Ontario College of Family Physicians
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DRAFT EXECUTIVE SUMMARY

Preparing for a Devolved, Population-Based Approach to Primary Care

Ontario College of Family Physicians

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Executive Summary

Introduction

Building on five position papers developed by the Primary Health Care Planning Group, the Expert Advisory Committee on Strengthening Primary Health Care in Ontario provided the Ministry of Health and Long-Term Care with recommendations for redesigning the primary care sector in early 2015 ("The Price Report"). It is anticipated that the Ministry will respond to these recent recommendations and propose greater devolution of the primary and community-based health-care sector to the local level. While the details of such a transformation are as yet unknown, it is assumed that organizations responsible for planning and commissioning primary care services for a defined population of residents ("patient care groups" in the Committee's report) will be formed at the sub-LHIN level.

To prepare itself to support the membership, the Ontario College of Family Physicians commissioned Dale McMurchy Consulting to develop this evidence brief to provide background and information that will help the College become more knowledgeable about this type of primary care model in other jurisdictions. The brief will also help the College to prepare to contribute to and shape the coming change in Ontario.

The document is based on published and grey documents and several key informant interviews. It is mainly based on the experiences of primary care commissioning groups (local organizations that plan, fund, oversee and sometimes deliver care for a defined population) in the U.K., Australia and New Zealand. Where applicable, it also includes insights and parallels from the implementation of Family Health Teams (FHTs) and Health Links in Ontario. These jurisdictions have had fundholding/commissioning roles in primary and community care for some time and have subsequently implemented various changes to these models. This brief reviews the structure and the successes and challenges related to local-level planning and commissioning models, as well as critical factors to consider at the initiation of change, the key levers of change, and the requirements for organizational development and management.

Start-Up Considerations

Experience and evidence indicate that there are a number of key considerations for initiating and implementing primary care transformation, particularly for implementing commissioning groups. Experience shows that when these factors are taken into account, implementation is smoother and the chances of success are greater. At start-up, the guiding principles for reform need to be identified and operationalized. Key considerations include the following:

Making a compelling case for change

Reformers need to make a compelling case for change. The evidence shows that the impetus for change is supported by a strong narrative indicating the potential benefits to clinicians, patients and the health-care system. Central authorities and sector leaders must be clear about the vision and goals of reform – they need to take moral leadership and clearly set out and stand by the aspirational goals for the primary care system.

Getting the right balance between prescription and experimentation

Striking the right balance between prescribed structures/processes and experimentation has been an ongoing challenge in health-care transformation. The balance between practice autonomy and accountability must also be addressed. While most would agree it is important to allow new initiatives to take a form that best reflects the local needs and environment, the Ministry should be definitive in its expectations, including governance structures, performance expectations and penalties for non-conformance, to ensure accountability for the investment of public funds.

Governance

Experience in several jurisdictions indicates that focusing on governance structures and processes throughout the system is critical to the success of transformation. Internationally, the nature and structure of the commissioning groups has evolved over time, often with a greater emphasis each time on corporate governance and skills-based boards and management. This increasing emphasis includes a greater focus on leadership, organizational development and change management.

Application process and requirements

The process by which organizations (or groups of organizations) apply to become a commissioning group is an important consideration for ensuring the creation of strong and effective entities. Both Australia and the U.K. underwent an extensive application process in forming and implementing the most recent commissioning groups. In the U.K., applicants had to complete an authorization process designed to test their core competencies; 80% initially failed to meet at least some of the assessment criteria.

How the funds flow

The way funds flow to primary care practices varies greatly across the jurisdictions studied and it can have varying effects depending on the structure and design of commissioning groups and the health-care system. Ontario's Price Report recommends incremental change, first with a separate stream of funding to family practices and then a merged system of funding flowing through the proposed sub-LHIN commissioning groups.

In each international jurisdiction examined, the fundholding and flow of funds was varied, multifaceted and complex. Usually, core funding for family physician contracts is set by the central authority, but contracting and accountability may be to the commissioning group. Funding flows and mechanisms are critical to incentivizing change (as well as disincentives and unintended consequences) and high performance and to the nexus of control. While there are strong arguments for having a central global budget at the local level for all primary and community-based care to increase integration and efficiency and improve performance monitoring, important concerns that arise from the nature of budget-holding and the flow of funds include the questions of how to

- Ensure the money follows population-based needs and issues
- Promote shared resources and economies of scale and bring groups together in this regard
- Redirect resources saved by economies of scale and other efficiencies and expand services with these resources
- Track, monitor and enforce accountability
- Define and clarify who is the funder and who is the service provider

- Address conflicts of interest, especially where family physicians have dual roles with the commissioning groups and their practices

Clarity of roles and responsibilities

The roles and responsibilities of the various stakeholders must be clear in the devolution of primary care to a population-based, locally commissioned model. Central authorities must provide a clear vision for primary care and other community-based health services. They also need to establish a comprehensive strategy that supports family practice and other primary care providers in developing extended roles. Central authorities play a role in strategic planning, establishing system priorities, providing guidance on quality and access standards, defining the core contract and enabling peer-led change. In delegating responsibility to the local level, administrators and clinicians need to be confident that the stated roles and responsibilities and associated authority will in fact be delegated.

During transformation, local commissioning groups play a role in supporting practices to manage change related to the new organizational arrangements. This support can include

- Defining expectations and contracts for service delivery
- Providing analytical and business development support to help practices create and implement business plans
- Providing professional development for the skills needed for organizational change
- Supporting priority-setting and strategic planning by developing local structures and facilitating collaborative efforts to develop local plans

Internationally, the role of commissioning groups was central to the successful implementation of change.

In relation to quality improvement, it is important to define the roles and responsibilities of the various central and regional bodies. It must be clear who is providing leadership, defining goals and targets, taking responsibility for achieving them, engaging and supporting family practices, and monitoring and responding to suboptimal performance.

The role of family physicians must also be well-defined and expectations clearly articulated. If part of the rationale for creating commissioning groups is to engage clinicians, increase their role in local decision-making and benefit from their expertise, commissioning groups need to build and sustain local family physician engagement and clearly define physicians' roles. Family physicians can be involved in a number of ways, including dedicating administrative time to the commissioning bodies as staff or board members, acting as practice representatives, participating in local reform consultation and planning sessions, or acting as practice leaders and champions.

Time required for change to take place

The evidence is clear that reform initiatives need to set realistic timeframes for achieving desired outcomes and managing risk. It takes time for providers to learn new ways of working and to implement changes that improve effectiveness and efficiency in the longer term. Internationally, commissioning models have evolved over time. Few of the models remained static and most changed based on experience during implementation (and changes in government).

As well, various aspects of the models were introduced incrementally. Some models started with reform model pilot projects, while others started by focusing on a particular aspect of the reform, with changes to other components following. An important lesson from these jurisdictions is that early changes influence how the reform evolves. Thus, the first step is critical and lays the groundwork for what follows. The way reform is initiated needs to be designed with consideration of the ultimate goals and the steps that must follow.

As well, clinically led organizations holding budgets and taking financial risk can take time to gain stability and deliver change and, thus, generally do not take on full global risk from the start. For example, in the U.S., most of the emerging Accountable Care Organizations have opted for gain-sharing contracts in their early years, rather than a mix of gain-sharing and risk-sharing.

Realistic estimates of the costs of transformation

International experience indicates that in addition to considering the time involved in transformation, adequate attention must be given to the costs of supporting successful transformation. Many health reform initiatives have faced challenges related to not having enough transition funding to support the process of change or one-off costs. Adequately financing change can increase the likelihood of success, improved efficiency and better outcomes. The following are some considerations for funding change:

- Assessing underlying financial viability
- Assessing local funding allocations and planning for funding continuity
- Knowing the costs of setting up a new organization, infrastructure and team
- Ensuring that project management and organizational development are funded
- Securing resources for dedicated transformation teams staffed by individuals with change management skills and credibility with clinicians to manage and drive the change process
- Providing short-term, external support to inject energy, pace and expertise
- Securing professional time for participation in change initiatives
- Sourcing resources for skills development and leadership training
- Funding visible improvements – "quick wins" – that can build momentum, demonstrate commitment and boost morale
- Funding staff or facilities to ensure service standards
- Investing in financial incentives
- Investing in engagement and collaboration activities

Geographic considerations

Internationally, some commissioning groups were aligned with the boundaries of the LHIN-equivalent regional health authorities; some groups spanned several authorities. This latter approach has strengths and weaknesses. It has hindered the ability of regional authorities to streamline activities within their geographic boundaries, and family practices may have commissioning agreements with more than one commissioner. However, some providers have achieved economies of scale by contracting with more than one commissioning groups across a wider geographical area.

A review of commissioning in Australia found a "lack of alignment has hindered governance, shared purpose and collaboration, and stymied effective strategies to integrate care, for example hindering multi-disciplinary clinical engagement to create locally relevant clinical health care

pathways. Alignment of geographical boundaries is a necessity for clinical alignment and to support patient flows, as most submissions and stakeholders agreed. In some jurisdictions creative approaches may be required to achieve alignment."

Levers for System Change

The literature, and international and national experience, shows that a number of levers support transformation of the primary care system locally, regionally and more broadly. The literature suggests that a combination of approaches – e.g., "prod" and "supportive" – at the organizational, practice and individual levels is often the most effective. The critical levers for primary care system transformation that need to be explored and addressed are as follows:

Acknowledging and addressing barriers to change

When first engaging in reform, it is important to identify, discuss and address stakeholder concerns and perceived barriers to implementing change. This step includes acknowledging the change process and addressing challenges related to resources, time, resistance to change and level of effort.

A change in culture and a culture of change

A change in culture

Across international jurisdictions and across Ontario, many believe it is time for a transformational culture shift within family medicine and that this shift should be reinforced by a systemic structural change. Some argue that without a change in culture, any reform will be flawed and will not achieve its goals. Primary care leaders need to speak out decisively for the aspirational goals of primary care and the health-care system. Some suggest that to ensure real transformation in Ontario, family medicine needs to strongly advocate its vision for primary care and support the voices of leaders, visionaries and younger family physicians over those of dissenters.

A culture of change

In addition to a change in culture (or in the ethos), transformation efforts require a culture of change to be firmly in place. According to one U.K. report on transforming family practice, "the development of this kind of culture is a necessary part of the transformation itself." Change occurs in environments where the culture is open to it and supports it. A culture of change has been described as one that engages people in decision-making based on "co-produced organizational values" and "a motivated workforce that responds to the vision and opts in by committing to improvement activities."

Developing a culture of change can mean convincing people that i) there are critical issues to be addressed and ii) the problems they believe to be intractable can in fact be fixed. In addition to needing motivation to make change, individuals need to see value in the improvement activities over and above their usual roles and they need to be supported in taking action and overcoming the challenges they face when implementing change. A report on accelerating change in the National Health System (NHS), speaks of needing "headspace to make change happen" and suggests this entails thinking beyond the day-to-day and creating the culture and attitude that "improving services [is] seen as part of their day job."

Key ingredients for addressing culture

A number of key elements support both a change in culture and the development of a culture of change. Both can be strengthened by

- A more positive tone and rhetoric about the health system and its reform goals
- A critical mass of clinicians actively supporting and advocating for change
- Support for clinicians who take leadership roles that may set them apart from, or against, their peers
- Identifying and nurturing potential clinician leaders
- Role modelling by clinical leaders
- An openness to working together
- Clinician involvement in the design and delivery of the reform initiative
- Developing and advocating for clinical standards, guidelines and performance benchmarks
- Addressing constraints imposed by external stakeholders and professional allegiances
- Central authorities working to create a common understanding and solve common problems
- Increased outreach, meetings and sharing among stakeholders
- Coordinated action across the health-care system
- Creating a sense of ownership
- A strong evidence base for change

Additional methods shown to support a culture of change in clinical practice are outlined in the body of this report. Many of them blend organizational systems and processes with reforming frontline professional practice.

Leadership

Leadership is another critical and defining factor in supporting change in primary care; it is discussed in the literature and by experts with experience in the field. "Leadership – particularly the ability to engage people with a clear vision for change, centred on patients – is arguably the most important factor for achieving successful change. Leadership needs to be collective and distributed throughout different levels of an organisation, with leaders facilitating collaboration and sparking enthusiasm." Some key attributes are associated with *transformational leaders* in health care – these are unique individuals who

- Set an aspirational vision
- Inspire, energize and mobilize people
- Create an evidence-based case and urgency for change
- Are strong and courageous enough to make real changes and to take the initiative rather than waiting for permission
- Visibly commit to transformation and act as role models, exemplifying desired behaviours
- Have a clear understanding of where the sector and/or organization is going, how to get there and how to communicate this direction and inspire others
- Engage stakeholders and frontline staff early and in a genuine manner
- Solicit expertise to solve problems and make better decisions
- Learn from the experiences of others, through trial and error and by taking risks
- Convince others there is a problem and that the solution is the right one and is possible
- Develop clear, simple goals
- Develop a credible reform plan and enable "quick wins" to demonstrate change

- Understand how to manage stakeholders, create "headspace" and have the courage to stand their ground on what they believe is right for their sector or organization
- Can successfully navigate "the politics"

High-quality candidates for leadership and senior management are needed to support system reform and ensure success. Experts speak of the importance of having people with the right expertise leading and supporting transformation. These change specialists need i) strong leadership skills to broker consensus and drive implementation and ii) advanced operational and managerial skills. The skills and capacities required (and that often need to be developed or augmented) include the following:

- The ability to identify and understand problems rapidly, to understand their root causes, to plan and prioritize how to solve them, and to manage implementation in a structured way (using data, staff knowledge, and experience and evidence from elsewhere)
- An understanding of how to manage and lead change, including long-term implementation
- The ability to draw on best practices and develop novel approaches to design solutions
- Practical experience in change and improvement methods and tools, and the ability to adapt and apply these to the specific circumstances
- The skills to manage and guide planning and implementation, including developing resource requirements, timelines, milestones, etc.
- The ability to train and empower others
- Skills for and/or a good understanding of data management and analytics and of performance measurement

Family physician engagement

Generally, there are two functions of commissioning groups that rely on different levels of physician engagement. The first function – commissioning services outside family practice – does not necessarily require the active involvement of a large proportion of family physician members; it requires sufficient clinical expertise and input to support decision-making. The second function – primary care planning – depends on all members engaging and accepting the role of the commissioning group in improving family practice.

The evidence shows that family physician engagement in commissioning reform initiatives and primary care reform in Ontario has ranged from "highly engaged" leaders to "dissenters." Reasons for dissent are numerous but are often a combination of practical constraints and philosophical objections. A commonly cited barrier to engaging members with the work of the commissioning groups is the lack of time and capacity in family practice. Membership in commissioning groups can entail more stringent contractual arrangements, an increased demand on physician time, more paperwork and wider policy measures. There is also concern among physicians that the devolution to local commissioning may cause (or appear to cause) them to make rationing decisions, especially during times of fiscal constraint. Other GPs suggest, however, that "this concern is overstated and balancing the concerns of individual patients against a responsibility towards the wider system has always been a central part of a GP's role."

New governance structures associated with commissioning groups need to support physician buy-in and engagement. The extent to which physicians feel they have ownership of the commissioning group influences their level of engagement. A review of the system in Australia

found that "there needs to be GP buy-in at both the governance and operational levels and for them to be able to see [the] benefit of their involvement." In Ontario, while this sense of buy-in was achieved in some FHTs, others have not met their full potential. According to a family physician in one FHT, "I would like to see more integration and collaboration between the physicians in the FHN and the FHT. We could do more in terms of integrated care and I don't think we have accomplished everything that we can."

In the U.K., most engagement with commissioning groups and input on decision-making is achieved through GP representation on the governing body and via practice representatives who participate in members' councils. The members' councils were designed to represent member practices within the commissioning group and were expected to play a role in setting the direction of the organization. GP representatives on the councils are to act on behalf of their practice and provide information to other members. Some constitutions hold practice representatives partially accountable for the behaviour of their practice colleagues.

Based on the evidence and experience of those implementing commissioning groups, critical factors found to support family physician engagement include the following:

• Communicating a clear vision of the reform objectives, including aspirational health system goals and a focus on quality improvement • Communicating a vision that describes how the reform and new entities are distinct from previous structures and organizations • Ensuring members understand the most important elements of the commissioning body's mandate and constitution • Prioritizing member relationships and cultivating a sense of collective ownership • Having a governance structure that supports the involvement of local clinicians in decision-making and delegates power where appropriate • Defining the roles of members, practices, the commissioning body and other governing bodies, with a clear understanding of authority and responsibility at each level • Clearly defining the role of the commissioning body in implementing quality improvement in primary care • Supporting peer-to-peer dialogue and performance review in small groups, particularly through face-to-face meetings	• Demonstrating early successes • Holding educational and other events (e.g., educational sessions, presentations by members of the governing body to the membership, forums for idea exchange and development, information sharing, presentations by other services) • Having websites or intranets with ready access to information • Enabling virtual communication with members • Enabling virtual and direct feedback mechanisms (e.g., feedback on concerns about commissioned services) • Creating telephone hotlines or other mechanisms to provide ready access to members of the governing body • Making practice visits in which commissioning body leaders meet family physicians, exchange information, seek volunteers and gain a better idea of what services are needed

Developing a foundation of integrated decision-making and collaboration

Another important lever supporting change to health system structures and delivery in a commissioning environment is having (or developing) a strong foundation for inter-organizational collaboration and working relationships with local health and social service providers. This foundation facilitates the creation of a health *system*. Levers for increased collaboration within primary care, and with the health system, include

- Having aligned incentives for collaboration
- Having a sense of urgency and/or willingness to innovate
- Having a positive working relationships among stakeholders
- Having support for the strategy and transformation efforts from commissioners, regulators and other organizations in the health system
- Taking into consideration participants' priorities, the dynamic of interactions and whether the focus is short or longer term
- Collaborating with other system organizations to solve specific problems (e.g., primary care and social services working to improve flow along the emergency pathway)
- Interacting with other local providers but not expending excess time and resources addressing problems beyond the particular organization's scope

Financial incentives

Several jurisdictions have used various funding models and financial incentives to spur change in primary care and much has been written on this topic. While micro-incentives have been found to result in improvements in targeted areas of care (but not wider quality improvements in non-incentivized areas), some suggest that financial incentive programs can be ill-suited to contexts of high goal ambiguity and complexity. Incentives can lead to prioritization of some goals over others and other unintended consequences.

In the U.K., GPs were thought to be trying to respond to too many different incentives at the same time and were overwhelmed by the combination – and competing priorities – of national and local incentive schemes and contractual performance measures. A report on transforming family practice in the U.K. concludes that "a different balance is needed between initiatives focused on clinical quality and outcomes and those which seek to redefine the role of primary care in whole-system changes. It is vital that policy-makers understand the impact of the various levers that they use and how they interact with each other."

Other funding levers have been shown to support change; such levers include funding for clinician training and capacity building, support for evidence-based education, and funds for family practices to contribute to redefining care pathways and reconfiguring services. This approach was referred to by an international physician leader as "paying for professionalism not performance."

Performance measurement, benchmarking and targets

The evidence is clear that data and measurement systems are critical to reforming the delivery of primary care and transforming the health-care system. Information technology use was widespread and data drove much of the planning, implementation and monitoring of commission groups internationally. Reform that incorporates data and measurement is characterized by

- Transparent measurement with simple measurement tools
- Getting the data collection and monitoring systems right
- Appropriate and supported IT infrastructure
- Functionality that supports collating data and benchmarking
- Systems that support quality improvement efforts and the sharing of best practices
- Timely availability of data

- Regular checks and audits
- Access to data throughout the system, organization and practice

Commissioning groups in the U.K. had several mechanisms for supporting quality improvement in family practice through audit and measurement. These mechanisms include

- Setting performance targets
- Sharing comparative performance data
- Providing education and information
- Facilitating peer review and peer pressure
- Providing financial incentives
- Establishing referral pathways, protocols and management centres
- Having medical audit advisory groups and clinical audit programs
- Imposing sanctions on underperforming practices
- Organizing practice visits to discuss performance problems
- Expelling practices from the commissioning group

Organizational Development and Management

Transforming to population-based commissioning models requires significant efforts in organizational development and management at the organization and practice levels. Key areas for focus and development are outlined below.

Addressing organizational barriers to transformation

Several barriers to transforming health-care organizations need to be addressed by leaders and managers from the start. Barriers need to be acknowledged and resolved to ensure successful transition.

Managing health organizations during transformation

Another critical component of a shift to commissioning groups is the development of effective organizations, at both the commissioning group and the practice/service level. Effective management structures – including rigorous strategic approaches, governance structures, change management processes, incentives, performance metrics and accountability – are needed at start-up and beyond. The following are some of the features that support the development of strong organizations:

- Clear accountability for reform initiatives, from the board through to the front line
- Management commitment to seeing the reform plan through, including how boards and funders hold organizations accountable
- Strategic business plans that translate a vision into an implementation plan
- Implementation plans with strategies for organizational development, workforce development and financial viability
- A structured approach to implementation, including measurable goals, milestones and performance scorecards; these tools need to be used consistently and systematically
- Effective management structures to monitor performance, manage and track progress and hold people accountable (some organizations set up a separate governance structure for the

transformation program to increase top management's level of attention and to encourage more strategic or transformational approaches)
- Skilled administrative and clinical leadership
- Clearly defined, evidence-based standards of care that are supported by clinicians and that create a focus for improvement through clear, common goals
- Multi-method training initiatives

Developing an enabling environment

An enabling environment supports and drives organizational change. Such environments are created by organizational policies, as well as national/central standards, explicit permission from central authorities and politicians to take risks and learn from mistakes, governing policies (e.g., financial incentives) that do not hinder change, and strong local relationships. The key factors that support an enabling environment in the implementation and management of commissioning models can include the following:

• External pressure for change • Central authorities that are amenable to change • Local support for change and/or local politics are addressed • Constructive relationships with authorities • Commissioners that are engaged in and support change • Cooperative inter-organizational networks • Consideration of external contexts – market, IT, political, regulatory, social, cultural • Acknowledgement of complex, high-risk environments • Removal of obstacles • Balance of incentives and sanctions • Alignment of organizational incentives and priorities with improvement activities	• A focus on where there is established best/good practice and any gaps between current and ideal performance • Consideration of financial context • Flexible payment structures • Navigable health-care structures • Participation is attractive for staff, including opportunities for career progression and role variety • Close attention paid to communication with all staff • Skilled strategic and operational managers executing organizational development initiatives and improvement projects effectively

Planning and change at the practice level

While many primary care practices have undergone significant reform in Ontario, most have not. The introduction of commissioning groups will likely require even more complex change processes at the front line of service delivery, including increased networking and partnering among providers. To support change, practices will need staff with business and organizational development skills and the capacity to manage the workload associated with change, and who also understand the nature and culture of family practice.

The following are examples of factors that support planning and change at the service delivery level – within a population-based, commissioning environment – some of which have been discussed in greater detail above.

• A common vision to provide community-based integrated care to enhance patient care • A dual narrative about benefits to patients and how participation in coordinated care initiatives will make the workday easier • A strong foundation of integrated work that new initiatives can build on	• New working relationships between GPs and specialists • Involvement of frontline staff in designing and implementing practice change • GP partners' willingness to personally invest their time and financial resources • Increased career opportunities for partners and

• Leadership across primary care, community and social services, promoting joint work and collaboration • Administrative and financial support to help form networks • Increased mergers, partnerships and networks • Investments in leadership training, meetings and project management to support implementation • Regular meetings among member practices and networked practices • Workshops and "action learning sets" with family physicians, community health and social services workers, and other professional groups to develop shared goals and values and aligned working practices • Incentives to attend network, multidisciplinary and educational meetings • Improved integration of family medicine, community and specialist services	staff • Diversification of income streams with less reliance on a core contract to increase business sustainability • Shared practice resources to increase efficiency • Professional education and development of clinical and organizational skills by family physicians • Peer review • Development of shared approaches to support change and performance improvement initiatives • Incentives to practices to develop care plans, care pathways, medical directives, etc. • Adoption of best practices and of standardized clinical care and management processes across sites • Investment in information technology • Better use of data to monitor care and drive change

Hiring for cultural fit

Transitioning primary care practices and organizations need staff that reflect the aspirational vision and values of the organization. In Ontario, some FHTs experienced significant human resource challenges in this regard, which impeded their teams' overall performance. Several FHTs altered their hiring practices based on early experiences. Some turned away potential hires or let staff go if they did not fit in with the organization's philosophy. Some FHTs left positions vacant rather than hire people they believed would be detrimental to the team and not fit into the team culture.

Standardizing clinical and management systems to support change

Some primary care practices and organizations use standardized internal processes and systems to support change and maintain quality. Poor management processes and unclear lines of accountability can detract from the organization's ability to perform consistently and efficiently. As well, some suggest that the lack of standardized operational processes within practices can reduce the time and space needed to focus on reform and practice improvement.

Internationally, primary care organizations have standardized systems in several ways. Some used jointly developed care pathways, guidelines and protocols as tools for changing clinical and referral practices within clinics and across the system. Others had standardized, systematic approaches to quality improvement and assurance across all sites and had internal "turnaround teams" to ensure all sites delivered a standard level of clinical care based on key performance indicators. Others provided standardized room layouts, clinical pathways and operational processes, and held regular meetings for peer review of treatment decisions and continuity of care during patient transitions between hospital and community.

Training and skills development

The evidence indicates that during change initiatives, individuals need skills to identify and solve problems. At least three types of skills have been identified as requisite to implementing change:

1. Technical skills, such as project management, clinical pathway design, change management and the use of quality improvement methodologies
2. Interpersonal skills, such as good communication, conflict management and negotiation
3. Learning skills, including collective reflection and debate

Various skills deficits have been identified in the primary care workforce that can limit its ability to deliver transformed services in an integrated, population-based environment. These deficits include the following:

- A limited understanding of population health
- Weak relationships with community health and social service professionals and poor understanding of their roles and scope
- Poor knowledge and skills for strategic planning, business case development, standardized operating systems, management of innovation, performance management and governance
- Lack of skills required to work across organizational boundaries
- Lack of familiarity with technologies that can support and transform patient care, including consultations using new media
- Limited skills in data analysis and comparison to support quality improvement and peer review
- Failure to adapt consultation style and content to individual patients' needs
- Lack of methods for care navigation

Approaches (often multifaceted) that can increase clinician capacity for implementing change and improvement include these:

• A central network to coordinate training that is consistent, replicable and responsive • Identification of core competencies and the development of a single competency framework • Development of competencies across disciplines • Accredited courses • Training hubs • Formal education and professional development • Coaching, peer support and facilitated discussions • Workshops and action learning sets • In-house mentoring, leadership and skills training programs • In-service training included as part of the job description/requirements, (e.g., for management and leadership roles)	• Web-based training and information resources across a network of practices • Increased exposure to new forms of patient consultation • Creation of time and space for staff from different professions to interact and participate • Increased collaboration and interprofessional work • Job performance appraisals and balanced scorecards for individual performance • Discussions with bodies responsible for professional training about broadening their curricula • Harmonization of workforce development strategies to ensure that newly qualified practitioners are capable of integrated and interprofessional practice

Size of practice groups and types of arrangements

The size of practice groups and the types of arrangements that are formed can also influence success within a commissioning environment. Small practices have limited infrastructure to improve patient access and augment services. They are more vulnerable to marginal reductions in income and usually have insufficient staff to respond to new service, clinical, administrative and regulatory demands. Larger practices generally benefit more in a commissioning model.

Nonetheless, it can be challenging to keep what staff and patients of small local practices value, while achieving economies of scale and maximizing opportunities for additional contracts. A study in the U.K. found that networked (versus merged) models could take transformation only so far without compromising the autonomy of individual practices, creating conflicts of interest and slowing decision-making. Significant effort and resources were required to create larger, single practices through mergers. But closer alignment of decision-making and a shared risk/reward approach was felt to offer more potential and better long-term sustainability. Careful analysis is needed to understand the risks and opportunities as organizations grow.

Addressing conflict of interest

Conflict of interest has been discussed in relation to commissioning authorities. While commissioners need to work closely with GP members and provider organizations, this cooperation can create conflicts of interest. Larger primary care organizations that take on additional commissioned work and operate in a market-based environment raise a real or perceived conflict of interest between family physicians as both commissioners and care providers.

The recent Australian reform removed service delivery from the role of the commissioner (except where there are no other services) because of perceived physician conflicts of interest in governance and management roles. One study in the U.K. showed awareness of and some concern about potential financial conflicts of interest. One area team manager suggested that some GPs may not yet understand the extent to which conflicts of interest could be a constraining factor in the future. There is also some concern about the role of GPs on the commissioning governing body. Physicians with a role in the commissioning group are to adhere to explicit local policies to manage conflicts of interest when bidding for new services. In some instances, GPs adopted either a provider or commissioner role to create separation within their organization. A report on the role of commissioning groups in supporting improvement in family practice concluded that,

> "If CCGs [commissioning groups] are to help foster this kind of innovation, the issue of conflicts of interest will inevitably come to the fore. For CCGs to commission enhanced primary care services from local GP-led provider organisations without risking incurring reputational damage to GPs, it will be important that conflicts of interest are managed robustly. The extent to which this becomes a constraining factor that limits the development of new forms of general practice remains to be seen"

Summary

A number of key themes have emerged from the evidence collected and interviews conducted for this brief. The successful implementation of commissioning groups will require a strong and vocal commitment – by governments, health authorities, stakeholder groups and clinician leaders – to the aspirational goals of a high-quality, patient-centred primary health-care system. This commitment includes the development of communication strategies and a strong show of support by family medicine for – and an acknowledgement of accountability to – health system goals. A change in the culture of family medicine is needed, along with the development of a culture of change at the practice level.

As part of implementing and supporting transformational change, strong, visionary, risk-taking leadership is required at all levels. A strong voice from family medicine in design and implementation from the start will support success. This means that many family physicians will need to take on leadership and, potentially, managerial roles throughout the system and may need to further develop their skills in this regard. International and local experiences have shown that strong governance and management structures, made up of individuals with deep and diverse skills, are essential to the transition to commissioning models.

The commissioning models in the U.K., Australia and New Zealand have evolved since their inception as strengths and weakness have been assessed and governments have come and gone. The same can likely be expected in Ontario. As was learned during the implementation of these international models, and by the experience with Family Health Teams and Health Links, there needs to be an appropriate balance between clear articulation of the model and its requirements – including governance and organizational structures, performance expectations and penalties for non-conformance – and allowance for the opportunity to experiment and innovate. The tensions associated with public funding of private organizations, and between the need to ensure clinical excellence and practice autonomy, also need to be addressed.

International experience has varied in terms of the number and size of commissioning groups, jurisdictional boundaries, the role of family physicians on – and the methods of engagement with – commissioning bodies, the role of commissioning bodies as funders and service providers, financial incentives, and how funds flow to family physicians. These elements need to be explored for the Ontario models. Potential conflicts of interest for family physicians in this regard – as well as in other areas – must be identified and addressed from the start. Additionally, the roles and responsibilities of authorities at all levels need to be clearly communicated and understood.

A critical component of this primary care system transformation is change at the practice level, including greater collaborative working relationships with other providers and sectors and a focus on high-quality clinical care and an improved patient experience. A number of models for incentivizing high performance are discussed in the body of this document, along with their associated pros and cons. The main consideration is that the approach must be multifaceted and consider the time and resources required for change. Internationally, there has been good success with family physicians taking leadership roles in terms of accountability and peer-led models for practice improvement, including formal peer-review programs.

Interviewees

Below are the key individuals interviewed via telephone and Skype for this evidence brief. Others in New Zealand, Australia, the U.K. and Canada were consulted and provided feedback and input by email.

New Zealand

Dee Mangin
Dee Mangin is an Associate Professor, Dept. of Family Medicine, McMaster University; Associate Professor, Director of Research, University of Otago, Christchurch, New Zealand; and a family physician at the McMaster Family Health Team

Dee moved to Canada from New Zealand in late 2013. Prior to moving to Canada she was the Director of the Primary Care Unit at the University of Otago, Christchurch as well as a Clinical Advisory Board member and Clinical Leader for Research Audit and Evaluation at the Pegasus Health Primary Healthcare Organization. She was a Ministerially appointed member of the Pharmaceutical and Therapeutic Products Advisory Committee to PHARMAC and served on the Southern Region Ethics Committee. She is a Fellow of the Royal New Zealand College of General Practitioners and in 2011 received their Distinguished Service Medal.

Her broad interests are rational prescribing, innovative models of primary care delivery, and the influences of science, policy and commerce on the nature of care. She has expertise in the effects on prescribing of pharmaceutical company promotion to consumers and physicians. She has wide clinical research experience in primary care using observational quantitative research methods including cohort studies, cross sectional studies and case control studies. She has specific experience in interventional studies: in community RCTs of innovative models of care, and of clinical interventions including antidepressant use, community acquired pneumonia, antibiotics in urinary tract infection, and in "deprescribing" trials of the reduction of multiple medicines in older adults in older age, and effective incorporation of evidence into patient centred practice.

Toni Ashton
Toni Ashton is a Professor of Health Economics in the School of Population Health at the University of Auckland in New Zealand. Her main research interests are in the funding and organization of health systems and health care reform, with much of her recent research focusing on various dimensions of health reform in New Zealand over the past decade. In addition to numerous articles in referred journals and several book chapters, she has co-edited a book on health policy in New Zealand. She has also co-authored three books on superannuation. Professor Ashton has been a member of a number of government working parties and taskforces has also undertaken a range of consultancies, including two for the World Health Organization.

Australia

Jane Gunn
Professor Jane Gunn is the Head of Department, inaugural Chair of Primary Care Research and Director of the Primary Care Research Unit at the Melbourne School of Medicine. Prof Gunn is a general practitioner and Head of the Department of General Practice. She has worked as an academic GP since 1991 and has been heavily involved in research, teaching and curriculum development. In 2009, she was appointed to the National Health and Medical Research Council Research Committee. She was also the chair of a Medicare Local and is working to establish the new Primary Health Network in her area.

Her research harnesses the patient experience to drive health care reform. Her research interests include depression in primary care, perinatal care, women's health, cancer screening, study design, and analysis within the primary care setting. Jane is particularly interested in randomised controlled trials, complex interventions, and combining quantitative and qualitative research methods in order to fully explore the questions that face the primary health care setting.

Grant Russell
Grant Russell is a primary care clinician and health services researcher. He is Head of School of Primary Health Care and Director of the Southern Academic Primary Care Research Unit (SAPCRU) at Monash University in Australia. Dr. Russell continues to work part time in a private general practice and teaches occasionally for Monash's Department of General Practice.

He is a graduate of the University of Western Australia and subsequently worked as a GP in Perth, setting up a small, independent general practice with colleagues prior to leaving for Canada in 2005 to work as an academic family physician and clinician investigator at the Department of Family medicine at the University of Ottawa.

Professor Russell's research program is directed towards understanding and measuring the impact of primary care reform on patients, clinicians and general practices. He has published extensively in journals such as the *Annals of Family Medicine, International Journal of Quality and Safety in Health Care, Family Practice* and the *Medical Journal of Australia*.

The U.K.

Chris Naylor
Chris Naylor is a Senior Fellow, Health Policy at the King's Fund. He conducts research and policy analysis and acts as a spokesperson for The King's Fund on a range of topics. He has led several major projects including a national evaluation exploring the development of clinical commissioning groups. He contributes to The King's Fund's work on integrated care and health system reform and has particular interests in mental health, community involvement and the environmental sustainability of health and social care.

Chris joined The King's Fund in 2007. He previously worked in research teams at the Sainsbury Centre for Mental Health and the Institute of Psychiatry, and has an MSc in public health from the London School of Hygiene and Tropical Medicine. He has also worked at the Public Health Foundation of India in Delhi.

Natasha Curry
Natasha Curry joined the Nuffield Trust in 2011 as a Senior Fellow in Health Policy. Her research interests include clinical commissioning, primary care provider models, integrated care, international health systems and NHS reform.

She is currently leading the Trust's two-year programme of research into the future of general practice and primary care. This mixed methods programme is tracking the development, activities and impact (on patients and professionals) of large-scale general practice organisations. In addition, Natasha is involved in various other projects including research into CCGs, emerging commissioning models and length of stay.

Prior to joining the Nuffield Trust in July 2011, Natasha was a fellow in health policy at The King's Fund. During her six years at the Fund, Natasha published widely on a number of subjects, including practice-based commissioning, the management of long-term conditions and approaches to clinical and service integration. Previously, Natasha worked as a consultant in health at Matrix Research and Consultancy Ltd and as the evaluations officer at the Chinese National Healthy Living Centre.

Ontario

Executive Directors, Family Health Teams
Family Physicians, Family Health Teams
Project Lead, Health Links
Project Partners, Health Links

Bibliography

Forthcoming