of the clinical network». (Executive physician director, FMG A).

From the second round interviews, we also observed a recurrent impeding factor related to higher level governance, which slowed the development of two FMGs. These two FMGs have reported the lack of communication, responsiveness and support from regional health authorities for allocation of resources. It's related to the funding of new activities, the provision of additional human resources, and the funding of IT resources. For example, the lack of additional funding to hire more health professionals (nurses and other health professionals) prevented two FMGs from registering more patients or achieving their targets (in terms of number of registered patients).

«We need to have... I think 4 or 5 more professionals...but there is currently no budget for additional professionals, although I have a signed agreement with the regional health authority although our physicians fulfilled their part of the contract, but the regional health authority failed to respect its commitments». (Physician, FMG A).

A majority of the interviewees identified the lack of continuous identification and monitoring of the needs of FMGs in order to sustain their development, from regional health authorities. Others identified the high turnover rate of professionals within regional health authorities which impede the continuous identification and monitoring of FMGs' needs in order to provide support when it is required.

Cycle 3: Final Research Cycle

Part 1: Objectives of the final research cycle in the context of the Quebec node case study

The final cycle of the research consisted in returning a brief overall summary/synthesis of our results (from the first and second round analysis) to the physician leaders of two of our three Family Medicine Groups (FMGs). This synthesis was made to get their insights on leadership roles, capacities, facilitating and impeding factors that had been identified all along the research. Further, a focus group with three physician leaders (representing two of our three FMGs) was conducted at the beginning of October. These three participants were the key leaders involved in the creation and implementation of their FMG.

- FMG A: two physician leaders (same participants as in the first and second round);
- FMG B: no physician participated in the focus group, because of time constraints;

- FMG C: one physician leader (the same participant as in the first round and second round).

This third round of data collection, conducted from August to October aimed at confirming the trend of leadership dynamic and capacity for the transformation of primary care in Quebec, more specifically for the introduction and the development of FMGs. Further, this focus group was designed to complete our comprehension of the leadership roles, capacities, facilitating and impeding factors of leadership from the implementation to the development of FMGs in their local health networks (Health and social services centers - “Centres de santé et de services sociaux” CSSS). In order to achieve these research objectives, three core questions were asked:

1. What is the current state of leadership in Quebec, for the transformation of primary care, specifically for the implementation and development of new organizations (i.e., FMGs)? What is working or not working in terms of stimulating and supporting health system transformation (i.e., family medicine transformation with the implementation of FMGs), and what contextual factors influence effective leadership action?

Specific sub-questions were asked:

1.1 Who is effective in stimulating and supporting the implementation and development of FMGs and what are the effective leadership roles?

1.2 What are the contextual factors that facilitate or impede effective leadership action/role?

2. Where are the gaps between current practices, the evidentiary base in the literature, and the expectations for the leadership outlined in the emerging health leadership capability/competency frameworks (e.g., LEADS), and how might a set of national standards for leadership be structured?

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 in Quebec, and enhance the development of quality health leader?

These questions are consistent with the core questions asked for the final/third cycle of the research in the context of the overall research study.

Part 2: Summary results of leadership for the transformation of primary care in Quebec (specifically for the implementation and the development of FMGs)

1. What is the current state of leadership in Quebec, for the transformation of primary care, specifically for the implementation and development of new organizations (FMGs)? What is working or not working in terms of stimulating and supporting health system transformation (i.e., family medicine transformation with the implementation of FMGs), and what contextual factors influence effective leadership action?

1.1 Who is effective in stimulating and supporting the initiation/creation, implementation and development of FMGs and what are the effective leadership roles?

Since the government developed a voluntary approach to physicians' involvement in the FMGs, the impetus for change came from medical clinics, specifically from physician leaders who had responsibilities and an important commitment towards the development of their clinics. Consequently, FMGs creation was started from the bottom. Nevertheless, to get physicians' involvement, regional health authorities created incentives such as financial incentives, administrative support and the provision of nurses for clinical support.

During the creation of FMGs, physician leaders (i.e., FMGs managers) exerted an important leadership both by identifying the need for renewing their model of family practice by creating FMG and by getting the support of their associate physicians for creating a FMG.

During the implementation phase of FMGs, physician leaders were the main drivers/initiators of change. They were in a central coordinating position in FMGs management, since they were involved in many activities such as patients' registration, team members' integration (including nurses and administrative agents) and clinical management (elaboration of nursing care protocols, development of care programs and care pathways, etc.). Associate physicians also exerted leadership particularly for clinical management (development of care programs) in collaboration with physician leaders.

We observe a more distributed leadership (across all members of FMGs) during the development of FMGs, although physician leaders remain the main coordinators of FMGs development by supervising the overall management of their FMG. Physician leaders more and more delegate the initiatives of developing and managing new programs and new clinical activities. Indeed, associate physicians now play an increasing role in clinical management: each physician contributes in initiating, developing and managing health programs; they are driving continuous clinical development of their group by proposing new ideas, new programs, etc. Nurses working within FMGs have now more leadership regarding monitoring patients, in collaboration with physicians. They are totally involved and jointly responsible of patients' management with physicians. Moreover in the three FMGs, they took more responsibility in diagnosing patients and in monitoring independently patients with chronic diseases.

At the external level, CSSS exert more and more leadership in supporting the development of partnerships (between FMGs and hospitals and clinics within their local health networks, i.e., CSSS) and interprofessional collaboration. Indeed, managers within CSSS provide their support in terms of organizing coordination, in order to facilitate the development of these new partnerships and interprofessional collaboration. The progressive development of partnerships and interprofessional collaboration leads to more integration and coordination of care between FMGs and CSSS for registered patients within FMGs.

1.2 What are the contextual factors that facilitate or impede effective leadership action/role, specifically for the development of FMGs?

The main contextual factors observed are related to external governance (local level governance and higher level governance):

We observed a major facilitating factor which is increasingly supporting the continuous development of FMGs. It is related to the shared vision within local health network (i.e. within CSSS, Health and social services centers) regarding FMGs values, goals and mission. CSSS now better recognize FMGs' contribution in terms of care accessibility. This shared vision or recognition facilitates the support from CSSS to provide more expertise for various activities: development of new clinical partnerships, development of interprofessional collaboration, implementation of new care organization, daily management activities, etc.

We also observed a major impeding factor related to higher level governance, which slowed the implementation and specifically the development of FMGs. Physician leaders reported the lack of overall vision of the development of FMGs on the part of both regional health authorities (Agences de la Santé et des Services Sociaux) and Quebec Federation of General Practitioners (Fédération des médecins omnipraticiens du Québec-FMOQ), in terms of clinical development (e.g., restrictive role of nurse practitioners) and in terms of administrative procedures (e.g., complexity of billing procedures and IT procedures). They also pointed out the lack of communication, responsiveness and support from regional health authorities for allocation of resources. This was related to the funding of new activities, the provision of additional human resources, and the funding of IT equipment and services. For example, the lack of additional funding to hire more health professionals (nurses and other health professionals) prevented two FMGs from registering more patients or achieving their targets (in terms of number of registered patients).

Another important higher level governance impeding factor is related to the lack of influential/mediating role by the Regional Department of General Medicine (Département régional de médecine générale-DRMG) towards regional health authorities. DRMG has very little influence on regional health authorities' decisions concerning FMGs development policies/orientation/direction. According to physician leaders, there should be a FMGs representative/regional director able to make decisions jointly with regional health authorities, in order to set regional directions for FMGs development.

In short, there is strong leadership for the transformation of primary care at the local level, coming from physician leaders of FMGs and managers of CSSS, but a lack of vision and leadership at the regional (regional health authorities) and provincial (ministry of health) levels.

2. Where are the gaps between current practices, the evidentiary base in the literature, and the expectations for the leadership outlined in the emerging health leadership capability/competency frameworks (e.g., LEADS), and how might a set of national standards for leadership be structured?

Many practices/capacities of leadership observed in the FMGs studied here are consistent with the LEADS framework, especially for physician leaders around the components “Engage others”, “Achieve results”, “Develop coalitions” and “Systems transformations”.

Regarding the components “Achieve results” and “Engage others”, we observed two types of capabilities exerted by physician leaders within FMGs. First, they had the ability to engage members, supporting and challenging them, creating engaging environment by sharing a personal vision and seeking to inspire a shared vision among FMGs’ members. Second, key leaders mobilized their capacity to align actions with collective vision, goals and mission of FMGs. Both types of capacities were mobilised for both implementation and development of FMGs (introduction of new clinical programs, elaboration of new nursing care protocols, new care organization, integration of new health professionals within teams, etc.). Nevertheless during the first years of implementation, physician leaders reported to be not very confident with change, administrative and team management. They developed these competencies and capacities all along the implementation of FMGs.

For the development of FMGs, we observed more capacities related to the components “Develop coalitions” and “System transformation”, with the development of new care organisation (e.g., Advanced access), interprofessional collaboration and partnerships (e.g., care pathways, shared care programs).

For the government, we observed a capacity regarding “System Transformation” since the government has created an effective voluntary approach to physicians’ involvement with incentives

(financial incentives, administrative support and clinical support), which succeeded in stimulating and getting the support of physicians in the creation of FMGs.

Nevertheless, we observed among external actors (regional health authorities, FMOQ), a lack of capacities for the continuous development of FMGs specifically for two components “Engage others” and “Develop coalitions”. In terms of “Engage others” capacity, regional health authorities have not communicated effectively with FMGs and fostered the development of FMGs. Regarding “Develop coalitions” competency, DRMG have not succeeded in navigating the socio-political environment, since DRMG is not playing an effective role in negotiating and setting directions for FMGs development jointly with regional health authorities.

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 in Quebec, and enhance the development of quality health leaders?

In view of our Quebec case study on the development of primary care through FMGs, some knowledge could be mobilized by the health system network into approaches, programs and tools in order to develop a culture of effective leadership.

Training programs for family physicians would be a learning opportunity in order to give them techniques and tools to better manage change for the implementation and development of their new organizations and develop specific competencies in administrative and team management. For medical residents who demonstrate an interest for management, mentoring programs could be developed (within family medicine units) and given by experienced physicians (e.g., experienced in FMGs implementation and management).

In terms of regional governance, there is a need to foster the leadership of DRMG (regional department of general medicine) for supporting the development of FMGs within their territory (regional network). According to physician leaders, a medical director, representing FMGs could be appointed to the DRMG. This new position/mandate could facilitate DRMG capacity to negotiate with regional health authorities, and so foster DRMG involvement/leadership to set regional directions for the development of FMGs within their territory.

Finally, incentives and policies could be put in place to enable and stimulate regional and local efforts to evaluate FMGs' performance in terms of accessibility, coordination and integration of care within the health system network. The results of such evaluation could help identify the areas for improvement in FMGs.

Part 3: Knowledge transfer plan after the final cycle of research

As part of cycle 3, we shared in writing and face to face our results with the leaders of the three FMGs. We plan to transfer the knowledge that emerged from this study in other ways. In that regard, we will develop a short synthesis of the key leadership results, which will be submitted to both policy-makers and local decision makers (physician leaders). The policy-makers identified are: one decision-maker within the Ministry of Health and Social Services and the president of the Quebec Federation of General Practitioners. The local decision-makers identified are: three physician leaders practicing in the three selected FMGs of the study. After submitting this synthesis, we plan to organize a meeting in order to discuss the results and to get the insights of decision-makers regarding leadership in the context of primary care reform.

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