Primary care renewal strategies in Manitoba

Family physicians' perceptions

Ashley Struthers MA Colleen Metge PhD Catherine Charette PhD
Karen Harlos PhD Sunita Bayyavarapu Bapuji MN Paul Beaudin PhD
Ingrid Botting PhD Alan Katz MB ChB MSc CCFP Sara Kreindler DPhil

Abstract

Objective To understand family physicians' perceptions of Manitoba's strategies for primary care renewal or reform (PCR).

Design Qualitative substudy of an explanatory case study.

Setting Rural and urban Manitoba.

Participants A total of 60 family physicians (31 fee-for-service physicians, 26 alternate-funded physicians, and 3 physicians representing provincial physician organizations).

Methods Semistructured interviews and focus groups.

Main findings Many physicians were hesitant to participate in PCR initiatives, perceiving clear risks but uncertain benefits to patients and providers. Additional barriers to participation included concerns about the adequacy and import of communication about PCR, the meaningfulness of opportunities for physician "voice," and the trustworthiness of decision makers. There was an appetite for tailored, clinic-level support in addressing concrete, physician-identified problems; however, the initiatives on offer were not widely viewed as providing such support.

Conclusion Although some of the observed barriers might fade over time, concentrating PCR efforts on the everyday realities of family physician practice might be the best way to build a primary care system that works for patients and providers.

Editor's key points

- Primary care is increasingly recognized as the foundation of the health care system. Since the early 2000s, policy makers across Canada have sought to strengthen this foundation through primary care renewal or reform (PCR). This study sought to explore family physicians' perceptions of PCR in Manitoba.
- This study uncovered both practical and social barriers to physician participation in PCR. Facilitators included in-person outreach, clarity about how initiatives would improve patient care, funding to offset the costs of participation, and implementation and practice support.
- Existing PCR initiatives were often perceived to be abstract or vaguely defined, oriented toward decision maker–identified problems, and lacking in obvious relevance to day-to-day clinical practice.

Points de repère du rédacteur

- Il est de plus en plus reconnu que les soins primaires représentent l'assise du système de santé. Depuis le début des années 2000, au Canada, les décideurs ont cherché à renforcer cette assise par des initiatives de renouvellement ou de réforme des soins primaires (RSP). Cette étude vise à explorer les perceptions qu'ont les médecins de famille du RSP au Manitoba.
- Cette étude a fait ressortir des obstacles d'ordre à la fois pratique et social à la participation des médecins au RSP. Parmi les éléments facilitateurs figuraient les efforts de sensibilisation en personne, des précisions sur les façons dont les initiatives amélioreraient les soins aux patients, la rémunération pour compenser les coûts de la participation, de même que le soutien à la mise en œuvre et à la pratique.
- Les initiatives de RSP existantes étaient souvent perçues comme abstraites ou vaguement définies, axées sur des problèmes cernés par les décideurs, et non évidemment adaptées à la pratique clinique au quotidien.

Stratégies de renouvellement des soins primaires au Manitoba

Perceptions des médecins de famille

Ashley Struthers MA Colleen Metge PhD Catherine Charette PhD
Karen Harlos PhD Sunita Bayyavarapu Bapuji MN Paul Beaudin PhD
Ingrid Botting PhD Alan Katz MB ChB MSc CCFP Sara Kreindler DPhil

Résumé

Objectif Comprendre comment les médecins de famille perçoivent les stratégies de renouvellement ou de réforme des soins primaires (RSP) au Manitoba.

Type d'étude Sous-étude qualitative d'une étude de cas explicative.

Contexte Manitoba rural et urbain.

Participants Soixante médecins de famille (31 médecins rémunérés à l'acte, 26 médecins rémunérés selon un autre mode et 3 médecins représentant des organisations médicales provinciales).

Méthodes Entrevues semi-structurées et groupes de discussion.

Principales constatations De nombreux médecins hésitaient à participer à des initiatives de RSP, percevant des risques évidents et des bienfaits incertains pour les patients et les professionnels. Parmi les autres obstacles à leur participation figuraient des préoccupations quant à la pertinence et à l'importance des communications relatives au RSP, à l'importance véritable des possibilités pour les médecins de faire entendre leur voix, et à la fiabilité des décideurs. On aurait voulu obtenir un soutien adapté aux cliniques afin de régler des problèmes concrets identifiés par les médecins; par ailleurs, les initiatives relatives à l'offre de participation n'étaient pas largement considérées comme procurant un tel soutien.

Conclusion Même si certains des obstacles observés peuvent s'atténuer avec le temps, la meilleure façon d'établir un système de soins primaires qui fonctionne pour les patients et les professionnels serait de concentrer les efforts sur les réalités quotidiennes de la pratique des médecins de famille.

As population health care needs continue to shift from acute and episodic to chronic and continuous care, primary care is increasingly recognized as the foundation of the health care system.[1-3] Since the early 2000s, policy makers across Canada have sought to strengthen this foundation[4] through primary care renewal or reform (PCR), which might include patient enrolment, interprofessional teams, support for group practices and networks, financial incentives and alternative payment models, and electronic medical records (EMRs).[5,6] Recognizing that most family physicians operate private fee-for-service practices and cherish their professional autonomy, each province has attempted to enact PCR through initiatives that family physicians will find attractive, or at least acceptable.[7,8] Thus, it is important to understand family physicians' perceptions of PCR initiatives.

The literature on PCR in Canada has focused primarily on the patient and financial outcomes of implementing payment models or team-based care.[9] Two Ontario-based studies investigated family physicians' willingness to participate in PCR initiatives. One study identified 5 categories of reasons for physician non-participation:

- practical barriers and working conditions,
- characteristics of the practice and financial considerations,
- philosophical objections,
- too many "unknowns," and
- other reasons (such as retirement or health reasons).[10]

The other study reported that most family physicians did not plan to join a family health network (a main component of Ontario's PCR strategy), despite agreeing that the organization of primary care and the funding model both needed to change.[11] Additionally, some Ontario- and Alberta-based studies have explored how physicians' perspectives evolved during participation in PCR.[12,13] There is a dearth of literature on how other provinces' PCR efforts have been received by physicians.[14] Our study focuses on Manitoba physicians' perceptions of PCR efforts undertaken by the province and its regional health authorities (RHAs), which are responsible for administering and delivering health services. The role of physician organizations, such as the colleges, in PCR will be explored elsewhere.

While Manitoba's earliest PCR efforts emphasized the direct provision of primary care services by RHAs, this approach evolved over the 2000s to include initiatives also seeking to influence the delivery of care within private fee-for-service clinics, such as advanced access training, embedded mental health professionals (shared care), and incentives for EMR adoption (a full description is provided in a companion article).[15] In 2010, PCR efforts intensified, spurred in part by a government promise to ensure a "family doctor for all" by 2015. Strategies of this period strove to expand the engagement of fee-for-service physicians and to promote alignment between private and public delivery models. New initiatives affecting physicians included Family Doctor Finder (a centralized service focused on connecting patients with primary care providers) and a Chronic Disease Management Tariff. My Health Teams (MyHTs, formerly *primary care networks*) represented the most novel and complex initiative. These entailed contractual agreements among an RHA, fee-for-service clinics, and other partners to collaboratively plan and provide coordinated services to patients within a geographic area. Each MyHT received resources to augment services, typically by hiring allied health providers to be shared among clinics. To participate, fee-for-service clinics had to commit to the "attachment deliverable," which required each MyHT to collectively attach 2000 new patients. While MyHTs built on an earlier demonstration project that supported improvement efforts within individual clinics (Physician Integrated Network), the multi-partner structure and attachment deliverable were new features. A closely linked initiative was the Interprofessional Team Demonstration Initiative (ITDI), which supported the hiring of interprofessional team members, such as nurses and physician assistants, into fee-for-service clinics. Willingness to join a MyHT and attachment of a further 500 patients were requirements for participation in ITDI. This unique suite of initiatives reflected decision makers' intent to tread a middle course, defining models of care neither so tightly as to invite resistance or "gaming" (the latter of which had arguably occurred in Ontario)[16] nor so loosely as to preclude accountability mechanisms (which had arguably occurred in Alberta).[17] We sought to learn more about Manitoba's experience by asking, What were family physicians' perceptions of the PCR strategies applied in Manitoba?

Methods

This qualitative substudy is part of a larger explanatory case study[18] to assess and understand the progress of PCR in Manitoba.[15,19] Case study methodology is used to "investigate a contemporary phenomenon in-depth and within its real-life context"[18]; the explanatory approach, grounded in a critical realist paradigm, focuses on developing causal accounts of observed phenomena. The substudy draws primarily on interviews and focus groups with 60 front-line family physicians conducted from May to December 2015. The interviews enabled in-depth exploration of physicians' perspectives and interpretations of PCR. The larger study also included interviews with 35 decision makers (provincial and regional policy makers and managers),[15] a review of PCR-related documents from 2000 to 2017, and observation of stakeholder engagement events in 2015 and 2016. Ethical approval was granted by the University of Manitoba Health Research Ethics Board.

To recruit participants, we sent an individualized letter or e-mail (as advised by the local RHA) to every family physician in 4 of Manitoba's 5 RHAs (the fifth, a remote region with few fee-for-service physicians, chose not

to join the study). Also, the Manitoba College of Family Physicians sent an e-mail invitation to its members to solicit study participation. These efforts yielded a diverse sample in terms of sex, geography, remuneration type, and level of involvement in PCR initiatives (from non-participants to PCR champions). By the end of the interviews, we deemed that data saturation had occurred; no new themes were emerging across the sample.

Interviews (30 to 60 minutes) and focus groups (60 to 90 minutes, 3 to 7 participants) followed a semistructured interview guide that included questions about participants' understanding of PCR, extent of involvement, awareness of strategies to promote participation, and perspectives on working with the health care system and what it would take for PCR to succeed in Manitoba. Questions included probes listing all current initiatives; however, few participants expressed opinions on specific provincial initiatives other than MyHTs and ITDI. Interviews were conducted in person, or by telephone when necessary, by 1 of 6 trained researchers (A.S., S.K., C.C., S.B.B., P.B.). Interviews were audiorecorded and transcribed verbatim. All participants provided informed consent and received a $100 honorarium and lunch.

Thematic analysis was used to develop a descriptive account of participants' perceptions and interpretations.[20] Two researchers (S.K., A.S.) read through transcripts several times, independently noting potential themes and ideas, and met frequently to discuss and develop a preliminary coding guide. Next, interview and focus group transcripts were entered into a qualitative analysis software program (NVivo 11) and coded according to the coding guide. Segments of text were assigned to categories according to the coding guide and were reviewed to ensure consistency within each category, with reassignment as needed. Categories were compared to identify overlaps and understand relationships, resulting in some categories being grouped together into themes. Credibility of the findings was enhanced by using multiple interviewers and analysts (triangulation), keeping a research journal, and ongoing review of findings by a diverse team that included researchers, physicians, and decision makers.[21] Team members' differing perspectives on health system change and physician-system relationships provided opportunities to challenge one another on emerging interpretations of the data.

Findings

Table 1 describes participants' characteristics. The sample was approximately evenly split between physicians who were and who were not involved in PCR initiatives; however, involvement was less a binary variable than a continuum (eg, not all members of a PCR-involved clinic were themselves actively engaged). Levels of awareness and support for PCR, while higher among those involved than those not involved, varied widely within both groups.

Table 1. Participant characteristics: *N = 60.*

CHARACTERISTIC	N
Remuneration model	
• Fee-for-service	30
• Alternate-funded	27*
• Representative of provincial organization	3
Region	
• Winnipeg	46†
• Southern	6
• Prairie Mountain	4
• Interlake-Eastern	3
• Northern	1
Urban or rural practice, population of centre	
• > 100 000	46†
• 10 000-100 000	4
• < 10 000	10
Sex	
• Male	36
• Female	24
Years in practice	
• < 5	11
• 5-9	12
• 10-20	4
• > 20	29
• Not stated	4

*Includes 1 physician working in both models.
†Includes 3 representatives of provincial organizations and 1 Winnipeg-based physician providing service to remote northern communities.

Overall, similar themes emerged from fee-for-service and alternate-funded physicians, with more variability within than between the 2 groups (exceptions are noted below). However, alternate-funded physicians were less likely to comment on how PCR initiatives affected them personally; some focused on the implications for their fee-for-service colleagues. This might reflect the fact that initial efforts to establish MyHTs concentrated on engaging fee-for-service physicians, and that ITDI did not apply to alternate-funded clinics. As a result, alternate-funded physicians generated a smaller proportion of the data relevant to this substudy.

Likewise, similar themes emerged across the urban and rural subsamples. However, rural physicians were more likely to state that they already provided PCR-congruent care (eg, comprehensive practice, rapid access); some perceived PCR initiatives as Winnipeg-centric and geared toward promoting features already present in rural clinics.

Physicians' attitudes toward participation in PCR were informed by specific practical considerations

(ie, perceived benefits and risks) but also general social considerations. Quotations representative of each thematic category are presented in **Table 2**.

Practical considerations: benefits and risks

Potential benefits to patients. Most physicians seemed open to involvement in initiatives that improved patient care without posing severe risks (financial, liability, or workload). However, few physicians seemed to have a clear sense of how PCR initiatives would improve patient access or care. Many thought PCR was about increasing patient attachment rates, as opposed to improving care for their existing patients.

Concerns about attachment deliverables. One of the most frequently raised risks of PCR participation, identified almost exclusively by fee-for-service physicians, was the inability to satisfy the attachment deliverables associated with ITDI and MyHTs. Many perceived these requirements to be unrealistic, especially if their patient panel was already too large or they were approaching retirement and wishing to reduce their workload. The perceived barrier posed by the MyHT attachment deliverable was recognized by decision makers, who in mid-2015 reiterated that the deliverable was a collective, not individual, responsibility.

Financial considerations. Perspectives also differed as to whether the resources allocated to PCR were sufficient to mitigate financial risk. For example, ITDI provided funding for an alternate care provider's salary and overhead costs; some physicians considered this adequate, while others identified additional overhead and lost revenue as consequences of a nonphysician using space that could have been used by a physician. Some also worried about competition and liability risks associated with increased use of alternate care providers. Many physicians believed appropriate incentives did not exist for after-hours care, on-call work, and care for patients with chronic disease (notwithstanding the introduction of the Chronic Disease Management Tariff). These concerns were primarily identified by fee-for-service physicians.

Concerns about workload and work-life balance. Many physicians described being too busy ensuring the viability of their practice and caring for patients to engage in PCR. Some felt burned out. Many feared PCR was intended to get them to work more, and this was not a reasonable option for many who already felt overburdened. Some anticipated that PCR initiatives might reduce their workload, while others questioned whether this would occur; for example, nonphysician providers might take the "easy" work, leaving physicians with only difficult and complex work.

Social considerations

Communication about PCR initiatives. Physicians most commonly described hearing about PCR initiatives through meetings, e-mail messages, and site leadership. However, many believed the communication was poor in terms of both quantity and quality. The messages did not appear to resonate strongly with most physicians. Some described the message as vague, unclear, or even disparaging to physicians. Many physicians thought in-person outreach was the best approach to communication.

Lack of physician voice. Primary care renewal initiatives contained several opportunities for decision makers to work collaboratively with physicians and involve them in decision making regarding implementation, such as through consultation (eg, town halls, outreach) and governance roles (eg, having physicians co-chair MyHT steering committees). A few physicians described themselves as champions, and some reported feeling "heard" or sharing in decision making. However, many thought they had little say or power in PCR. Some believed key elements of PCR initiatives, such as MyHTs, were determined before physicians were invited to participate, thus precluding input into these decisions. Several also questioned whether efforts to solicit their input were authentic or merely tokenistic.

Climate of mistrust. Some (particularly fee-for-service) physicians expressed distrust of decision makers, especially in certain regions where past actions had already contributed to a climate of suspicion; for example, the Winnipeg region's changes to inpatient care models during the early 2000s, which forced family physicians out of some hospitals. Some physicians described their current relationship with their RHAs as positive, but others perceived an ongoing lack of positive acknowledgment and respect from decision makers.

Desire for targeted support. Some physicians appreciated the support provided by the government or RHAs, in particular assistance with EMR implementation and optimization; others were looking for more support with this and other PCR initiatives. Social and practical issues were interlinked. Physicians felt heard to the extent they saw decision makers taking actions that responded to their needs and concerns. Several physicians suggested that 1-on-1 outreach that responded to the self-identified needs of individual clinics through concrete, tailored support would be more useful to them than the PCR initiatives currently offered. In other words, they wanted decision makers to ask clinics where help was needed and work with them to find solutions.

Discussion

This study provided insight into family physicians' perspectives on the PCR strategies pursued in Manitoba as of late 2015. Although each province has taken a unique approach to PCR, the observed facilitators and barriers

Table 2. Excerpts of participants' comments, by theme

THEMES	QUOTATIONS
Practical considerations	
• Potential benefits to patients	• "I think if you talked to most primary care physicians … whether or not they engage more is not so much 'pay me more' but 'how is engaging with you going to help me better care for my patients.' That's the primary thing for most people" (ALT-51, urban [FG]) • "I'd want to know what were the goals for it and does it provide an advantage for our clients in this area over what we've got at the moment" (FFS-31, rural)
• Concerns about attachment deliverables	• "We're looking at [ITDI], but the catch is always … 'take 500 patients' …. And … our numbers are crazy big and … [sigh] when that's always attached to the bottom of it, none of us will go near it" (FFS-41, urban [FG]) • "But don't just ask us to take more and more patients. Do you know what I mean? I think that's the message that we are getting, that, you know, they want us to take more patients" (FFS-8, urban)
• Financial considerations	• "The other thing that sold it was, I think, from a financial point of view it was either neutral or favourable. So, I think there was the perception going into it that from a financial point of view it's going to be a good thing too" (FFS-20, rural) • "So the [physician assistant's] wage is paid by the province or by the [RHA] … it's better for patient care, [but] the bottom line it doesn't help me in any way, shape, or form" (FFS-21, urban)
• Concerns about workload and work-life balance	• "For the doctors who are busting their butt, day in and day out, to ask those doctors, well we want you to do more, it's like, I don't think so. I mean, they're stressed to the max already; you can't ask those people to do more" (FFS-7, rural) • "Yeah, I want to be able to provide the optimum care for my patients, but at the same time I also want to have time to be able to care for my family" (ALT-52, urban [FG]) • "I have no time to participate in any sort of projects" (ALT-40, rural) • "If we have people joining us who do the relatively easy work, that's not what we're looking for … that just leaves the crappy, harder work for us to do" (FFS-5, rural)
Social considerations	
• Communication about PCR initiatives	• "I didn't feel it was particularly transparent … [there was] a lot of bureaucratic language that didn't really mean the same thing for everyone … [and a] lack of specific information for what it would entail. It does feel that the impetus is on me to find out anything about it …. And, you know, I'm a little busy" (FFS-4, urban) • "The message I get is actually very pejorative: you're not doing your job" (ALT-58, urban [FG]) • "I went online and I tried to look at what this was …. There's no one page saying, 'this is what we've done and this is how we feel that this is going to impact quality of care and quantity of care' …. It's like pie-in-the-sky type stuff" (FFS-10, urban) • "I think some of the website has some of it …. But I feel I don't, I don't know if it's enough to really convince me to take it one step further and inquire about it" (ALT-18, urban)
• Lack of physician voice	• "I just wish that the region, when they approach us for our opinion, it's because they want our opinion … in the process of making a decision, and not our opinion on the decision that's already been made" (FFS-42, urban [FG]) • "The structure [of My Health Teams] was set up and it was given to physicians to say, this is the structure that it's going to be … these are the goals … and the goals aren't bad, but they were told to us" (ALT-37, urban) • "The reason I say maybe they don't want us to come is because if we don't come we can't tell them something they don't want to hear, and we can't give them information that will compel actual, real change that will take actual, real money" (FFS-24, urban)
• Climate of mistrust	• "It left a really bad taste in everybody's mouth. It really made you feel like you weren't valued in the hospital, that they'd just summarily boot you out after 30 years of hard work there" (FFS-11, urban) • "So they need to kind of come back … and just as group to say to family doctors, 'We're sorry; we screwed up; you guys are the important parts of the system" (FFS-24, urban) • "There's a long, in some cases pretty entrenched, issue with trust … and some of it's unfounded and a lot of it is kind of long-held grudges" (EXT-1, urban)
• Desire for targeted support	• "So go talk to a clinic, talk about what their challenges are, where their biggest expenses are, how can the region help, where are the inefficiencies, how can we cut the inefficiencies?" (FFS-21, urban) • "The areas where I need help it isn't available, and the areas where help is offered I don't need it" (FFS-7, rural) • "So, I think you need somebody like I said, like on-site there who can work with you specifically to figure out what the problems are" (ALT-49, urban [FG])

ALT—alternate-funded, EXT—current or past leader of a provincial physician organization, FG—focus group, FFS—fee-for-service, ITDI—Interprofessional Team Demonstration Initiative, PCR—primary care renewal, RHA—regional health authority.

to physician engagement likely apply in other jurisdictions. Facilitators included in-person outreach, clarity about how initiatives would improve patient care, funding to offset the costs of participation, and implementation and practice support. Trust was also key and was enhanced when decision makers took time to build relationships. Conversely, physicians who doubted decision makers' trustworthiness, or saw PCR initiatives as presenting clear risks but uncertain benefit, hesitated to participate. There appeared to be a strong appetite for tailored, clinic-level support in addressing concrete, physician-identified problems. However, existing PCR initiatives were not widely perceived to offer this type of support; MyHTs in particular were often viewed as abstract or vaguely defined, oriented toward decision maker–identified problems, and lacking in obvious relevance to day-to-day clinical practice. MyHTs were arguably the flagship PCR initiative, and physicians' perceptions of them appeared to strongly colour their overall attitudes toward PCR. Some physician concerns might have been allayed through better communication; however, the conceptual nature of MyHTs might have made it difficult to develop clear, straightforward messages. On the other hand, those physicians who championed PCR initiatives articulated their anticipated benefits and expressed hope that more physicians would participate once benefits had been realized.

Our findings are broadly consistent with the literature on physician engagement, which emphasizes the importance of communication,[22-24] listening to and acting on physician ideas,[22] involving physicians as partners in decision making from the beginning,[22,23,25-27] and providing support and education.[22,23,25,27-29] To varying degrees, Manitoba's PCR initiatives reflected these elements, but not necessarily in ways that most physicians identified as meaningful or useful. Many perceived the prevailing approach to be top-down, with opportunities for input coming only after key decisions had been made. It is possible a bottom-up approach, starting with clinic-by-clinic outreach and support, and building toward system change, might have been more acceptable to physicians. However, this possibility raises further questions: Is it feasible to implement a clinic-by-clinic approach across an entire province with hundreds of family physicians? If so, could myriad clinic-by-clinic solutions ultimately be aligned to establish a primary care *system* in which all patients receive well coordinated care that meets universal standards? Alternatively, would clinic-by-clinic outreach uncover common needs for which standard approaches could be developed collaboratively by physicians and decision makers? These questions are relevant beyond Manitoba, as each province has struggled to realize an optimal balance between top-down and bottom-up approaches to the advancement of PCR.[15]

Limitations

This study has several limitations. Study participants were self-selected and their perspectives might differ from those of non-participants. We also sampled physician perspectives at a particular point in time (several years into the implementation of MyHTs and linked initiatives, but early in most physicians' exposure to these initiatives). Thus, we do not know how their perspectives might have changed over time. Also, physicians were receiving information about PCR from many sources and did not always clearly distinguish among government, RHAs, and physician organizations. Thus, it is not possible to fully attribute findings to particular strategies by particular organizations. While the sample was sufficiently geographically diverse to give an indication of rural-urban commonalities and differences, it did not permit conclusions about issues that might be specific to a particular RHA or locality; further, we did not explore issues that might be unique to northern Manitoba. Finally, we examined a single province; cross-jurisdictional comparative research could illuminate whether other provinces face similar challenges and opportunities.

Conclusion

This study uncovered both practical and social barriers to physician participation in PCR. Although some barriers might recede with time, others might require substantive change in the way that initiatives are designed and implemented. There is an important opportunity, in Manitoba and potentially in other provinces, to advance PCR goals through 1-on-1 outreach supporting the development of clinic-level solutions that are individualized, flexible, and rooted in physicians' concrete experiences. Refocusing the PCR conversation on the day-to-day realities of clinical practice might help physicians and decision makers advance toward their shared goal of improving primary care for patients.

Ms Struthers is a research associate with the Evaluation Platform of the George and Fay Yee Centre for Healthcare Innovation at the University of Manitoba in Winnipeg. **Dr Metge** is Associate Professor in the Department of Community Health Sciences at the University of Manitoba. **Dr Charette** is a researcher with the Evaluation Platform of the George and Fay Yee Centre for Healthcare Innovation and Assistant Professor (part-time member) with the Department of Community Health Sciences at the University of Manitoba. **Dr Harlos** is Professor in the Department of Business and Administration at the University of Winnipeg. **Ms Bapuji** is a former research associate for the Evaluation Platform of the George and Fay Yee Centre for Healthcare Innovation and is currently Research Officer with the Australian Health Practitioner Regulation Agency in Melbourne, Australia. **Dr Beaudin** is a researcher with the Evaluation Platform of the George and Fay Yee Centre for Healthcare Innovation. **Dr Botting** is Assistant Professor in the Department of Community Health Sciences at the University of Manitoba, Corporate Secretary with the Winnipeg Regional Health Authority, and former Director of Health Services Integration for the Winnipeg Regional Health Authority Family Medicine–Primary Care program. **Dr Katz** is Professor in the Department of Family Medicine and the Department of Community Health Sciences and Manitoba Health Research Council Chair in Primary Prevention Research at the University of Manitoba. **Dr Kreindler** is a researcher with the Health System Performance Platform of the George and Fay Yee Centre for Healthcare Innovation, Assistant Professor in the Department of Community Health Sciences, and Manitoba Research Chair in Health System Innovation at the University of Manitoba.

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Contributors

Dr Kreindler and **Ms Struthers** contributed to study design; data collection, analysis, interpretation; and writing the manuscript. All other authors contributed to the study

design, as well as to writing or revising the manuscript. **Dr Charette, Ms Bapuji,** and **Dr Beaudin** also contributed to data collection.

Competing interests
None declared

Correspondence
Ms Ashley Struthers; e-mail **astruthers@wrha.mb.ca**

References

1. Wagner EH, Austin BT, Davis C, Hindmarsh M, Schaefer J, Bonomi A. Improving chronic illness care: translating evidence into action. *Health Aff* (Millwood) 2001;20(6):64-78.
2. Davis K, Schoenbaum SC, Audet AM. A 2020 vision of patient-centered primary care. *J Gen Intern Med* 2005;20(10):953-7.
3. Starfield B. Toward international primary care reform. *CMAJ* 2009;180(11):1091-2.
4. Jaakkimainen RL, Barnsley J, Klein-Geltink J, Kopp A, Glazier RH. Did changing primary care delivery models change performance? A population based study using health administrative data. *BMC Fam Pract* 2011;12:44.
5. Hutchison B, Levesque JF, Strumpf E, Coyle C. Primary health care in Canada: systems in motion. *Milbank Q* 2011;89(2):256-88.
6. Levesque JF, Haggerty JL, Hogg W, Burge F, Wong ST, Katz A. Barriers and facilitators for primary care reform in Canada: results from a deliberative synthesis across five provinces. *Healthc Policy* 2015;11(2):44-57.
7. Gilbert F, Denis JL, Lamothe L, Beaulieu MD, D'Amour D, Goudreau J. Reforming primary healthcare: from public policy to organizational change. *J Health Organ Manag* 2015;29(1):92-110.
8. Martin D. Of honey and health policy: the limits of sweet, sticky substances in reforming primary care. *Healthc Pap* 2012;12(2):34-9.
9. Carter R, Riverin JF, Gariepy G, Quesnel-Vallee A. The impact of primary care reform on health system performance in Canada: a systematic review. *BMC Health Serv Res* 2016;16:324.
10. Neimanis IM, Paterson JM, Allega RL. Primary care reform: physicians' participation in Hamilton-Wentworth. *Can Fam Physician* 2002;48:306-13.
11. Hunter DJW, Shortt SED, Walker PM, Godwin M. Family physician views about primary care reform in Ontario: a postal questionnaire. *BMC Fam Pract* 2004;5:2.
12. Reay T, Goodrick E, Waldorff SB, Casebeer A. Getting leopards to change their spots: co-creating a new professional role identity. *Acad Manag J* 2016;60(3):1043-70.
13. Chreim S, Williams BE, Hinings CR. Interlevel influences on the reconstruction of professional role identity. *Acad Manag J* 2007;50(6):1515-39.
14. Peckham A, Ho J, Marchildon GP. *Policy innovations in primary care across Canada. A rapid review prepared for the Canadian Foundation for Healthcare Improvement.* Toronto, ON: North American Observatory on Health Systems and Policies; 2018.
15. Kreindler SA, Metge C, Struthers A, Harlos K, Charette C, Bapuji S, et al. Primary care reform in Manitoba, Canada, 2011-15: balancing accountability and acceptability. *Health Policy* 2019;123(6):532-7. Epub 2019 Mar 27.
16. Glazier RH, Klein-Geltink J, Kopp A, Sibley LM. Capitation and enhanced fee-for-service models for primary care reform: a population-based evaluation. *CMAJ* 2009;180(11):E72-81.
17. Alberta Health. *Primary care networks review.* Edmonton, AB: Government of Alberta; 2016.
18. Yin RK. *Case study research: design and methods.* 4th ed. Thousand Oaks, CA: Sage Publications; 2009.
19. Kreindler SA, Struthers A, Metge CJ, Charette C, Harlos K, Beaudin P, et al. Pushing for partnership: physician engagement and resistance in primary care renewal. *J Health Organ Manag* 2019;33(2):126-40. Epub 2019 Feb 7.
20. Miles MB, Huberman AM. *Qualitative data analysis: an expanded sourcebook.* Thousand Oaks, CA: Sage Publications; 1994.
21. Patton MQ. Enhancing the quality and credibility of qualitative analysis. *Health Serv Res* 1999;34(5 Pt 2):1189-208.
22. Kaissi A. Enhancing physician engagement: an international perspective. *Int J Health Serv* 2014;44(3):567-92.
23. Skillman M, Cross-Barnet C, Singer RF, Ruiz S, Rotondo C, Aha R, et al. Physician engagement strategies in care coordination: findings from the Centers for Medicare & Medicaid Services' Health Care Innovation Awards Program. *Health Serv Res* 2017;52(1):291-312. Epub 2016 Dec 2.
24. Spaulding A, Gamm L, Menser T. Physician engagement: strategic considerations among leaders at a major health system. *Hosp Top* 2014;92(3):66-73.
25. Bååthe F, Norbäck LE. Engaging physicians in organizational improvement work. *J Health Organ Manag* 2013;27(4):479-97.
26. Pannick S, Sevdalis N, Athanasiou T. Beyond clinical engagement: a pragmatic model for quality improvement interventions, aligning clinical and managerial priorities. *BMJ Qual Saf* 2016;25(9):716-25. Epub 2015 Dec 8.
27. Pariser P, Pus L, Stanaitis I, Abrams H, Ivers N, Baker GR, et al. Improving system integration: the art and science of engaging small community practices in health system innovation. *Int J Family Med* 2016;5926303:1-8.
28. Suelflow E. Systematic literature review: an analysis of administrative strategies to engage providers in hospital quality initiatives. *Health Policy Technol* 2016;5(1):2-17.
29. Taitz JM, Lee TH, Sequist TD. A framework for engaging physicians in quality and safety. *BMJ Qual Saf* 2012;21(9):722-8.

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