

Effectively engaging physicians in system change

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Abstract

What started as a prospective study to support clinical leaders and inform strategies to engage their peers in system change was impacted due to a rapidly evolving political agenda amid a pandemic, affecting both organizations and outcomes. Participants in this mixed methods study in one Local Health Integrated Network (LHIN) in Ontario included clinical leaders and community physicians over a period of 14 months. As the provincial government shifted regional healthcare governance from LHINs to Ontario Health Teams, there was an increase in the engagement of community physicians and leaders identified a noticeable culture shift with the potential to drive change. High-performing healthcare systems are dependent not only on physicians who can lead and engage others but a government that can acknowledge this.

Background

When it comes to understatement, categorizing the past 2 years in the Ontario healthcare system as eventful would top the list. In 2018, the newly elected government wasted no time before announcing monumental changes to the system,¹ eliminating 14 Local Health Integration Networks (LHINs) and collapsing six agencies into one superstructure named “Ontario Health.” Regional authority for coordination and integration of healthcare services is being transferred to community-based Ontario Health Teams (OHTs).

Deteriorating relationships with physicians after “several years of fractious negotiations” and the prolonged absence of a physician services agreement was now an issue for the incoming administration. In early 2019, an arbitrated agreement was reached for a favourable 4-year deal.²

Fast forward 1 year as COVID-19 wreaked global havoc. Ontario physicians were immediately engaged in the constant adjustments necessary to deal with this unprecedented event that has affected millions around the globe and coping with the second highest number of provincial cases in the country.³ The healthcare workforce is now hailed as heroes and applauded from balconies around the world for their work on the frontlines.

Substantive change has taken place, and as frontline providers, physicians remain at the core of health system reform. Change does not happen without physicians in the lead, engaged, and in active pursuit of a better system for their patients.

Leading and engaging

Previously, LHINs were provided with funding for clinical leaders to “provide leadership for local clinical engagement.”⁴ Engaging physicians became particularly important amid the long-standing climate of discord between the government and physicians. As LHINs were being dismantled, however, the clinical leadership teams become one of the first casualties.

Kaissi⁵ defines engagement as taking an “active interest” and applicable at various levels including engagement within a system. Those who are engaged want to make a difference to feel part of something bigger. Disengagement happens when they feel they have not been consulted on decisions that affect them, when change is policy-driven, or when poor communication leads to conflict.⁶ Strengthening physician culture and working with frontline physicians as partners in change are lofty and laudable goals; clinical leaders have a daunting task. They must enable inclusive decision making and foster mutual respect within the profession while keeping the best patient care at the centre of the process. Both physician leadership and engagement are “essential elements” for a healthcare system to function well.⁷

The original purpose of this study was to support the clinical leaders in one LHIN in engaging their peers to improve the system of care and better understand the optimal strategies for increasing engagement. Support for the leaders included in-house leadership group learning in leading change and systems transformation and based on LEADS framework⁸ and CanMEDS 2015 Leader role.⁹ What started as a prospective study, however, became an observational study of leadership and engagement of clinical leaders and community physicians in a critical healthcare system change, where the organizational structures changed externally and rapidly from LHINs to OHTs. As a result, this study adjusted its original focus and turned to examine the leadership and engagement of clinical leaders and community physicians in the climate of system change. This community-based study was

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a collaboration between one LHIN and a Canadian university in Ontario.

Methods

We used a mixed methods concurrent design for this study. The quantitative component was an on-line survey to collect information from community physicians about their engagement in regional system priorities. The qualitative component employed a phenomenological approach using semi-structured interviews with clinical leaders to explore perceptions about what facilitated or hindered the engagement of physicians in system change. A comprehensive literature review informed the development of data collection tools and agreed upon by the research team following two iterations. The survey and interviews were conducted at baseline and at 1 year for the purpose of examining change during the study.

Ethics approval was obtained from the university Health Sciences Research Ethics Board and amended as required when the project unfolded differently than anticipated. All participants were provided with information about the study and informed consent was obtained.

Setting and participants

This study was conducted in one LHIN in Ontario between January 2019 and March 2020. While the LHIN serves about a half million permanent residents, there are wide fluctuations in population in this area due to a large number of seasonal residents and its proximity to lakes. Two groups of participants were recruited. Purposive sampling was used to recruit interview participants who were members of the LHIN clinical leadership team, all of which were physicians and included sub-regional leads, emergency care leads and critical care leads. To recruit survey participants, an email was sent to all community physicians in the region using existing contact lists to invite participation in the study, with a letter of information and consent form linking to an on-line survey. Due to this networked distribution method we were dependent upon the comprehensiveness of those lists, of which we estimated as 400-450 in the target group. To promote participation, each survey participant could opt to leave their contact information at the end of each of the two surveys for entry to a draw for an iPad.

Data collection and analysis

An on-line survey (Qualtrics) used Likert scales to measure community physicians' support to and being supported by the regional system and their current and future level of engagement in regional system priorities. Some questions in the survey were open-ended to allow for input on how participants chose to engage in regional initiatives and elaborate on challenges associated with their participation. The survey was conducted at study inception and repeated after 1 year. The survey was distributed through established networks such as hospital groups, family health teams, medical clinics, and family physician groups.

At the same two time points (study inception and at 1 year), semi-structured interviews were scheduled with the clinical leadership team to explore the factors associated with engagement of peers in system change and their assessment of success. This provided an opportunity to understand why some approaches to engaging peers worked and some were less successful. All interviews were audio recorded and transcribed verbatim.

Descriptive statistics analysis was performed on survey data to identify the demographics of participants at both time points. Chi-square analysis was conducted to compare responses on related questions in each survey. Independent *t* test analysis was used to compare the responses of the participants who completed the survey at study inception and at 1 year. Due to unbalanced sample sizes at two time points, unequal variances were considered in *t* test analysis.

Two authors conducted the qualitative analysis using an inductive technique with double coding of all transcripts, comparing codebooks and resolving discrepancies before proceeding with thematic analysis. As well, thematic analysis was performed on the open-ended responses in the survey. Both quantitative and qualitative analyses were reviewed and discussed with the research team to identify key findings.

Findings

The physician engagement on-line survey was distributed between January and March 2019, with 101 valid responses collected. The same survey was distributed in January 2020, with 22 valid responses collected. As participants focused on combating the spread of COVID-19 since February 2020, we assume that their attention to our survey was affected. Seven interviews with clinical leaders took place in January 2019, and five interviews were completed in March 2020.

Community physicians participating in the engagement survey

Over half of the participants (52.5% and 63.6% at baseline and 1 year, respectively) were family physicians. Close to half of the participants (36.6% and 40.9% at baseline and 1 year, respectively) were in practice over 20 years. No significant difference was identified in the distribution of years of practice between the two groups of participants ($P = .43$).

We asked community physicians about their familiarity with regional priorities, their support for those priorities, whether they felt supported by the regional system, and their current and projected future participation levels in those priorities. At study inception, participants felt that they supported regional system priorities more than they were supported by the regional system ($P = .00$). After 1 year, their support for and their assessment of being supported by the regional system did not change ($P = .01$; see Online Appendix 1).

Table 1 shows that the overall average grading to survey questions increased after 1-year period except for the item "I feel supported by the regional system." Participants' familiarity with the regional system and their current and future level of participation in regional system priorities slightly increased

Table 1. Comparison of participants' responses to engagement in regional system priorities at two time points

	Mean		Median		t	Sig. (two-tailed)	Mean difference	Std. error difference	95% CI difference	
	Baseline	1 year later	Baseline	1 year later					Lower	Upper
Familiarity with regional system priorities	3.08	3.45	3.00	3.50	-1.56	.128	-.375	.240	-.864	.114
Your support of regional system priorities	2.97	3.41	3.00	3.00	-2.25	.031	-.439	.195	-.834	-.043
Feel supported by the regional system	2.63	2.59	3.00	2.00	.16	.876	.039	.249	-.469	.547
Current level of participation in regional system activities	2.41	2.55	2.00	2.00	-.46	.649	-.140	.304	-.760	.481
Future level of participation in regional system activities	2.57	3.05	2.00	3.00	-1.58	.116	-.471	.298	-1.060	.118

Table 2. What determines future participation in regional priorities

Theme	At study inception	At 1 year
Remuneration for time	"Payment for involvement and contract with government (PSA)" "Physician payment of these activities"	"It often feels like physicians are the only ones at the table who need to sacrifice income in order to participate"
A clear mandate/direction of Ministry of Health	"if I truly understood that there was a real plan to offer comprehensive care to my patients"	"Continued lack of direction from the Ministry" "A clear direction of what is happening with the LHINs/health teams"
If participation valued and made a difference	"A sense that my and that of my colleagues opinions and sense of the priorities mattered" "Visible appreciation of my role as family physician" "Evidence that my involvement actually influences regional decision making in a timely fashion"	"Communication that primary care physician input is valued and important" "If my participation would make a difference"

Abbreviation: PSA, physician services agreement.

compared with baseline; however, these changes were not significant. Compared to the response to "your support of regional system priorities" at study inception, the response to this item was significantly higher after 1 year ($P = .031$). This indicates that participants had greater degrees of support for regional system priorities over the 1-year period. However, their assessment of being supported by the regional system did not increase ($P = .876$).

When asked what would influence their level of participation in the upcoming 12-month period, responses fell into three predominant themes: participation would increase if, there was remuneration for time spent, there was a clear mandate from the Ministry of Health regarding direction and, their participation was valued and they could see how it made a difference (Table 2). These themes were consistent at both time points.

Interviews with clinical leaders

All seven members of the clinical leadership team employed by the LHIN participated in the first interview, and five of these same leaders participated in the interview 1 year later although no longer employed by the LHIN at that time. This group of physicians continued to have a leadership role in their communities without remuneration from the provincial or regional system.

We asked leaders to rank engagement levels within their sub-region using a Likert scale, their rationale for that ranking, their relationships with their peers, and strategies to engage them. In both initial and final interviews, one predominant theme was clear and voluntarily addressed by all participants—the value of clinical leadership. This was especially interesting due to the fact that participants began the study as part of a leadership team with remuneration, whereas 1 year later, they were individual leaders serving their communities as a volunteer.

All noted increased engagement of physicians in their communities with some intriguing reasons given for that change to engagement levels:

That transparency to the OHT is a much easier vehicle into which physicians can have buy in.

It's interesting to see the collaboration and willingness to participate when there's something that is affecting people so dramatically.

I see the OHT as a way of actualizing what the initial vision for LHINs was.

The change from an LHIN clinical leadership role to a community leadership role served to emphasize four key differences over the 1-year period. Table 3 shows that the overall engagement level as perceived by clinical leaders increased, it

Table 3. Clinical leader perception of engaging peers in system change

Theme	At study inception (LHIN)	At 1 year (Post LHIN)
Level of engagement within sub-regions (Likert scale and comments)	3.07 median “Engagement levels vary” “Cynicism, apathy, closed group” “Smaller community physicians tend to be more engaged”	3.9 median “Increased engagement, rallying around this whole COVID-19 issue, willingness to participate when something that is affecting people” “Colleagues responding to fact that the OMA is aligning with OHT and reorganizing clinical care as opposed to just deciding around funding” “A really positive culture shift that clinicians can get behind”
Relationships with peers as leader	“No relationships harmed” “Increase in networks of colleagues”	“Easier to engage peers—lots of suspicion of the LHIN as managing body not a ‘doing’ body” “The OMA coming in support of OHTS and CFPC providing Main Pro credits that’s really helped in terms of leading and having physician buy in”
Strategies to engage peers in system change	“See the system as a system—different service levels make it hard to see being part of system” “Empower people to have their say” “Compensate for time spent, recognize time spent” “Mandate engagement: If their input has no bearing on outcomes—that’s the worst”	“You have to keep them informed, ask them to be part of it, and then demonstrate that you’re taking their input and engagement seriously” “Make it relevant for patient care” “OCFP regarding Main Pro credits—it’s not remuneration but it’s acknowledgement for your time”
Value of clinical leadership	“Seen as positive (be of service) and a negative (have no power)” “Physician leadership should be formally and informally recognized, attention to successive leaders”	“Having the support of other leaders is important (sole leader vs previous team of leaders). Whether just from a mental health point of view you feel like you’re not in this alone, collectively we’re sharing same thoughts and stresses” “Really important to keep topic of physician leadership front and centre. I am happy to see that there’s a lot of attention being paid to that”

Abbreviations: LHIN, Local Health Integration Network; OHT, Ontario Health Teams; OMA, Ontario Medical Association; CFPC, College of Family Physicians of Canada; OCFP, Ontario College of Family Physicians.

became easier to engage peers in change, and that clinical leadership remained valuable.

Discussion

While the hypothesis at the beginning of the study was that supporting the development of clinical leaders would have an impact on physician engagement, it became evident that having committed leaders was not enough. The shift from LHINs to OHTs, the amelioration of soured relationships with physicians, and the massive surge of appreciation for those on the frontlines have fostered a whole new environment for system change. Even though both LHIN and OHT structures were designed to further healthcare integration, LHIN goals were viewed as abstract, whereas the OHTs are action-oriented. This resonates with physicians seeking to effect real change at the patient level. Distrust of government runs deep in the physician community and members are not easily duped by promises of change.

Change in healthcare will not happen unless physicians are engaged in the process. Choosing to become involved in local or regional initiatives beyond one’s hours of practice requires assurance that time spent is value-added, respected, and remunerated when possible. The availability of medical

education credits for physicians engaged in the development of an OHT not only equates to reimbursement for their time, but more importantly, it demonstrates respect for their expertise at community planning tables.

Governments must see physicians as partners in change efforts. Policy-level decision making without practice-level input only serves to set up roadblocks to system change. It is at the practice level that patients and providers will be most affected. Evidence of relationships gone awry is leading to an exodus of physicians from Canada’s fourth most populous province which will have an immediate impact due to gaps in care throughout the province and seemingly no willingness on the part of the province to get back to the bargaining table.¹⁰ A disengaged and disgruntled professional group exhausted from frontline pandemic work does not bode well for any healthcare system.

Physician leadership is critical to physician engagement. Physician leaders are committed individuals and respected by their peers as they bring the authenticity of understanding the professional and practical realities of being a clinician to change leadership. Many assume leadership roles despite a lack of sustained remuneration, and it is their passion for making a difference at a large scale that propels them.

Physician leadership, however, continues to require highlighting and celebrating. Camaraderie and peer support are important for physicians who lead to keep going, to help them develop skills, and to feel like they are not in this alone.

Limitations

This study is not without limitations. Data collection in one LHIN with the dismantling of the clinical leadership team shortly after the study started abbreviated the two year initial timeline, challenging the ability to observe change over time. Being dependent upon existing physician contact lists may not be comprehensive and using a network distribution method for surveys challenged the ability of the study team to communicate with all community physicians. Just prior to the study conclusion, COVID-19 rapidly changed the responsiveness of everyone in the healthcare system which influenced participation rates of all community physicians dealing with a crisis. Future studies related to community-based leadership by physicians engaged with the development of Ontario Health Teams would continue to inform engagement strategies and, ideally, would encompass a longer time span in order to identify transformative change in the system.

Conclusion

A high-performing healthcare system is not achieved easily as many variables impact the complex nature of healthcare. Living through a pandemic has increasingly demonstrated the critical need for a system that can be depended upon during a crisis and the professionals working in that system called upon to steer us all out of chaos. While too soon to predict, the experiences related to COVID-19 will undoubtedly affect leadership roles for both physicians and non-physicians as it highlights the dynamics of rapid change, correspondingly nimble responses and the need to work well together. Just as the pandemic placed additional clinical care responsibilities on physicians, coupled with the immediate need for them to step into new roles and rapidly affect changes at the front line, it further highlights the need to better understand how to garner similar investment in engagement at the system level for sustainable change. Understanding physician engagement is more critical for all leaders now than it was before the pandemic. No one government can ensure that all elements of a high-performing system are in place at the same time, however, identifying what works and why informs progress. Physician leadership and engagement is fundamental to healthcare system change. Partnering for success means that governments, administrators, and physicians have to work together respectfully and honestly in order that the gaps in care can be effectively addressed and that small-p politics doesn't get in the way for the patients who seek care. Recent gains in the healthcare system in the province of Ontario demonstrate that engagement begins with respect.

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Supplemental material

Supplemental material for this article is available on-line.

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