Overview

Primary-care leadership will be essential to the success of Ontario Health Teams (OHTs). Primary-care leaders and their OHT partners will need to engage the full diversity of primary-care providers in order to achieve the quadruple aim of improving care experiences and health outcomes at manageable per capita costs, and with positive provider experiences. Primary care is essential for achieving the first of these three aims and primary-care providers are a key provider group for the fourth aim. Moreover, primary-care providers are a key way through which patients will be 'attributed' to OHTs for the purposes of OHT funding and accountability.

Teams on an OHT readiness path will need to have an approach to: 1) helping the full diversity of primary-care providers understand the OHT landscape; 2) supporting primary-care providers to become leaders in their OHT and help shape it; and 3) working with these primary-care leaders to encourage the active participation of as many primary-care providers as possible in their local OHT. Regardless of the membership composition and organizational leadership model of a prospective OHT, all teams – even those that already include strong primary-care leadership – will need to focus on expanding their primary-care leadership and engagement.

> **Box 1: Coverage of OHT building blocks & relevance to sections in the OHT full application form**
>
> This RISE brief addresses **building block #6**:
> 1) defined patient population
> 2) in-scope services
> 3) patient partnership and community engagement
> 4) patient care and experience
> 5) digital health
> 6) **leadership, accountability and governance**
>   o **proactive provider engagement at all levels (domain 47)**
> 7) funding and incentive structure
> 8) performance measurement, quality improvement, and continuous learning
>
> It is relevant to **section 4** (how will your team work together?) and specifically question 4.2 in the OHT full application form.

Helping the full diversity of primary-care providers understand the OHT landscape

Primary-care provider engagement will need to encompass providers drawn from:
1) the full spectrum of primary-care-related professions, including family physicians and nurse practitioners, among others;
2) the full spectrum of primary-care models in which they practise, including:
   a) primary-care clinic models that range from traditional fee-for-service practices (including solo physician offices and walk-in clinics) to organizations that tick many of the boxes for a patient's 'primary-care home' (e.g., Family Health Teams), as well as hybrids between the two (e.g., Family Health Groups), and
   b) community-governed primary-care models that serve socially disadvantaged and hard-to-serve populations (Community Health Centres), Indigenous peoples (Aboriginal Health Access Centres and Indigenous Interprofessional Primary Care Teams), and small rural and First Nations communities (nursing stations), as well as the broader population (Nurse Practitioner-led Clinics); and
3) the full spectrum of primary-care service models they offer, which can range from specialized (e.g., focusing specifically on emergency-room care or palliative care) to comprehensive (i.e., providing a broad range of services to patients of all age groups and with any health condition).

These providers will need to understand the long-term vision for OHTs, such as the collective accountability for achieving the quadruple aim in a defined population, and the focus on proactively identifying patients with the greatest needs and coordinating services from multiple sectors to ensure these needs are met. They will also need to

understand which priority populations their local team will be focusing on in year 1, as well as have a working familiarity with the OHT building blocks that their local team will be designing with their input, and the general timelines for any changes that are likely to affect them.

Helping such diverse types of primary-care providers understand the OHT landscape can be accomplished through at least three mechanisms:
1) promotion of the outreach efforts of provincial groups that have well-established relationships with and actively support different types of providers, such as:
    a) Ontario College of Family Physicians,
    b) Ontario Medical Association (OMA) section on general and family practice, as well as the OMA more generally, which maintains a dedicated webpage listing its many [OHT-related resources for physicians](#) (including webinars that are also profiled on the 'Join events' part of the RISE website) and a dedicated email account to receive comments and questions ([oma_oht@oma.org](#)),
    c) Nurse Practitioners' Association of Ontario,
    d) Registered Nurses' Association of Ontario (for nurse practitioners and nurses working in primary care),
    e) Alliance for Healthier Communities (for community-governed primary-care models), as well as Community Health Ontario which the Alliance contributes to and through which the Alliance and its partners have developed a [webinar series](#) about OHT-related issues (which is also profiled on the 'Join events' part of the RISE website),
    f) Association of Family Health Teams of Ontario, and
    g) Indigenous Primary Health Care Council;
2) outreach through existing local networks (e.g., a network that brings together local community-governed primary-care organizations; a local Ontario Medical Association section on general and family practice); and
3) stand-alone communication, which may be a short-term option for teams that can't rely on existing local networks and which is likely to be a long-term necessity for all OHTs as they develop increasingly rich relationships with the primary-care providers serving the population for which the OHT is accountable.
A review of a broad range of family-physician-engagement mechanisms can be downloaded from the 'Key resources' section at the end of this RISE brief.

While profession-specific (or practice or service model-specific) conversations can be helpful in the short term, the types of interprofessional and cross-model collaborations that teams will be seeking to support will also be well served by conversations that involve providers from different professions and models.

Supporting primary-care providers to become leaders in their OHT and help shape it

Teams on an OHT readiness path will need to identify primary-care providers who are current or emergent leaders and match them up with an appropriate leadership role in an OHT, which can include:
1) its governing body (which is a topic addressed in RISE brief 3 about collaborative governance);
2) its executive leadership group;
3) its operational management group;
4) a primary care-specific working group; or
5) another type of OHT working group (e.g., one addressing a priority population, such as older adults with complex medical conditions).
Teams can potentially draw at least some of their primary-care leaders from those who played leadership roles in Local Health Integration Networks or in integrated-care initiatives like Health Links.

Teams will also need to support primary-care providers in their OHT leadership roles by encouraging their participation in provincial groups that enable and assist primary-care leaders, such as:
1) the Ontario College of Family Physicians' [Leadership in Primary Care Network](#), which supports leadership development and mentorship for family physicians;

2) the Ontario Medical Association's efforts to connect physician leaders engaged in OHTs with one another; and
3) the Association of Family Health Teams of Ontario and the Ontario College of Family Physicians, in partnership with the Change Foundation, which have initiated a [Primary Care Virtual Community](#) to support primary-care leaders in their work on OHTs (and which can be joined by completing a brief [online survey](#)).

Another example of relevant work is the planned adaptation of the '[10 high-impact actions to [free up] time](#)' from the U.K. National Health Service to the Ontario context. One activity to which primary-care providers' freed-up time can be devoted is primary-care leadership to help shape their local OHTs.

Depending on the primary-care model in which a provider works, being asked to take on a leadership role in an OHT is likely to trigger questions about being remunerated for time spent in such roles, especially when the role takes them away from direct patient care for which they are paid (as would be the case with many family physicians, for example). Teams on an OHT readiness path may want to develop a policy about remunerating primary-care providers for taking on leadership roles (e.g., what types of practice and service models and what type of providers or staff will be eligible for payment, at what rates, and for which types of expenses).

Encouraging primary-care providers' active participation in their local OHT

Once local primary-care leaders have been identified, teams on an OHT readiness path can work with them to build (or rebuild) the type of trusting relations with primary-care providers in their community that are a pre-condition to many types of OHT success, including the active participation of as many primary-care providers as possible in an OHT.

Active participation means that primary-care providers voluntarily commit – based on an existing relationship built on trust or a desire to develop such a relationship – to partner with health providers and organizations in their local communities to achieve the quadruple aim. The concrete manifestations of such active participation include:
1) signing a team's self-assessment;
2) signing a team's application if the team is invited to full application; and
3) signing a contract (or equivalent) with the ministry if the team is invited to become an OHT Candidate.

Signing up is far from a given. Many factors will play into a primary-care provider's decision to sign up; some obvious, others less so. There is a robust science to what drives provider decisions and actions, guided by the principle that it is important to understand what *factors* drive a decision so that any *strategy* put in place is designed to address those factors. Starting with a strategy first may produce a strategy that does not work because it is not fit-for-purpose.

Primary-care leaders involved in preparing a full OHT application can harness the science of provider behaviour change to support informed decisions about signing up by their peers. Readers wishing to move directly to the factors that may influence a sign-up decision can skip this paragraph and the next four paragraphs, and resume reading at the first full paragraph at the top of page 5.

The 'behaviour-change wheel' brings together key approaches to understanding and promoting provider behaviour change into one comprehensive and integrated framework (see the 'Key resources' section below). The behaviour-change wheel proposes that primary-care provider decisions and actions depend on three key factors (or 'sources of behaviour'):
1) capability (the physical and psychological capacity to engage in the behaviour);
2) motivation (all the brain processes that energize and direct behaviour, not just goals and conscious decision-making, and hence all of the habitual processes, emotional responding and analytical decision-making); and
3) opportunity (all the physical and social factors that lie outside the individual that make the behaviour possible or prompt it).

Five of the nine strategies (or 'intervention functions') on the behaviour-change wheel may be appropriate to address particular capability, motivation or opportunity concerns related to supporting informed decisions about signing up:

1) education (providing information to increase knowledge or understanding);
2) modelling (providing an example for people to aspire to or imitate);
3) persuasion (using imagery and other communications to induce positive or negative feelings or stimulate action);
4) training (imparting skills); and
5) enablement (increasing means or reducing barriers to increase capability or opportunity).

Two additional strategies may be considered by some but not others to be appropriate here: 1) environmental restructuring (using prompts and other approaches to change the physical or social context); and 2) incentivization (creating an expectation of reward). The final two strategies would not be considered appropriate: 1) coercion (creating an expectation of punishment or cost); and 2) restrictions (using rules to reduce the opportunity to engage in competing behaviours).

The five strategies can in turn be supported by three of seven types of policies on the behaviour-change wheel that may be appropriate in supporting informed decisions about signing:

1) guidelines (creating documents that assist primary-care providers in understanding the benefits, harms and other considerations involved in making a decision about signing up);
2) communication/marketing (using print, electronic or broadcast media to inform primary-care providers about signing-up considerations); and
3) service provision (delivering a service that assists primary-care providers with making a decision about signing up).

The other four types of policies would not be considered appropriate here: 1) environmental/social planning (using city and other planning tools); 2) fiscal measures (using taxes to reduce or increase the financial cost); 3) regulation (using voluntary agreements, principles or rules); and 4) legislation (making or changing laws).

A list of questions – drawn from the 'theoretical domains framework' (see the 'Key resources' section below) – can be used by primary-care leaders to identify the capability, motivation and/or opportunity factors that may affect their peers' decisions and actions.

1) Capability

Do they know about the responsibilities involved in joining the OHT? (*knowledge*)

Do they know how to join the OHT? (*knowledge*)

Do they feel they have the ability to do what is involved in joining an OHT? (*skills*)

Do they know that joining an OHT may allow others to take on tasks that they do not feel able to do? (*skills*)

Are there other options they are considering besides joining the OHT? (*decision processes*)

2) Motivation

Is their role in the OHT clear to them? (*professional role and identity)*

Do they consider signing up to the OHT as part of what a primary-care provider like them does? (*professional role and identity)*

Are they confident that they can sign up? (*beliefs about capabilities)*

Are they optimistic that signing up to the OHT will be a good thing? (*optimism*)

Do they think that signing up will benefit their patients? (*beliefs about consequences*)

Are the rewards of signing up clear and motivating to them? (*reinforcement*)

Are they concerned about any negative effects of joining? (*reinforcement*)

Are they worried about signing up? (*emotion*)

Does signing up fit into their priorities? (*goals*)

Do they want to sign up? (*intentions*)

3) Opportunity

Do they feel supported by their profession and colleagues to join? (*social influences*)

Do they know anyone else who has signed up? (*social influences*)
Do they feel their current practice is set up for them to join the OHT? (*environmental context and resources*)

Ideally OHTs and their primary-care leaders will engage a diverse sample of primary-care providers to work through this list of questions, and not just those drawn from the same profession or the same practice or service model as them. The factors that emerge as particularly important will likely vary by type of profession and model (e.g., a solo family physician with a specialized focus versus a nurse practitioner working in a community-governed comprehensive primary-care model), by other characteristics of the provider (e.g., early-career physician trained in an interprofessional model versus late-career physician who is nearing retirement from solo practice), and by characteristics of the community (e.g., whether there is a long history of trusting relationships between primary-care providers and local hospital and community leaders).

Primary-care leaders will likely want to have done some preparatory work so they can respond to the queries from their peers that the list of questions is likely to elicit, such as:
1) how will signing up benefit their patients (motivation – beliefs about consequences) – e.g., access to a patient portal, a number to call 24/7, a care coordinator, and the full spectrum of health and human services for those most in need, as well as additional benefits that may come from the re-investments in front-line care that would come with any shared savings at the level of the OHT;
2) how will signing up benefit them, including:
   a. rewards (motivation – reinforcement) – e.g., being involved in conversations about how to make their local health system more responsive to their patients and being able to have more ready access to specialists if OHTs can organize this on their collective behalf, and
   b. having others take on tasks that they do not feel able to do (capability – skills) – e.g., care coordinators facilitating transitions from hospital to home and information-technology professionals designing and supporting the implementation of light-touch clinical decision support;
3) might signing up have any negative effects for them (motivation – reinforcement) – e.g., taking up time that could be spent in direct patient care, introducing new administrative or financial burdens, diminishing their professional autonomy, introducing new accountabilities for access and quality, or hurting relationships with other physicians in their practice if they decide to join an OHT and the practice does not (or if the practice decides to join an OHT and they do not);
4) what other options are they considering (capability – decision processes) – e.g., 'waiting it out' until the government changes or 'moves onto something new;' and
5) who are they looking to for information and advice (e.g., local opinion leader and/or a provincial association) and what are they hearing from them about potential benefits and negative effects?

As local primary-care providers help primary-care leaders and the broader OHT to understand how they see the sign-up decision (and more generally the commitment to partner), teams can then start to develop strategies that address what really matters most to different types of providers. For some, the optimal strategy may be education about how the OHT can benefit patients, while for others it may be 'enablement.' Teams can also start to identify for the Ontario government and Ontario Health the types of policies that would support informed decisions about signing up. On the other hand, some teams may find that they need to postpone such work and instead focus on building (or re-building) trusted relations with primary-care providers in their community.

Key resources

Atkins L, Francis J, Islam R, O'Connor D, Patey A, Ivers N et al. A guide to using the Theoretical Domains Framework of behaviour change to investigate implementation problems. Implementation Science 2017; 12:77.

McMurchy D. Evidence synthesis: Strategies and approaches to enhance family physician engagement. London, Canada: Dale McMurchy Consulting (for the Thames Valley Family Health Team); 2018.

Michie S, van Stralen MM, West R. The behaviour change wheel: A new method for characterising and designing behaviour change interventions. Implementation Science 2011; 6: 42.

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