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DEVELOPING BETTER PARTNERSHIPS IN A FAMILY HEALTH TEAM

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Organizational Improvement Plan:

DEVELOPING BETTER PARTNERSHIPS IN A FAMILY HEALTH TEAM

August 25th, 2019

Submitted by Jennifer Fillingham

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Glossary

Attachment (patient): Refers to the enrollment or registering of a patient to a specific family physician or nurse practitioner. Also known as “rostered.” In Ontario, patients can only be attached or rostered to one provider who bills the Ministry of Health and Long-Term Care for primary care of the patient.

Authentic leadership theory (ALT): One of two leadership theories that inform this OIP. Authentic leadership theory focuses on leader-follower relationships and a leader’s role and influence on these relationships (Avolio & Gardner, 2005; Avolio, Walumbwa, & Weber, 2009).

Board (the): The FHT’s Board of Directors. The Board is composed of all physicians who practice at the FHT (the subject of this OIP). As a registered non-profit corporation, the Board is accountable for the FHT’s mandate and performance (Association of Family Health Teams of Ontario, 2018).

Community Care Access Centre (CCAC): Before May 2017, CCACs were 14 regional organizations in Ontario responsible for arranging in-home health services for community-based patients. In May 2017, the provincial government amalgamated each CCAC with its regional Local Health Integration Network (LHIN) counterpart, ostensibly to save money and streamline healthcare planning and delivery. The term CCAC is no longer in use; these organizations became Home and Community Care divisions within the new LHINs that, in 2019, will be dissolved (Ministry of Health and Long-term Care, 2019b).

Complexity leadership theory (CLT): One of two leadership theories that inform this OIP. Complexity leadership theory seeks to understand the components of a complex system, how

they interact and how they contribute to the whole (Baltaci & Balci, 2017; Uhl-Bien & Arena, 2017).

Family health team: Family health teams are primary healthcare organizations that integrate non-physician healthcare professionals, for example registered nurses and social workers, into physician practice (Rosser, Colwill, Kasperski, & Wilson, 2011). Currently, approximately three million Ontarians are enrolled with 184 family health teams across 200 communities (Ministry of Health and Long-Term Care, 2016b).

FHT (the): One of 184 family health teams in Ontario and the subject of this OIP.

Health Links: An Ontario-wide program that empowers geographic sub-regions to develop community-based strategies for coordinating care for medically and socially complex patients (Evans, Grudniewiz, Wodchis, & Baker, 2014; Grudniewicz, Tenbenschel, Evans, Gray, Baker, & Wodchis, 2018). There are currently 82 Health Links in Ontario (Ministry of Health and Long-term Care, 2018); and the FHT is the lead organization for its sub-regional Health Link.

Local Health Integration Network (LHIN): A LHIN is both an organization and a geographic region. Between 2007-2019, Ontario was divided into 14 organizational LHINs, each responsible for healthcare planning within the region it served. Each LHIN is further divided into sub-regions. For example, the FHT operates within one of multiple sub-regions in its LHIN, although several of its programs are offered across the entire LHIN/region.

In February 2019, the provincial government announced a series of healthcare transformations including the dissolution of regional LHINs and centralization of their planning functions into a ‘super agency’ (Ontario Health). Ongoing healthcare changes, including the dissolution of

LHINs, are acknowledged in Chapter Three, however Chapters One and Two make reference to the regional LHIN as it has been in place for the duration of the OIP writing process.

Manager (the): The author of this OIP and a FHT employee responsible for programs that fall into three categories: sub-regional initiatives for which the FHT is funded by the Ministry of Health and Long-Term Care; programs with a shared goal of delivering services to non-FHT patients; and programs that extend primary healthcare to patients who are medically and/or socially complex.

Ministry of Health and Long-Term Care (MOHLTC): Provincial (Ontario) government ministry responsible for administering the health care system, including long-term care.

Non-FHT patients: Patients who are not attached to any type of primary care, including the FHT, or are rostered to a physician who does not practice with other healthcare practitioners. This term is used only in this OIP.

Ontario Health Teams (OHTs): Ontario Health Teams are a new concept introduced by the provincial government in February 2019 as part of a broader set of healthcare transformations. There are no OHTs yet in existence, but they are described in tabled legislation as healthcare providers organizing themselves to deliver “coordinated [curricula] of care to a defined geographic population or patient segment” (Crawly, 2019). Many communities across Ontario, including the FHT’s sub-region, are responding to a provincial call for expressions of interest in community-generated OHTs announced April 3rd, 2019 (Ministry of Health and Long-Term Care, 2019c). This activity has been identified as the subject of a test of change for this OIP (described in Chapter Three).

Organizational Cultural Assessment Instrument (OCAI): An evidence-based tool developed by Cameron and Quinn (2011) used to profile organizational cultures as one of four types: adhocracy, clan, hierarchy or market.

Partnership Learning Model (PLM): PLM is a healthcare framework developed by Bailie, Matthews, Brands, & Schierhout (2013) that is presented as a potential solution for the OIP (Chapter Two). The model is framed around comprehensive primary healthcare, and includes embedded concepts related to systems thinking, health systems strengthening and knowledge translation.

Plan-Do-Study-Act (PDSA): A quality improvement tool to support strategic and other planning processes (Varkey, Reller, & Resar, 2007) that is well established within Ontario’s healthcare system (Health Quality Ontario, 2018).

Private Sector-Public Partnership (PPP): Private sector-public partnerships are a type of inter-sectoral and/or inter-organizational partnership endeavour that, as suggested by the title, brings the private sector into public endeavours. Within PPPs, the *private sector* usually denotes any for-profit commercial enterprise, while the *public* refers to municipal, state/provincial or national government represented by administrators or governmental agencies mandated to deliver and manage public goods (Nishtar, 2004). In some cases, the “public” part of the partnership may denote the non-governmental sector.

Problem of Practice (PoP): A PoP is a “persistent, contextualized, and specific issue embedded in the work of a professional practitioner, the addressing of which has the potential to result in improved understanding, experience, and outcomes” (Carnegie Project on the Education Doctorate, 2016, para. 14). The PoP addressed by this OIP is the FHT’s lack of robust

frameworks and evidence-informed resources to support the development and implementation of effective partnerships.

Primary care (PC): A term generally used to denote a patient’s first entry point into a healthcare system. Primary care services include the diagnosis, treatment and management of diseases; and are usually associated with physician practitioners (adapted from Deber, 2018). In Ontario, these may be general practitioners or family physicians.

Primary healthcare (PHC): Sometimes used as a synonym for primary care, or, more recently, a term to describe a broader set of primary care services including health promotion, disease prevention and rehabilitation (adapted from Deber, 2018). This definition also implicitly recognizes the roles of healthcare practitioners beyond family physicians, for example social workers and nutritionists.

PHC is more commonly used in this OIP (than PC) because the FHT is interprofessional and engaged in the full spectrum of PHC activities, either directly or through its partnerships.

Relational coordination (RC): RC theory is a “mutually reinforcing process of communicating and relating for the purpose of task integration” (Brandeis University, 2018a). It is part of the identified solution for the PoP described in this OIP.

Rostering (patient): Refers to the enrollment or registering of a patient to a specific family physician or nurse practitioner. Also known as “attached.” In Ontario, patients can only be attached or rostered to one provider who bills the Ministry of Health and Long-Term Care for primary care of this patient.

Social Determinants of Health (SDHs): Twelve social and economic conditions that impact mental and physical health, for example, aboriginal status, early life and education, housing, and income (Canadian Mental Health Association, 2018).

System change model (SCM): A change model for system-level change that was developed for this OIP by integrating and elaborating on two organizational change models: Cawsey, Deszca, and Ingols (2016) Change Path Model; and Kotter (1996).

Sub-region: A geographic subset of one of Ontario’s 14 LHINs. The FHT operates within one of multiple sub-regions in its LHIN (although several of its programs are offered across the entire LHIN/region). In February 2019, the provincial Minister of Health announced the dissolution of the LHIN organizations and it is anticipated that the geographic boundaries of regions and sub-regions in Ontario could change (Ministry of Health and Long-Term Care, 2019a).

Test of Change (TOC): A TOC is an iterative process in which a small (usually) pilot project is undertaken to implement a change and learn from it before widespread adoption. A TOC is part of the implementation plan described in Chapter Three.

Abstract

This organizational improvement plan (OIP) considers the experience of an Ontario family health team whose growing portfolio of partnerships requires evidence-based structure. A brief review of the literature suggests that partnerships are best understood as social constructs, shared spaces that are co-created through the multiple perspectives of their contributors. Synthesis of competing perspectives, integration, is a recurring theme throughout the OIP. Two well-known organizational change models are integrated to create a system change model (SCM) more applicable to the system-level change inherent to healthcare partnerships and this OIP. SCM is supported by an integrated approach to leadership, the incorporation of two leadership theories that value different types of relationships, one within systems (complexity), and the other between people (authentic). Four potential solutions are presented, and a preferred option identified: adopting and adapting a partnership framework for multi-sectoral collaboration by integrating Relational Coordination where communication and relationship-building could support task integration across partner organizations. A test of change partnership using one of the family health team's most ambitious collaborations is identified, and a supporting change implementation plan described using the SCM framework. The OIP was authored during a time of significant transformation in Ontario's healthcare system, sometimes giving the writing process the feel of field reporting. As such, it is likely that the healthcare landscape will change again, rendering the concepts of this OIP more applicable to the author's practice than any specifics in the implementation plan.

Keywords: healthcare partnership, primary healthcare, family health team, Ontario Health Team

Executive Summary

This Organizational Improvement Plan (OIP) considers the experience of an Ontario healthcare organization whose growing portfolio of partnerships requires evidence-based structure. Chapter One introduces the OIP's target, a family health team (the FHT) that engages in partnerships to support community programming and patient care. Using an approach consistent with Wittkuhn (2012), the OIP is predicated on an imagined state in which the FHT is engaged in intentional partnerships that are evidence-informed, enable resource-sharing, and improve the FHT's work, particularly patient care.

The OIP was undertaken by the Manager, a FHT employee responsible for the majority of FHT partnerships and whose leadership approach is reinforced by the FHT's adhocracy culture, a hands off institutional leadership style that allows employees significant autonomy in their work. The Manager's leadership stance is also influenced by liberal, critical and Indigenous lenses, all of which align well with the OIP's partnership focus. In addition, the Problem of Practice (PoP) and OIP are informed by pragmatic and social-constructivist worldviews; and underpinned by Creswell's (2007) assumptions about the qualitative research approach. Creswell's epistemological, axiological, rhetorical and methodological assumptions about qualitative research not only apply to the manner in which this OIP inquiry was undertaken, but are also consistent with the OIP subject matter. Like qualitative research, partnerships are social undertakings influenced by a multiplicity of perspectives about reality, knowing, values, languages and processes.

In keeping with a pragmatic approach, to better situate the PoP addressed by this OIP, a brief review of the partnership literature addresses four lines of inquiry: 1) the nature of partnerships; 2) the evidence for and against partnerships; 3) the characteristics of successful

partnerships; and 4) methods of evaluating partnerships. Of particular interest to this OIP is the idea that collaborations between partners are social constructs created through the multiple perspectives of their contributors. Ideally, a resultant partnership is a shared place and culture with norms and ways of operating different than those of the participating institutions.

Chapter Two builds on an ongoing theme of integration, and outlines a system-level change model (SCM) developed for this OIP by integrating two well known organizational change models; and supports the model with authentic and complexity leadership theories. SCM is used to frame a critical organizational analysis of the FHT and its partnerships. Based on this analysis, four potential solutions to the PoP are proposed. The first is to adopt an evidence-based, multi-sectoral partnership framework for the FHT's system-level partnerships. However, generalized partnership frameworks require significant adaptation to make them relevant to a particular context, suggesting a more targeted framework may be a better option. The second solution is to adopt a healthcare partnership framework. Yet, the predominant examples in the literature are either too granular, being focused on the teams directly supporting patients, or too conceptual and high-level making them difficult to implement. As the FHT requires more operational support for its multi-agency collaborations in healthcare, a third option, Relational Coordination, is proposed as a way of integrating tasks across multiple players through structured communication and relationship-building activities. While all three solutions have elements that would support the FHT's partnership portfolio, no single solution fully addresses the FHT's needs.

In keeping with the spirit of integration that characterizes this OIP and partnerships, Chapter Three further develops the fourth and preferred solution: adopting and adapting a framework for multi-sectoral, system-level partnership (Randle & Anderson, 2017); and

integrating Gittell's (2016) Relational Coordination where communication and relationship-building could support shared tasks. To animate this solution, Chapter Three outlines an implementation plan for a test of change (TOC) project using SCM. TOCs are a commonly employed tool in health care in which desired changes are tested through small pilots, and later scaled and widely disseminated. Although this suggests testing the proposed solution on a simple FHT partnership may be the best approach, for example a bilateral partnership with one other organization, the OIP TOC targets one of the FHT's most ambitious collaborations, a FHT-led planning table. The rationale for this larger pilot is two-fold. The planning partnership is a multi-lateral collaboration of over 25 partner organizations that represent different jurisdictions and sectors, making the partnership an apposite test of the Randle and Anderson (2017) framework. Second, there is an immediate need for cross-sectoral, system-level collaboration within the FHT's sub-region. Provincial changes to the legislation governing Ontario's healthcare system are upending operations across the FHT and the province, and compelling an urgent and coordinated sub-regional response, making the FHT's planning collaboration a timely TOC.

The OIP writing process has taken place during a time of great change and flux in the Ontario healthcare system, sometimes giving the writing process the feel of field reporting more than an academic pursuit. This has many implications, including a possible future state in which the FHT's organizational structure is significantly changed along with those of its community partners. For this OIP, it means the ideas and concepts developed through the writing process are likely more relevant to the author's practice, than any specific details of the implementation plan.

Chapter One: Introduction and Problem

In Ontario, healthcare leaders are increasingly engaged in institutional partnerships related to planning, staffing, delivering programs, and sharing assets to achieve seamless patient care, often with fewer resources. Several years ago, the *Patient's First Act (Bill 41)* incentivized partnership, in part by removing barriers to healthcare integration (Ministry of Health and Long-term Care, 2016a). Over the last year, widespread transformations in Ontario's healthcare system, including new and amended legislations, are providing further impetus for purposeful resource-sharing through partnership, in part due to cuts to Ontario's provincial budget, 39% of which goes to healthcare (Closing the Gap, 2018).

This Organizational Improvement Plan (OIP) considers the experience of one healthcare organization whose growing portfolio of partnerships requires evidence-based structure. Chapter One describes the organizational context, introduces and develops a problem of practice (PoP), and summarizes key organizational change considerations, including leadership. Chapter Two develops an integrated system-level change model to support change, operationalizes it with authentic and complexity leadership theories, identifies possible strategies to address the PoP, and reviews ethical considerations. Finally, Chapter Three presents the preferred solution including a test of change project, communication and evaluation strategies, next steps and concluding considerations.

Organizational Context

Family Health Teams in Ontario

The target of this OIP is a family health team in Ontario (the FHT). Family health teams are primary healthcare (PHC) organizations that integrate non-physician healthcare professionals, for example registered nurses and social workers, into physician practice (Rosser, Colwill, Kasperski, & Wilson, 2011). This interprofessional model of care was established in

2005 by the Ontario government as part of a broader strategy to increase residents' access to team-based PHC. At present, three million Ontarians are enrolled with 184 family health teams across 200 communities (Ministry of Health and Long-Term Care, 2016b).

The achievements of family health teams are contested. Studies have found that patients are highly satisfied with their collaborative and team-based approach (Rosser, Colwill, Kasperski, & Wilson, 2011), contributions to enhanced health knowledge (Gocan, Laplante, & Woodend, 2014), and same-day access to care (Conference Board of Canada, 2014). However, patient satisfaction is only one type of healthcare outcome. In a comparison of the family health team with other PHC models, Glazier, Hutchinson, and Kopp (2015) found that family health teams are not necessarily increasing equitable access to care in Ontario, or achieving superior health outcomes. For example, compared to other PHC models, family health teams:

- are more prevalent outside major urban areas;
- tend to serve patient populations with higher incomes and who are born in Canada;
- are more likely to care for patients with less complex health conditions; and
- achieve comparable patient outcomes such as emergency department visits, hospital admission rates and use of specialist services (Glazier, Hutchinson, & Kopp, 2015).

Given their comparatively modest results, family health teams are expensive when considered against other types of PHC in Ontario (Haydt, 2018). All family health teams are, at present, directly funded by MOHLTC in an effort to ensure sustainability of the model (Meuser, Bean, Goldman, & Reeves, 2006). However, while family health teams are known to lead to higher income satisfaction for family physicians (Rosser, Colwill, Kasperski, & Wilson, 2011), the provincial government has indicated they will not fund any *new* teams, in part due to what appears to be unexceptional returns on significant investment (Marchildon & Hutchison, 2016).

This type of provincial decision provides important context to the FHT whose vision, mandate, institutional leadership approach and programs are significantly influenced by provincial requirements related to governance, funding, and broader healthcare priorities.

The FHT: Mission and Goals

The FHT is a family health team in Ontario that has been operating for over twelve years. While sharing much in common with other family health teams, the FHT's specific mission is to provide excellence and leadership in several areas, including patient-centred PHC that is inter-professional and evidence-informed. It does so by serving over 20,000 patients who are supported by approximately 20 physicians and 20 other healthcare professionals including nurse practitioners, registered nurses, physician assistants, pharmacists, social workers and nutritionists¹. The FHT differs from other family health teams in that, based on the needs of its community, it also serves low-income and otherwise socially disadvantaged residents through targeted clinics and programming, often in partnership with other organizations. In addition, the FHT is one of multiple family health teams in the province that receives program funding from MOHLTC to lead sub-regional² initiatives; and to extend its services to patients who are not

¹ Exact numbers are not presented to protect identity of organization.

² Since 2006, Ontario has been divided into 14 Local Health Integration Networks (LHINs) that are both geographic regions and organizations, each of which has been responsible for healthcare planning within the region it serves. A LHIN region is further divided into sub-regions. For example, the FHT operates within one of multiple sub-regions in its LHIN. In February 2019, the provincial Minister of Health announced the dissolution of the LHIN organizations and it is anticipated that the geographic boundaries of regions and sub-regions in Ontario will change (Ministry of Health and Long-Term Care, 2019a).

affiliated with the FHT or any type of PHC, or who are rostered to physicians that are not based in teams, i.e., are rostered to solo practitioners.

FHT Partnerships.

Partnerships are key to accomplishing the FHT’s mission. FHT partnerships range from bi-lateral agreements with other healthcare institutions or community-based organizations, to multi-lateral collaborations across sectors. Of the former, the FHT is engaged in a number of institution-to-institution joint ventures including, for example, with a local hospital to share a psychiatrist. Of the latter, the FHT receives provincial funding to lead two sub-regional level collaborations that involve a multitude of partners: 1) *Health Links*, a well-researched, province-wide program that coordinates care for medically and socially complex patients in Ontario sub-regions (Evans, Grudniewiz, Wodchis, & Baker, 2014; Grudniewicz, Tenbenschel, Evans, Gray, Baker, & Wodchis, 2018); and a sub-regional planning table with over 25 health and community partner organizations that, until recently, was collectively tasked with providing healthcare recommendations to the regional Local Health Integration Network – previously MOHLTC’s planning and funding intermediary in the region.³

Institutional Leadership Approach

The FHT’s institutional leadership approach, while influenced by provincial trends and requirements, is largely a consequence of the FHT’s organizational culture and governance

³ In February 2019, the province announced healthcare reforms that, in addition to dissolving Ontario’s LHINs, will re-situate planning with Ontario Health, a new agency (Ministry of Health and Long-Term Care, 2019a). This calls into question the future mandate of the sub-regional planning table; however, as will be explored in Chapter Three, an emerging opportunity for this system collaboration will be the focus of a test of change project.

structure, a physician Board of Directors. This section describes the results of an assessment of the FHT's organizational culture; and the influence of physician leadership on the organization.

FHT Organizational Culture

For the purposes of this OIP, the author assessed the FHT's institutional culture using Cameron and Quinn's (2011) Organizational Cultural Assessment Instrument (OCAI), an evidence-based tool used to profile organizational cultures as one of four types: adhocracy, clan, hierarchy or market. Figure 1 depicts the results of the assessment, and shows the FHT as strongly oriented to an adhocracy. While the next section explains and elaborates on these findings, it should first be noted that the assessment was undertaken only by the author of this OIP, limiting the findings. In a review of assessment instruments, including OCAI, Tobias et al. (2009) identified limitations of organizational cultural assessment, including: misclassifying institutional cultures; ignoring important aspects of an organization's work, invalidating its classification; and failing to appreciate the adaptive advantage of a particular culture. These are all compounded when assessment is conducted by a single individual, as in this OIP.

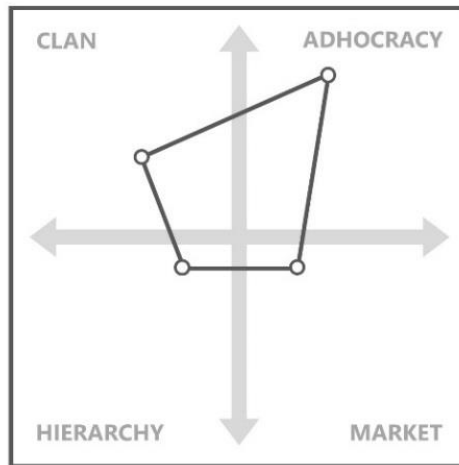


Figure 1. Organizational culture profile of the FHT based on the application of Cameron and Quinn's (2011) Organizational Cultural Assessment Instrument (OCAI).

An OCAI adhocracy like the FHT is characterized as entrepreneurial, innovative and visionary, a non-hierarchical organization that is responsive to emerging needs, issues and ideas (Cameron & Quinn, 2011). This orientation is reflected in, and likely facilitated by, the FHT's decentralized institutional structure: a cross matrix of independent teams that are defined by profession, for example, nursing team, reception team etc., or by function. To elaborate on the latter, an example is the FHT's interprofessional clinical teams that work directly with subgroups of FHT patients. A second example is a team, led by the author of this OIP, that delivers predominantly off-site programs and services to non-FHT patients, and the focus of further discussion in the *Leadership Position, Agency and Lenses* section. Within each of the FHT's multiple teams, managers have, at least to-date, significant autonomy and priority-setting agency based on their judgement and the needs of their portfolios. This degree of scope will be further explored in the *Leadership Position, Agency and Lenses* section, and reflects the FHT's adhocratic culture, despite the noted limitations of the assessment.

Physician Leadership and the FHT.

The FHT's operational culture is strongly influenced by a historically hands-off Board of Directors (Board) composed of all physicians who practice within the FHT. Being a non-profit corporation, the Board is accountable for the organization's mandate and performance (Association of Family Health Teams of Ontario, 2018). This type of Board makeup is not unique to the FHT. While family health teams may adopt physician-led, community-led or mixed governance structures, community-led boards - the only type of governance that is reported, are known to be low, only 27 of 184 family health teams (Association of Ontario Health Centres, 2009). So, physician leadership characterizes the governance of most family health teams.

Haydt (2018) situates a predisposition towards physician-centric leadership as consistent with a broader bias in Canadian healthcare that favours physician authority. An example of, and contributing factor to this bias can be found in medical education, the physician's training journey from medical school, through residency, to continuing professional development for practicing physicians. Leadership is ever-present in the national competency framework for Canadian medicine, *CanMEDS 2015*, that situates physician leadership within the clinician-patient relationship, institutions and the healthcare system (Frank, Snell, & Sherbino, 2015). However, despite a purported emphasis on training physicians for leadership positions, there is minimal consideration of physicians' impact on healthcare outcomes outside their patients' clinical results. Grady (2016) suggested that physicians' capacity for innovation as clinicians could be extrapolated to influence healthcare systems. Similarly, Denis and van Gestel (2016) compared and contrasted contributions of physicians in Ontario and the Netherlands to overall healthcare system performance. Yet these and other studies lack insight as to *how* physician leaders *explicitly* contribute to organizational and system performance. This ambiguity is

consistent with the current experience of the FHT in which the Board is identified as the institution's leadership body, yet lacks presence in the strategy and daily operations of the organization.

The lack of day-to-day presence by FHT Board members is consistent with broader leadership challenges common in healthcare: an emphasis on physician leadership that is undermined by an obvious and necessary prioritizing by clinicians of their patients. An interesting glimpse of this tension in practice is reflected in analyses by Waldman and Cohn (2008) and Cinaroglu (2016) who contrasted how clinicians and administrators differently interpret their organizational roles and accountabilities. For example, physicians' professional accountabilities are to regulatory bodies whereas managers tend to be accountable to their direct supervisors, who are collectively accountable to a board. Consequences of competing perspectives between clinicians and administrators may include gaps and conflicts that undermine an institution's ability to undertake a shared vision. When considered in the context of family health teams, where single individuals are acting both as physicians *and* organizational leaders, the challenges outlined by Cinaroglu (2016) may be even more pronounced in that the management function is poorly represented, if at all. Within the FHT, the Board has, in part, addressed their conflicting roles as administrators and clinicians by delegating leadership to an Executive Director and Physician Lead. Both operate with minimal Board input and model their relationship with the Board in their interactions with their own direct reports.

Over the last several months, emerging influences are starting to drive increased leadership engagement by the FHT Board: 1) a provincial emphasis on strengthening the governance of family health teams (Association of Family Health Teams of Ontario, 2018); 2) an independent, internal review of the FHT's governance and leadership by the Board itself,

resulting in governance re-structuring that is currently underway; and 3) provincial healthcare transformation that will be further considered in Chapter Three. Despite these developing influences, the legacy of the Board's hands-off approach has contributed to an adhocratic institutional culture, including providing the author of this OIP significant autonomy to, among other things, pursue this OIP to support her portfolio.

Leadership Position, Agency and Lenses

This OIP is authored by the FHT's Manager of Programs (Manager). The Manager oversees FHT programs that fall into three categories: sub-regional initiatives for which the FHT is funded by the MOHLTC, e.g., the local *Health Links* program and sub-regional planning; programs with a shared goal of delivering services to non-FHT patients; and programs that extend PHC to patients who are medically complex, i.e., they have four or more medical conditions, and/or socially complex, i.e., they experience significant social barriers to accessing health care. This section will briefly consider how historic provincial directives and the FHT's culture come together, and complement the Manager's leadership scope and approach. This leadership stance is informed by liberal, critical and Indigenous lenses, and is supported by authentic and complexity leadership theories.

Leadership Agency

The Manager has significant scope to manage partnerships, programs and employees in her portfolio; and, in many ways, is more influenced by these than by the FHT's senior leadership. Perhaps the strongest example of where provincial priorities, FHT culture and the Manager's leadership agency and approach are mutually reinforcing is a legacy MOHLTC imperative that the FHT support non-FHT patients' access to team-based PHC. In keeping with its assessment as an adhocracy, the FHT has responded quickly to MOHLTC requests over the

last two years for enhanced programming of this type. Currently, the Manager oversees approximately 20 staff across several locations delivering these types of programs. Reporting directly to the Executive Director and Physician Lead, the Manager has weekly touch-bases with her superiors to describe progress and get advice; however, in keeping with the adhocratic culture described, she has autonomy in how she undertakes and accomplishes this work.

In addition to the FHT's adhocratic culture, the Manager's autonomy is bolstered by the practical requirements of the program portfolio. The majority of FHT programs are supported by partnerships that involve external stakeholder engagement and relationship management, requiring that the Manager spend much of her time away from FHT locations. So, in practice the Manager often spends more time with partners and visiting off-site direct reports, than she does with other FHT employees, a reinforcement to the FHT's adhocracy culture that favours independence and situational decision-making.

Leadership Lenses

The FHT's programs related to sub-regional planning, addressing unequal access to PHC, and supporting medically and socially complex patients, as well as the FHT culture, are all consistent with and complement the Manager's leadership style that is informed by tenets of liberalism, critical and Indigenous thought. For example, within liberalism, the values of self-autonomy and critical thinking described by Gary (2006) are consistent with the FHT's reliance on employee independence and personal problem-solving, traits also valued by the Manager.

In addition to, and perhaps because of an inclination towards the liberal principle of critical thinking, the Manager is influenced by critical thought, an analytic perspective that seeks to understand circumstances through a social justice lens (Davies, Popescu, & Gunter, 2011; Rottmann, 2007). This requires that leaders analyze and deconstruct situations and relationships

to understand power dynamics. For example, of relevance to this OIP, within the FHT the Manager has positional power by virtue of her oversight of the programs and partnerships portfolio and direct staff reports. External to the FHT, however, the Manager has no positional authority with partners and other stakeholders, and the Manager must rely on referent and persuasive power to accomplish partnership goals (Elias, 2008; Raven, 1993). Some of the power dynamics influencing this OIP are further explored later this chapter.

A critical lens also informs the Manager's personal approach, and the FHT's community programs. For example, several FHT programs are predicated on an understanding that health is mediated by social determinants of health (SDHs), twelve social and economic conditions that impact mental and physical health (Canadian Mental Health Association, 2018). SDHs are inherently about power, or vulnerable patients' lack of it, and are influenced by, "stratification and social class divisions [that] define individual socioeconomic position within hierarchies of power, prestige and access to resources" (World Health Organization, 2010, p. 5). Limitations in SDHs such as housing have been shown to have more impact on health than lifestyle (Mikkonen & Raphael, 2010).

A strong foil to the critical practice of deconstruction and social justice, are the paired concepts of recontextualization and integration that are consistent with Indigenous thought (Munroe, Borden, Orr, Toney, & Meader, 2013). An underlying theme or element of partnership – the ultimate topic of this OIP - is integration. For example, Penuel, Coburn, and Gallagher (2013) characterize partnership as a type of place-making, or, "an *intersection* of different subcultures to coordinate work and sometimes create new forms of social practice ..." (p. 239). Similarly, practice-scholars interested in system-level collaboration identify place-making - shared space and shared culture - as enablers to successful collaboration (Randle & Anderson,

2017); while other partnership researchers, for example, Walshe, Caress, Chew-Graham, and Todd, 2007, identify and challenge barriers to integration, and thus partnership. So, given the congruence of the Manager's leadership stance, the nature of her work, and the topic of partnership, integration is an important theme in this OIP.

Leadership Theories

While the Manager's leadership approach is informed by several ways of seeing the world and workplace, her responsibilities involve both direct team management, and partnership management within which there are no direct reporting relationships. Accordingly, the Manager is strongly influenced by leadership theories that value different types of relationships: authentic leadership that focuses on leader-follower relationships and a leader's role and influence on these relationships (Avolio & Gardner, 2005; Avolio, Walumbwa, & Weber, 2009); and complexity leadership that seeks to understand the components of a complex system, how they interact and how they contribute to the whole (Baltaci & Balci, 2017; Uhl-Bien, & Arena, 2017). Key features of the two theories are compared in Table 1, and re-visited in Chapter Two.

Theory feature	Authentic leadership Theory (ALT)	Complexity leadership theory (CLT)
Focus	Concerned with understanding self (leader), and relationship between leader and follower(s) (Northouse, 2016).	Concerned with relationships between constituent components of a system and how they contribute to whole (Plsek & Wilson, 2001).
Key elements of theory	Avolio, Walumbwa, and Weber (2009) identified four factors that can be developed in authentic leaders: <ul style="list-style-type: none"> i. Self-awareness ii. Internalized moral perspective iii. Balanced processing iv. Relational transparency. 	Built around idea of complex adaptive systems, a metaphor for organizations in which units of work interact in neural-like networks around shared goals, outlooks etc. (Uhl-Bien, Marion, & McKelvey, 2007).
Characteristics of leaders	According to George (2003), authentic leaders: <ul style="list-style-type: none"> – understand their purpose – have strong values about the right thing to do – establish trusting relationships with others – demonstrate self-discipline – are passionate about their mission. 	<ul style="list-style-type: none"> – Focused on <i>role of leadership</i> (not individuals) in understanding and influencing navigation, processes, and outcomes in complex systems (Lichtenstein, Uhl-Bien, Marion, Anson, & James, 2006) – Non-hierarchical, and equally values the contributions of all members of system and emphasizes creative problem solving and learning (Baltaci, & Balci, 2017).
Limitations	<ul style="list-style-type: none"> – Overly biased towards leaders' capacities and influence (vs. followers). – Overlaps with other leadership theories, for example transformational and ethical. 	According to Baltaci, & Balci, 2017, Complexity leadership: <ul style="list-style-type: none"> – assumes all units are equally capable of contributing (not necessarily true) – the interdependent interactions of agents are hard to analyze.

Leadership Problem of Practice

The PoP addressed by this OIP is the FHT's lack of evidence-informed resources to support the development and implementation of effective partnerships to achieve concrete outcomes. While this PoP is being introduced as a deficit, its approach is consistent with Wittkuhn (2012) who classified three ways of solving problems, the third being less about problem solution and more about imagining a desired state in an iterative process of conceptualization, development and refinement. So, as will be elaborated later this chapter, this OIP is predicated on an imagined state in which the FHT is engaged in intentional partnerships that are evidence-informed, enable resource-sharing, and improve the FHT's work.

This PoP is influenced by broader trends in Ontario's healthcare sector incentivizing, and increasingly requiring, institutional collaboration around planning, staffing, delivering programs, and sharing other resources to achieve seamless patient care. The latter, seamless care, is a legislative requirement under the current *Patient's First Act (Bill 41)* (Ministry of Health and Long-term Care, 2016a). This legislation amalgamated and amended other Ontario Acts with the goal of improving patient-centred healthcare, in part by removing barriers to integration such as lack of communication between primary and tertiary institutions (Ministry of Health and Long-term Care, 2016b). For the last several years, organizations, including the FHT, that receive funding from MOHLTC have been encouraged to participate in integration partnerships for various reasons, including: creating new connections between primary care providers, inter-professional health care teams, hospitals, public health and community care to facilitate smooth patient transitions; reducing healthcare administration costs by removing redundancies and sharing staff; ensuring communities' diverse populations are meaningfully reflected in community health planning; and strengthening the voices of patients and families in their own

health care planning. Family health teams in particular have been encouraged to participate in partnerships to extend programs and resources (Ministry of Health and Long-Term Care, 2017).

More recently, there is a strong likelihood that the partnership-incentivizing *Patient's First* (2016) legislation and related programming will soon be replaced. In 2018 there was a change in provincial government; and in February, 2019 the new Minister of Health announced a series of transformational healthcare changes, including to *Patients First* (Ministry of Health and Long-Term Care, 2019a). While the impacts of these changes are not yet fully understood, the tabled replacement legislation, *People's Health Act* (originally the *Health Systems Efficiency Act*), and associated documents, for example a new forecast on Ontario healthcare spending by the Financial Accountability Office of Ontario (2019), suggest that amalgamations could replace partnerships as the government attempts to tackle provincial debt through healthcare reform.

While there is growing confusion within healthcare about the motivations, requirements and nature of partnerships, on a day-to-day basis many healthcare organizations like the FHT are actively involved in them. However, despite this prevalence of partnerships, there is limited sector-specific evidence on how to ensure meaningful collaborations that contribute to improved patient outcomes in healthcare (Ansari, Phillips, & Hammick, 2001). This OIP will consider what evidence-informed practices from healthcare and other sectors the FHT might adopt to ensure its partnerships are developed and enacted intentionally, support its programs, better use resources, and produce tangible results.

Framing the Problem of Practice

In addition to the leadership lens and leadership theories described previously, this PoP is informed by pragmatic and social-constructivist worldviews; and underpinned by Creswell's (2007) assumptions about the qualitative research approach. Of the latter, Creswell's

epistemological, axiological, rhetorical and methodological assumptions about qualitative research not only apply to the manner in which this OIP inquiry has been undertaken, but are also consistent with the OIP's subject matter. Like qualitative research, partnerships are social undertakings influenced by a multiplicity of perspectives about reality, knowing, values, languages and processes.

Constructivist and pragmatist worldviews also align with Creswell's (2007) assumptions, and this OIP's focus on partnerships. Of the former, constructivism, social partnerships are, by their very nature, an effort to navigate complexity, and *construct* shared meaning and goals amongst individuals or organizations (Penuel, Coburn, & Gallagher, 2013). However, partnerships are also practical endeavours, driven by specific motivations and desired outcomes, sometimes independent of the individuals and organizations participating, for example, in an externally directed partnership. So, in comparison to social constructivism, but complementary to it, the pragmatist worldview is driven by the internal needs of an intellectual pursuit and is not constrained by a particular philosophy or reality, but instead borrows from any worldview, assumption or methodology that will support – and help answer – an investigation (Creswell, 2007). Given social, cultural and historical context are key considerations in the pragmatic worldview, understanding an evidence base and different perspectives on an issue are important methodological tools. Accordingly, the remainder of this section explores the idea of perspectives on partnership using the Bolman and Deal (2017) Four Frame model; and the subsequent section, *Questions Emerging from the PoP*, summarizes an evidence-base for partnerships.

Key Perspectives on FHT Partnerships

The Bolman and Deal (2017) Four Frame model is a way for leaders to analyze a situation, such as an organizational challenge, using four different perspectives or lenses to ensure they are not stuck in one way of seeing. In the case of this OIP, the framework is applied to the concept of partnerships to help better situate the OIP for problem-solving and a test of change project in Chapter Three. The first three frames (Structural, Human Resources and Symbolic) are used to analyse generalized elements of FHT partnerships (Table 2). The fourth frame, Political, is used to analyse power dynamics between the FHT and one of its most significant partners, a funder (Table 3).

When considered in aggregate, the FHT's partnerships involve approximately 35 community and healthcare organizations. Given the number and diversity of institutions, it is not practical to analyze the perspectives of each partner organization, or even each partnership. Table 2, developed by the author, addresses the *concept* of FHT partnerships by analyzing important partnership elements using three of Bolman and Deal's (2017) frames. First, the Structural Frame considers FHT partnerships according to rules, roles, goals, policies and technologies. Second, the Human Resources Frame tries to understand FHT partnerships through a lens that favours human needs, wants and relationships. And third, the Symbolic Frame explores FHT partnerships as an intersection of culture, meaning, metaphor and ritual. As indicated in the table, elements of all three frames are reflected in interdependent concepts addressed throughout this OIP. However, it should be noted, that similar to the OCAI assessment depicted in Figure 1, this analysis was conducted solely by the author of this OIP and shares some of the same limitations.

Table 2 <i>Three Perspectives on Partnerships</i>			
Element	Structural	Human Resources	Symbolic
Purpose and benefits of partnerships	To <i>organize</i> institutional agreements around mutual goals	To bring <i>people together</i> who have shared goals	To <i>inspire</i> a group of people to undertake a shared endeavour/quest
Partnership priorities	Clear <i>terms of reference, goals, roles & responsibilities</i>	<i>Relationships</i> between partner organizations	Building a <i>culture</i>
Partnership leadership	Rooted in hierarchy and based on <i>social architecture</i>	Based on likeability and ability to <i>bring people together</i> and keep them <i>motivated</i>	Based on <i>inspiration</i> , specifically tapping into <i>culture</i> and <i>metaphors</i> that <i>inspire</i> partners
Planning and decision-making	Based on <i>agreements, terms of reference</i> etc.	Based on <i>maintaining relationships</i>	Rooted in <i>shared culture</i> and <i>metaphor</i>
Interdependent concepts in this OIP	Structured change management through adapted System Change Model (SCM) (<i>Further developed in Chapters One and Two</i>)	Relationship focus of authentic and complexity leadership theories (<i>Further developed in Chapters One and Two</i>)	OCAI results (FHT as adhocracy) and Penuel, Coburn, & Gallagher (2013) concept of partnership as placemaking (<i>Further developed in Chapters One and Three</i>)
<i>Note.</i> Developed by author using frames from Bolman and Deal’s (2017) Four Frame model.			

An additional perspective of interest to this OIP is Bolman and Deal’s (2017) fourth frame, the Political frame that is primarily concerned with conflict, competition and power. Understanding situations in terms of power dynamics is part of the social justice perspective

introduced in the *Leadership Lenses* section. In addition, politics in healthcare can have implications for patient outcomes. For example, in a 2009 commentary, Blendon and Steelfisher contended that failure to integrate evidence into patient care is primarily a political failure, an inability to understand and take advantage of political levers and power dynamics to facilitate change or overcome barriers.

Vital, but quickly evolving political context to this OIP pertains to one of the FHT's most significant partners, the regional LHIN that over the past two years has been both partner and funder to the FHT.⁴ In 2017, an amendment to the 2006 *Local Health Integration Network Act* re-shaped the purpose and scope of Ontario's 14 LHINs (Ministry of Health and Long-Term Care, 2017). Through the enactment of the associated *Patients' First Act*, in May 2017 all 14 LHINs were amalgamated with 14 Community Care Access Centres (CCACs), organizations previously responsible for arranging health services for community-based patients. The goal of this transformation was to localize healthcare decision-making, and legislatively empower the new 'super' LHINs (Ministry of Health and Long-term Care, 2017). However, a largely unexplored consequence of these mergers was that the LHINs were transformed from policy organizations and intermediaries of the MOHLTC, to decision-makers with control over all funding and service coordination in their respective regions. For the FHT, its local LHIN went from being a FHT partner to *the* funder of many FHT programs and partnerships, creating problematic, and political, context. Table 3, developed by the author, summarizes types of power using Elias (2008) and associated considerations for the LHIN and the FHT; and Table 4, also

⁴ Although in February, 2019 the province announced healthcare reforms that included dissolution of Ontario's 14 LHINs (Ministry of Health and Long-Term Care, 2019a), for the majority of the OIP writing process the regional LHIN has been intact and constituted a significant influence on the FHT.

developed by the author, summarizes generalized elements of FHT partnerships using the Political Frame. It should be noted, that as was the case with Figure 1 (*OCAI Assessment*) and Table 2 (*Perspectives on Partnership*), these assessments were undertaken in isolation by the author of this OIP; Tables 3 and 4 therefore represent one way of interpreting the Political frame, not *the way*.

	<u>LHIN</u>	<u>FHT</u>
Type of power (Based on Elias, 2008)	Positional / legitimate and able to use coercive, reciprocity and/or reward power.	Referent and expert (rooted in their work in primary care and reputation in the sub-region).
Context/Other power considerations	<ol style="list-style-type: none"> 1. Enactment of <i>Patient's First Act</i> gave LHINs control over allocation of all healthcare resources. 2. The LHIN is an amalgamation of two organizations and caused significant <i>internal</i> power struggles. 3. In February, 2019 the provincial government announced changes including dissolution of the LHINs and changing power dynamics in the sub-region. 	<ol style="list-style-type: none"> 1. Historically, the FHT had a type of legitimate power in that it received funding directly from the Ministry of Health and could not be coerced by the LHIN. <ul style="list-style-type: none"> – Currently the FHT receives some funding from MOHLTC LHIN. 2. The FHT is part of a sub-regional planning table making a proposal for a post-LHIN region.
<i>Note.</i> Developed by author using Elias' (2008) types of power in row 1.		

Table 4 <i>Power Perspective on LHIN and FHT</i>		
	LHIN	FHT
Purpose of Partnerships	<ul style="list-style-type: none"> – A means of extending LHIN’s scope and control in sub-region. – A means of better engaging in and producing mandate of service coordination, particularly in face of organizational dissolution. 	<ul style="list-style-type: none"> – A way of better using scarce resources to deliver patient care. – A means of supporting community-based colleagues. – Some partnerships are mandated or encouraged by funders (MOHLTC and/or LHIN).
Leadership Perspective	<ul style="list-style-type: none"> – All activity should be controlled by LHIN currently responsible for managing all resources in region. – Traditional, hierarchical approach to leadership; not reflective. 	<ul style="list-style-type: none"> – Preferred is distributed or shared between partners. – Relatively hands-off (consistent with adhocracy culture).
Planning and decision-making	<ul style="list-style-type: none"> – Planning and decision-making for partnerships should be integrated within broader LHIN planning and their system plan. – In face of healthcare changes announced in February 2019, their future role in planning is unclear. 	<ul style="list-style-type: none"> – Similar to leadership perspective, focus is on distributed and shared planning and decision making.
<p><i>Note.</i> Developed by author using Bolman and Deal’s (2017) Power frame from Four Frame Model.</p>		

Questions Emerging from the PoP

In addition to exploring different perspectives on an issue, understanding an evidence base is an important methodological tool within the pragmatic worldview. This section further explores what is known about four lines of inquiry that emerge from this PoP:

1. How are partnerships conceived and defined?
2. What is the evidence for, and against healthcare partnerships?
3. What is known about developing and maintaining successful partnerships?

4. How are partnerships best evaluated?

What follows is a brief review of partnership literature that addresses these foundational queries in general, and as they pertain to the FHT.

What is Partnership?

While *partnership* is a widely-used term, there is not a shared understanding of the concept. At its most general, partnership has been described as a way of dealing with, and actualizing complex policy issues (Boydell & Rugkasa, 2007). In comparison, Glendinning (2002) offered a more granular definition of partnership as, “denot [ing] a particular type of relationship in which one or more common goals, interests, and/or dependencies are identified, acknowledged and acted upon, but in which the autonomy and separate accountabilities of partner organizations remain untouched” (p. 118). The first definition is vague and hard to implement; and the latter does not necessarily reflect partnerships in practice. For example, participating partners’ autonomies and accountabilities often “touch” (Boydell & Rugkasa, 2007). This idea of interdependence or connection is further explored by Penuel, Coburn, and Gallagher (2013) who proposed the idea of *place-making*, framing partnership as purposeful or planned intersections of subcultures: “linked activities with distinct norms, tools, and rules for thinking, speaking, and acting together” (p. 239). In this conceptualization, partners more than touch and co-create shared, bounded space through their collective work with features and practices distinct from the daily operations of participating institutions.

Healthcare partnerships tend to be less conceptual and more practical, targeted at improving health outcomes. For example, Boydell and Rugkasa (2007) described multi-institutional collaborations in the United Kingdom aimed at reducing health inequity. Butt, Markle-Reid, and Browne (2008) considered bilateral institutional agreements implemented by

interprofessional healthcare providers with shared goals of improved healthcare delivery. And in Ontario, a provincial trend of funding and fostering partnerships to improve non-FHTs' patients access to team-based PHC, aims to develop *cultures* of partnership and collaboration to improve provincial-level patient outcomes (Advancing Access to Team-Based Care, 2018).

The Evidence for and Against Partnership

As the literature reflects differing conceptualizations and rationales for partnership, the achievements of partnership are similarly debated. Partnerships are endemic to community and healthcare endeavours, and are often espoused as good and helpful (Dowling, Powell, & Glendinning, 2004). Yet, there is minimal evidence to support unreserved confidence causing Ansari, Phillips, and Hammick (2001) to advocate for, “more evidence and less rhetoric” (p.216). Some have answered their call. In a 2011 report on partnerships in healthcare, Hunter, Perkins, Bambra, Marks, Hopkins, and Blackman, endorsed institutional partnerships and posited that successful partnerships are those that foster on-the-ground decision-making. A hospital-based study by Beech et. al. (2013) indicated that intentional partnerships contribute to improved integration and communication between institutions, resulting in better patient outcomes. While both Davies (2002) and later Boydell and Rugkasa (2007) explored less tangible or soft benefits of partnership, that “lack visibility, yet it seems that those involved ... intuitively know their value” (Boydell & Rugkasa, 2007, p. 227).

In practice, the literature suggests that whether or not healthcare partnerships are ‘good,’ they are difficult to administer, particularly those that address shared planning, decision-making and human resource management (Walshe, Caress, Chew-Graham, & Todd, 2007). For example, Boydell and Rugkasa (2007) detailed the difficulties of partnership administration including: time and associated opportunity costs of participation in a partnership; the risks of partnerships

becoming overly focused on shop talk; the tyranny of consensus; tokenism; and partnerships that obscure, “responsibility, authority and accountability” (p. 225). So, while partnerships are widespread, the evidence for their successful implementation and even efficacy is not robust.

Ensuring Successful Partnerships

There is a growing body of literature that, regardless of efficacy considerations, is predicated on the reality of partnerships and proposes best practices for their implementation. These range from what to avoid, to what to plan for. On one end of the spectrum, Walshe, Caress, Chew-Graham, and Todd (2007) identified five types of barriers to successful partnerships in palliative care (structural, procedural, financial, professional and legitimacy). They advocated that institutional partners collectively identify and address these barriers to ensure patient well-being and warn against collaborating as a, “panacea for issues of fragmentation” (p. 48). Other researchers have proposed a more pro-active approach and focus on building for success. For example, Osborn (2009) identified trust as the foundation to successful long-term partnerships. Boydell and Rugkasa (2007) proposed a conceptual model for effective healthcare partnerships that scaffolds how to develop, implement and evaluate institutional partnerships. And for those practitioners less interested in theoretical constructs and more interested in ‘how to’ guides, Randle and Anderson (2017) identified nine areas of consideration for system-level collaborations to address complex, multi-sectoral issues.

Finally, a key, but less explored criterion for successful partnership, particularly multi-sectoral collaborations, is system-level leadership. For example, in Randle and Anderson’s guide to building system-level partnerships, one of the nine building blocks explicitly considered is collaborative governance. In this framework, leader-participants play multiple roles including as stewards, investors, and builders of collaborative infrastructures, requiring a diversity of

leadership competencies. Within this framework: “System leadership is an act of persuasion that needs to have an evidence base for change” (Randle & Anderson, 2017, p. 43).

Evaluating Partnerships

The results of this brief literature review reflect a plurality of viewpoints related to the nature, goals, value, effects and strategies for ensuring successful partnerships. The need to build an evidence base through evaluation of partnerships is less contested. Two types or approaches to evaluation are most prevalent in the literature: theories of change, and realist evaluation. Theories of change are evaluation models that depict the relationship and rationales, including theoretical bases, for how a program’s inputs and activities interact with an external context to bring about planned outcomes (Blamey & Mackenzie, 2007). In comparison, realistic evaluation, originally developed by Pawson and Tilley (1997), and later elaborated on by Pawson (2002), attempts to understand and describe the unique features of a program or initiative and its interactions with a specific environment. This evaluative process can be summed up in a well-known equation for realist evaluation: context + mechanism = outcome. Implicit to both approaches is the idea that a single partnership or initiative is under evaluation, however given the differing, arguably complementary foci, both evaluation approaches can be employed within a given evaluation.

Challenges Emerging from Main Problem

This brief literature review captures and summarizes current discussions related to partnership. A significant challenge that crosses all themes reviewed is the practical application and implementation of the collective knowledge in the healthcare context, specifically the FHT’s PHC setting. For example, the FHT’s bi-lateral partnerships with other primary care institutions are different than its multi-sectoral collaborations with over 25 health and community partner

organizations, with different mandates and funders. In contrast to the number, diversity, magnitude and complexity of FHT partnerships, there are relatively few FHT staff with the capacity and time to dedicated to partnership cultivation and management. In addition, healthcare is notoriously siloed (Deber, 2018) and the FHT's interest in more intentional partnerships is not uniformly shared across organizations.

Leadership-Focused Vision for Change

There are two types of change under consideration in this OIP: organizational-level change, specifically the development of evidence-informed partnership processes for the FHT; and the system-level change that is implicated by several of the FHT's current partnerships. This section will consider the elements of change from the FHT's institutional perspective; and the following section, *Organizational Change Readiness*, will more broadly consider readiness for change in the FHT's geographic sub-region.

Vision for Change

In keeping with Wittkuhn's (2012) third option for problem-solving - envisioning a desired state, the fundamental vision for change in this OIP is that the FHT has a strategy for implementing partnerships that are evidence-informed and aimed at improving service delivery and patient outcomes. Supporting frameworks and/or tools will inform the FHT's current and future partnership work and could be piloted through any of partnerships in which the FHT is currently engaged. The authentic and complexity leadership theories introduced earlier could support facilitation of this change, particularly as they pertain to building and supporting relationships amongst the staff supporting the FHT's partnership work (authentic leadership); and understanding and navigating relationships between the constituent components of collaborations (complexity leadership).

This vision differs from the current state in which the FHT has multiple partnerships with little structure. While the majority of the FHT’s current partnerships have some type of underpinning documentation, for example Memorandums of Understanding, often these are rushed documents with little intention, and minimal follow-up. These are not the touchstones for partnership-placemaking described by Penuel, Coburn and Gallagher (2013), in which partnerships develop norms and ways of operating distinct from contributing partners. The majority of FHT partnerships suffer from a lack of shared goals and outcomes in practice, regardless of whether or not anything is written down. This general approach - paper-based partnerships that are poorly implemented - is not unusual. In an appropriately titled article, *The Rhetoric and Reality of Partnership Working*, Dhillon (2005) described the wide gap between the ideas and aspirations of partnerships in the education sector and their operationalization, a phenomenon also witnessed in healthcare (Butt, Markle-Reid, & Browne, 2008). Narrowing this gap is an impetus for this OIP.

While the direct unit of change for this OIP is the FHT, given the FHT’s numerous health and community partners, successful implementation of this OIP could also influence how healthcare partnerships are undertaken and implemented in the sub-region in which it operates. For example, given the healthcare transformations mentioned previously in this chapter, the test of change project described in Chapter Three targets a sub-regional partnership.

Change Drivers

There are two significant drivers of change supporting this proposal: the FHT’s aforementioned portfolio related to partnerships; and enabling provincial trends driving healthcare partnerships in Ontario.

As described previously, the FHT is involved in multiple partnerships, the majority of which support or enable expansion of FHT programs to non-FHT patients. For example, currently the Manager and author of this OIP oversees partnerships that include:

- a permanent expansion of the FHT to increase PHC services to refugees not previously affiliated with the FHT, involving three bi-lateral (institution-to-institution) partnerships;
- a shared in-home primary care team between two organizations with the goal of delivering care to medically and socially complex patients in their home;
- an off-site program with four social workers who provide dedicated clinical therapy to patients of over 50 physicians who collectively serve 60,000 – 70,000 non-FHT patients;
- an upgrade and expansion of the sub-regional *Health Links* program, for which the FHT is the sub-regional lead agency, involving over ten community and health partner-organizations, in part to meet new provincial funding requirements (Health Quality Ontario, 2018); and
- a sub-regional planning process involving over 25 community and health organizations that was originally created to make healthcare recommendations to the regional LHIN⁵.

So, the FHT is currently engaged in partnerships that range in scope, partners, identified goals and outcomes; and all would benefit from, and potentially serve as potential pilots for applying increased intentionality and evidence to support their implementation.

⁵ As noted previously, in February, 2019 the Minister of Health announced a series of healthcare changes including dissolution of the LHINs (Ministry of Health and Long-Term Care, 2019a). This has impacted the original goal of the sub-regional planning table, however as will be discussed in Chapter Three, the table is continuing in an adapted form, and will be the subject of this OIP's test of change project.

In addition to the FHT’s pre-existing partnership portfolio, there is strong incentive by the provincial government – at least historically, for the FHT to maintain and engage in additional partnerships related to planning, staffing, developing and delivering programs, and sharing assets to improve non-FHT patient care. Under the previous provincial government, the funding focus was on partnerships to address equity of access in primary care. To elaborate, several years ago, the Ontario government signalled an intention to cease funding new family health teams and instead look for alternative, less-expensive ways of connecting patients who were not attached to team-based PHC (Rosser, Colwill, Kasperski, & Wilson, 2011). Currently, millions of patients in Ontario are cared for by independent family physicians, and are consequently without access to interprofessional PHC (Glazier & Kopp, 2015). Additionally, there are 800,000 citizens in Ontario who are not attached to *any* sort of primary care (Ontario Medical Association, 2015). In recognition that these patient attachment/lack of attachment patterns result in differing levels of care across Ontario, until very recently MOHLTC directed significant funding to programs aimed at increasing residents’ access to team-based primary care. Several of the FHT’s current partnerships are fully or partially funded through these initiatives constituting a significant funding stream and an important impetus for ensuring that the FHT’s partnerships produce meaningful results⁶.

Priorities for Change

Given the FHT’s extensive involvement in partnerships, and the existence of multiple associated relationships, identifying priorities for change will help the FHT navigate an achievable way forward. There are three priorities related to the change and focus of this OIP: 1)

⁶ It should be noted that the provincial government’s February (2019) changes may impact the continuation of some of these programs.

synthesizing the current state of evidence related to partnerships, particularly in complex systems; 2) adapting and integrating the evidence to make it applicable to the healthcare context, specifically the FHT's work, for example, through the identification and modification of appropriate frameworks and tools; and 3) engaging with stakeholders, particularly institutional partners, to pilot and implement best practices in partnership.

The first two priorities, synthesis and adaptation of the evidence to the FHT's context, are relatively straightforward and require building on and expanding the evidence introduced in the *Questions emerging from the PoP* section of this OIP. The third priority, implementation through stakeholder engagement, is more complex and includes several sub-priorities: 1) relationship management within the FHT; 2) stakeholder engagement with partner institutions, including around change management; and, underpinning the first two sub-priorities, 3) evidence uptake and implementation. The following section of this OIP, *Organizational Change Readiness*, considers the first two sub-priorities by adapting two change management models to address the initiation of system-level change. However, the third sub-priority, evidence uptake, requires a different type of model that considers how knowledge is disseminated and implemented in healthcare. This is the purview of knowledge translation, the discipline that broaches the chasm between evidence and implementation of new knowledge to improve health outcomes and efficiencies in health care (Graham et al., 2006). Knowledge-translation and its potential contributions to this OIP will be re-visited in Chapter Three as an implementation support.

Organizational Change Readiness

Developing best practices for partnerships is consistent with the FHT's purpose, taking an evidence-based approach to practicing medicine; and the FHT's assessment as an adhocracy using Cameron and Quinn's (2011) OCAI. As described previously, these are both strong

enablers for the Manager who has autonomy for pursuing her portfolio, including identifying, synthesizing and implementing evidence-informed partnerships to support FHT programs.

Therefore, the OIP aligns well with the FHT’s way of operating and will not require significant readiness work *within* the FHT.

In comparison, it will be important to establish a rationale with FHT partners for incorporating evidence and best practices into their collaborations, including identifying supporting drivers one partnership at a time. In anticipation of this broad readiness work, this OIP considers the initial, and complementary stages of two organizational change models: Kotter’s (1996) *Eight Stages of Change* and the Cawsey, Deszca, and Ingols (2016) *Change Path Model* depicted in Figure 2.

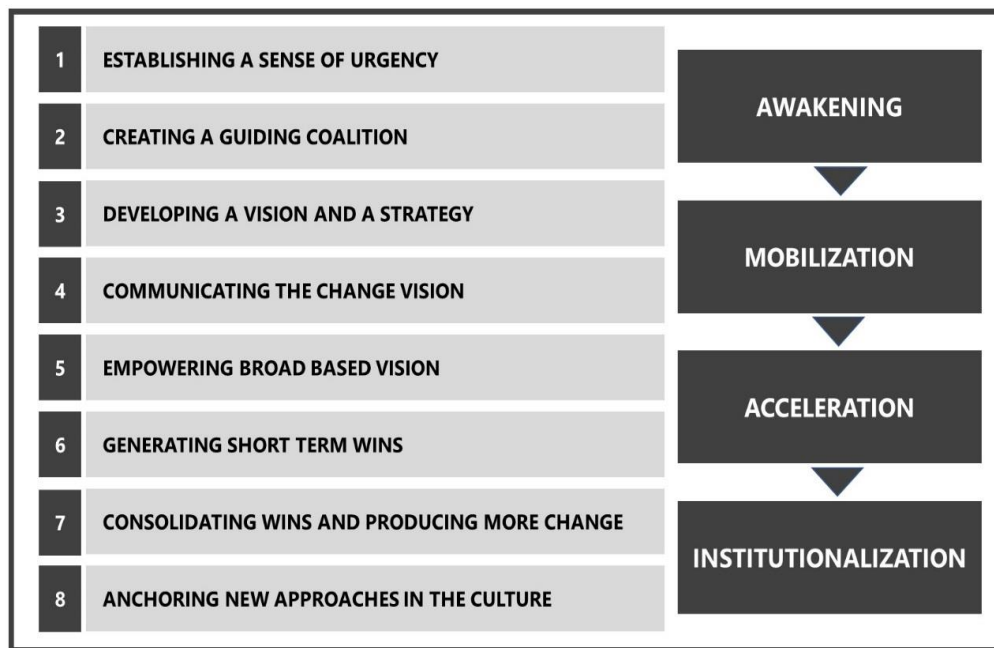


Figure 2. Two well-known change models: Kotter’s Eight Stages of Change, adapted from Kotter (1996) (left); compared with Change Path Model, adapted from Cawsey, Deszca, and Ingols (2016).

Both of these well-known change models are predicated on inspiring a need and vision for change. Within the Kotter (1996) model, the first three stages (establishing a sense of urgency, creating a guiding coalition and developing a vision and a strategy) prescribe steps that leaders may follow to initiate and visualize change; while the *Change Path Model* more broadly considers human, emotional underpinnings and processes necessary to initiating change in the awakening and mobilizing phases (Cawsey, Deszca, & Ingols, 2016). However, the two models also share characteristics that limit their full applicability to this OIP: 1) they address only organizational-level change; 2) they are framed around a single change event; and 3) implicit to each model is an assumption that change is linear, following a stepped approach that takes place in discrete stages in isolation from other activity (Pollack & Pollack, 2015).

Healthcare system change, and the partnerships that support system change, are far more complex than suggested by the Kotter (1996) and Cawsey, Deszca, and Ingols (2016) models. Perhaps no other system suffers more than healthcare from what Fullan (2008), described as *initiativitis*: “the implementation of change effort after change effort without regard to how efforts interact with each other [or] existing systems...” (p.155). In an early tome on management, Drucker (1980) described healthcare organizations as ‘two-headed monsters,’ whose leaders face an almost impossible task of navigating medical and organizational priorities (Cinaroglu, 2016). And this assumes change is within a single healthcare organization, however complex; it does not extrapolate to the system-level engagement of multiple partnerships concurrently pursuing numerous, sometimes competing, changes such as those being experienced by the FHT and healthcare partners in 2019. This type of environment has been referred to as a VUCA environment (volatile, uncertain, complex and ambiguous) in healthcare (Pabico, 2015) and will be re-visited in Chapter Two.

To better address FHT partnerships and the system-level change they support, Chapter Two will build on the principles of readiness found in both the Kotter (1996) and Cawsey, Deszca, and Ingols (2016) models, and integrate and adapt them into a system level change model to support this OIP.

Forces Shaping Change

Within this chapter, there has been reference to the complexity of the healthcare system that may influence and impact the FHT’s day-to-day work, including its partnership work. While it is difficult to be specific about these forces, for example, by unique partnership, Figure 3 summarizes high-level forces or influences that are either enabling the FHT’s partnership work - from evidence development to implementation, or impeding it. In addition, Figure 3 identifies influences that constitute important context or competing priorities in the sub-region.

<p>ENABLING FORCES</p>	<ul style="list-style-type: none"> ▪ FHT culture (adhocracy) ▪ There is an evidence base to support partnership work! ▪ Recognition amongst community partners of need to better align work initiatives and resources ▪ Pre-existing personal relationships amongst community partners ▪ Funding impetus for partnerships focused on integration, minimizing duplication and sharing resources
<p>IMPEDING FORCES</p>	<ul style="list-style-type: none"> ▪ Time – everyone is busy ▪ Predisposition towards silos ▪ Lack of resources (e.g., personnel dedicated to partnerships) ▪ Changing MOHLTC mandate and priorities ▪ Lack of integration at Ministry levels (Health and Community) ▪ Partners’ competing institutional needs and priorities
<p>CONTEXT AND COMPETING PRIORITIES</p>	<ul style="list-style-type: none"> ▪ Influx of complex and vulnerable patients to community, including refugees ▪ Capital campaigns ▪ Many new senior leaders in community (in part due to surge of retirements) ▪ Institutional requirements including internal planning initiatives

Figure 3. This figure outlines general forces influencing the FHT’s ability to develop and implement evidence-based partnerships in the sub-region.

Conclusion

Chapter One introduced the target of this OIP, the FHT, a family health team that is looking to introduce structure and evidence to its partnership portfolio. The OIP is being undertaken by the Manager, a FHT employee whose leadership approach is both influenced and reinforced by the FHT's adhocratic culture – a hands off institutional leadership style that allows FHT employees significant autonomy in their work. The Manager's leadership stance, that is influenced by liberal, critical and Indigenous lenses, aligns well with both her organizational position and the focus of this OIP, partnerships. To better situate the PoP addressed by this OIP, there is a brief review of the partnership evidence. Of particular interest to this OIP is the idea that collaborations between partners are social constructions created through the multiple perspectives of their contributors; ideally, a resultant partnership is a shared place and culture with norms and ways of operating different than those of the participating institutions. This type of integration is a theme throughout this OIP, and is further exemplified by the use of two supporting leadership theories: complexity leadership that is concerned with how the components of complex systems interact; and authentic leadership that is focused on leaders' relationships with themselves and their followers. These two leadership theories and their shared foci on relationships, albeit different kinds, will animate a system change model that is being developed for this OIP. Chapter Two will build on the contextual ideas and themes introduced in this chapter, and move into planning and development by further outlining the system change model as a way of facilitating the change associated with this OIP, and FHT partnerships.

Chapter Two: Planning and Development

This chapter supports the OIP by further developing a system-level change model (SCM) introduced in Chapter One, and operationalizing it with authentic and complexity leadership theories. SCM is both a model to support inter-organizational partnerships, and a way of navigating the change associated with developing and implementing best practices for FHT partnerships - the focus of this OIP. The chapter then describes four possible solutions that the FHT might employ to develop an evidence-based partnership practice, and concludes with a review of ethical considerations.

Framework for Leading the Change Process

The System Change Model

As discussed in Chapter One, change in healthcare rarely occurs in isolation from other change activity, and change initiatives often involve multiple organizations. This section layers two well-known change models to create an integrated model for system-level change. This model will support the FHT as it facilitates changes associated with its partnerships, and the change implicit to incorporating partnership best practices within the FHT.

As indicated in Chapter One, the majority of change models target organizational-level change and thus have limited applicability to the inter-organizational work of partnerships and system-level change inherent to healthcare. Figure 4 layers two such models introduced in Chapter One, Cawsey, Deszca, and Ingols (2016), and Kotter (1996), to create a new integrated system change model (SCM) for this OIP. Borrowing from each constituent model, there are five components to SCM: 1) awakening, 2) mobilization, 3) acceleration, 4) systematization, and 5) communication and relationship-building.

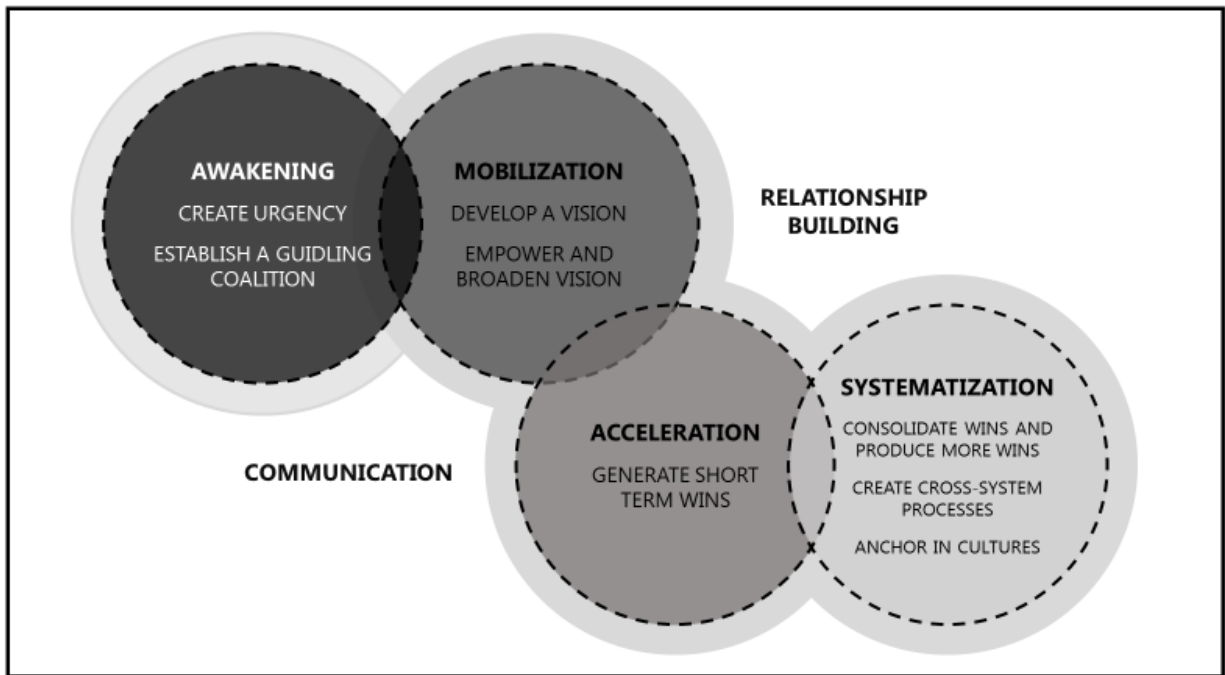


Figure 4. This figure layers elements of Kotter (1996) and Cawsey, Deszca, and Ingols (2016) change models to create the System Change Model (SCM), an integrated model to support system change.

In contrast to the linear and stepped organizational change models from which SCM is derived, the adapted system-level model has five differentiating characteristics:

1. Broad areas of activity originating from Cawsey, Deszca, and Ingols (2016) that are not strictly sequential or linear, but overlapping - often concurrent, in recognition of the messiness of system change and its co-occurrence with other activity.
2. Porous boundaries versus the contained steps and stages of the originating change models, to reflect that system-level change is often not clearly bounded, and shares space with competing priorities and activities, including other change initiatives.
3. A recognition that communication, a discrete stage in the Kotter (1996) model, is integral throughout a change initiative, and does not begin and end in a single stage.
4. The inclusion of relationship-building as a complementary, companion activity to ‘communication’ to reflect the complex and multi-directional communications and

relationships that underpin change initiatives, particularly those involving multiple stakeholders.

5. The ‘institutionalization’ step originally derived from Cawsey, Deszca, and Ingols (2016) has been replaced by ‘systematization’ to better encapsulate the development and codification of interactions between institutional stakeholders partnered in system change.

The next section further considers the five components of SCM by describing and developing two leadership theories to support implementation of the new change model. The subsequent section then uses SCM to frame a critical organizational analysis to better focus this OIP.

Leadership Approaches to Change

SCM alone is not enough to facilitate change; leadership is needed to animate the model, and to actualize the partnership work SCM is meant to support. This section further describes the two leadership theories introduced in Chapter One: Complexity leadership theory (CLT) that seeks to understand the components of a complex system, like healthcare, including how these components interact and contribute to a whole (Baltaci, & Balci, 2017; Uhl-Bien, & Arena, 2017); and authentic leadership theory (ALT) that focuses on leader-follower relationships, and leaders’ relationships with themselves (Avolio & Gardner, 2005; Avolio, Walumbwa, & Weber, 2009).

Complexity Leadership Theory

CLT is a leadership theory that, as suggested by the term, considers the role of leadership within complex systems. Theories of complexity science first evolved in the physical sciences as a way of understanding complex systems like ecosystems (Bak, 1996; Regine, & Lewin, 2000), and have been more recently considered in the context of social organizations and the knowledge

era (Uhl-Bien & Marion, 2001). Integral to CLT is the idea of complex adaptive systems, a metaphor for organizations or collaborations in which units of work, from individuals to organizations, interact in neural-like networks: “bonded in a cooperative dynamic by common goal, outlook, need, etc.” (Uhl-Bien, Marion, & McKelvey, 2007, p. 299). CLT is not concerned with the actions of any one constituent part, for example specific individuals, but how the components of a system interrelate, and the outcomes of these interactions (Plsek, & Wilson, 2001). Within CLT, leadership is not imbued in the traits or actions of individuals, but is instead an emergent event, occurring in the interactive spaces *between* agents in a system (Lichtenstein, Uhl-Bien, Marion, Anson, & James, 2006).

While CLT is a helpful way of conceptualizing interactions within a complex system, it has limitations, particularly its relative immaturity, associated lack of evidence, and an inherent assumption that all agents and components within a complex system are equally capable of interacting with each other and the environment (Uhl-Bien, Marion, & McKelvey, 2007). Of the latter, as suggested by the discussions in Chapter One about the privileging of physician authority in healthcare, and the impact of SDHs on patient care, equivalent influence is not necessarily present in all systems. Individuals, organizations and other system components have varying degrees of power and scope. In addition, the interdependent interactions of agents assumed by CLT are hard to quantify and analyze (Baltaci & Balci, 2017; Lichtenstein, Uhl-Bien, Marion, Anson, & James, 2006). In part, this is because individuals and organizations are subject to external and confounding pressures beyond their control. For example, in Ontario’s healthcare system these may include: federal and provincial health priorities; funding requirements; regulatory obligations (in Ontario there are 26 regulatory bodies for 29 distinct healthcare professions (Federation of Health Regulatory Colleges of Ontario, 2018)); resource

constraints; and the multiple, concurrent system level changes suggested in Chapter One. Finally, CLT is more descriptive than prescriptive meaning it is more helpful to understanding *what* is happening, rather than influencing outcomes. This latter reality is part of the rationale for identifying a second, hands-on and complementary leadership theory to support SCM and this OIP.

Authentic Leadership Theory

In comparison to CLT that is minimally interested in the role of individual leaders, ALT is almost exclusively concerned with personal relationships, including those of authentic leaders with followers, and themselves. George (2003) described the shared goals of ALT leadership as pursuing purpose with passion, practicing values, leading with both heart and head, establishing meaningful relationships, and demonstrating self-discipline. In pursuit of these aspirations, ALT leaders are characterized by four essential elements or factors (Avolio, Walumbwa, & Weber, 2009). The first is balanced processing, or what Kernis (2003) described as unbiased processing, a leader's intention or ability to, as objectively as possible, consider multiple perspectives. Tied to unbalanced processing is a second element, internalized moral perspective that enables an authentic leader to make decisions in line with their values and not to conform, at least uncritically, to social norms or pressures. A third element, relational transparency, is reflective of the types of relationships leaders aspire to have with their followers: open, honest, and underpinned by authentic behaviours and interactions. And integral to all three is the fourth factor, self-awareness, an authentic leader's ability to continually reflect on themselves and their relationships. So, authentic leaders bring a strong sense of self and moral compass to their relationships and work.

While ALT addresses the individual interactions of people, it could be argued this strength is also a limitation. ALT's focus on character and personal attributes are difficult to operationalize, and thus ALT faces a similar challenge to CLT, a leadership theory that is difficult to quantify, measure and analyze (Avolio, Walumbwa, & Weber, 2009; Cooper, Scandura, & Schriesheim, 2005; Fusco, O'Riordan, & Palmer, 2016). In addition, ALT is challenged by its overlap with other leadership theories, for example transformational and ethical leadership theories, resulting in conceptual boundaries that are difficult to delineate. Despite these limitations, the tenets of ALT support the Manager and author of this OIP in actualizing SCM through its focus on people. This will be further explored in the *Combining Leadership Theories* and *Critical Organizational Analysis* sections that follow.

Combining Leadership Theories and SCM for this OIP

Neither CLT nor ALT can independently support this OIP or the facilitation of system change. While they each have something to offer as distinct theories, they are more supportive of this OIP as an integrated leadership approach. To better envision their potential contributions to this OIP, Table 5 re-visits ALT and CLT and considers leadership actions consistent with each theory that could support implementation of different components of SCM, specifically when applied to a partnership. Although the FHT is engaged in multiple partnerships, this table generalizes activities that could be applied to any FHT partnership. How the model may be tailored and applied to support this OIP is the subject of the following section.

Table 5 Layering Actions Consistent with Authentic and Complexity Leadership Theories on SCM			
System Change Model (SCM)		Leadership Theories	
Components of Cawsey, Deszca, & Ingols (2016)	Components of Kotter (1996)	Potential Authentic leadership actions to support partnerships	Potential Complexity leadership actions to support partnerships
Activation	1. Create sense of urgency 2. Establish guiding coalition	<ul style="list-style-type: none"> – Initiate and foster relationships with system stakeholders – Develop shared power structure with clear org. roles and responsibilities 	<ul style="list-style-type: none"> – As a coalition, undertake system mapping to understand system components, processes and interactions
Mobilization	3. Establish vision 4. Broaden and empower vision	<ul style="list-style-type: none"> – Keep coalition members engaged – Support shared or distributed power 	<ul style="list-style-type: none"> – Vision should be cross-sectoral with embedded commitments
Acceleration	5. Generate short term wins	<ul style="list-style-type: none"> – Situate wins as partnership wins, not organizational 	<ul style="list-style-type: none"> – Focus on initial partnerships and shared activities
Systematization	6. Consolidate wins and produce more wins 7. Create cross-system processes 8. Anchor in cultures	<ul style="list-style-type: none"> – Encourage individuals to see themselves as more than organizational employees – Value institutional partnerships 	<ul style="list-style-type: none"> – Create strong system-wide coalitions
Communication	9. Communicate throughout all activities	<ul style="list-style-type: none"> – Focus is on fostering and nurturing relationships within a coalition 	<ul style="list-style-type: none"> – Focus on developing cross-sectoral framework, and keeping orgs focused on shared goal

Critical Organizational Analysis

Thus far, the focus of the SCM discussion has related to navigating system change inherent to FHT partnerships. However, developing an evidence-based strategy for managing FHT partnerships is *the* foundational change under consideration in this OIP. This section synthesizes a critical organizational analysis using components of the SCM framework to better understand FHT gaps and opportunities related to the PoP and OIP. Given the FHT's leadership role in several sub-regional partnerships, this analysis extends beyond the FHT as an organization, and considers sub-regional trends and implications. The analysis also expands on the VUCA lens introduced in Chapter One as an important implementation consideration. The preceding section, *Potential Solutions*, then addresses this analysis by identifying potential strategies that address the identified gaps and/or opportunities.

Change in a VUCA Environment

As noted previously, the FHT and its partners work in a VUCA environment (volatile, uncertain, complex, ambiguous). The VUCA acronym was originally coined to describe the international business environment at the turn of the 21st century (Lawrence, 2013), and has more recently made its way into the healthcare lexicon (Pabico, 2015). To better explain the acronym, *volatility* refers to the speed of change in an external environment (Sullivan, 2012a). For example, the FHT, and other healthcare organizations in Ontario, are working to keep up with the rapidly changing priorities of the provincial government. Closely associated with the idea of volatility is *uncertainty*, a resulting lack of predictability around issues and events that impacts leaders' abilities to forecast and plan (Kinsinger & Walch, 2012). For family health teams like the FHT, the provincial change of government is making it difficult to plan even for the current fiscal year given funding uncertainties and ongoing change announcements. Complexity is an oft

used word to describe the healthcare system (supporting CLT as an appropriate strategy for this OIP); within the VUCA paradigm, *complexity* refers to numerous and overlapping problems that are challenging to isolate and understand (Sullivan, 2012b). The sheer number of FHT partnerships, multiple stakeholders, and complicated funding arrangements, all exemplify healthcare system complexity. Finally, *ambiguity* refers to a lack of clarity or shared meaning around events that further compound a healthcare leader's ability to predict and plan (Caron, 2009). Partnerships perfectly embody the challenges of conflicting perspectives and meanings associated with a change event, but also present an opportunity for creating shared meaning - a strategy for achieving change in a VUCA environment (Lawrence, 2013).

Communication and Relationship Building – Ongoing Activity in SCM

Clear communication, from conceptualization to implementation, is essential to both healthcare delivery and system change, particularly in a VUCA environment. Within medicine, the Canadian medical education framework introduced earlier, *CanMEDS 2015*, devotes two of seven competency domains to communication (Frank, Snell, & Sherbino, 2015); and good communication skills are similarly prioritized in most other healthcare professions (Merlino, 2017). Communication is also recognized as important to the change models on which SCM is founded. Within the Kotter (1996) model, communication is the fourth of eight linear steps, and focuses on communicating a change vision to stakeholders through 'multiple channels, multiple times.' Conversely, while communication is less explicitly addressed in the Cawsey, Deszca, and Ingols (2016) model, it is implied throughout its four phases, and most directly addressed in the Mobilization phase.

Communication is similarly integral to SCM, although as noted previously, how SCM addresses communication differs from its derivative models in two ways: communication and

relationship-building are explicitly considered throughout a change process; and communication extends beyond articulating and promoting a singular vision for change, to aspiring to ongoing clarity through every stage of a change initiative. Lawrence (2013) described clarity as an intentional way of making and conveying sense out of chaos, and identified it as a strategy for dealing with a VUCA environment. This approach translates well to SCM that recognizes communication is not about identifying one message to be re-iterated and re-framed for each audience *a la* Kotter's (1996) 'multiple channels, multiple times' strategy, but emphasizes multiple messages that are co-created through relationships based on the specific needs of a given SCM phase. As such, the status of communications and relationships within the FHT and amongst its partners will be addressed within each SCM phase in the following analysis.

Awakening

The inception phase in SCM is Awakening. Similar to the Cawsey, Deszca, and Ingols (2016) model, Awakening occurs near the beginning of a change process, but unlike Kotter's (1996) Change Path Model, SCM recognizes that this activity overlaps with other phases, including Communication and Relationship-building. Activities during this phase include confirming the nature of change, describing a possible future state, and beginning the process of clarifying and disseminating a vision for change. The gap and proposed change in this OIP were introduced in Chapter One: that the FHT becomes engaged in intentional and productive partnerships that are rooted in best practices, and achieve improved service delivery and healthcare outcomes.

The status and needs related to communications and relationship-building during this phase are different within the FHT than without. As described in Chapter One, developing an evidence-base for the partnership portfolio does not require extensive buy-in or participation by

the FHT. So, within the FHT, communication will focus on “push” communications, including reports, verbal updates, and the introduction of specific evidence-based partnership tools to the Executive Director, Physician Lead, the Board as needed, and staff groups impacted by particular partnerships. Many such channels already exist at the FHT, Table 6 summarizes key internal (FHT) audiences, and identifies what pre-existing communication channels might be employed to introduce, engage and update FHT stakeholders during the Awakening phase.

<i>Table 6 Push Communications within FHT</i>		
Audience	Formal Communication Channel	Informal Communication (where applicable)
Executive Director & Physician Lead	Weekly updates (in-person and email)	As needed calls, meetings, emails and reviews (e.g., of specific frameworks)
Physician Board	Bi-weekly Board meeting	Indirectly through updates to Executive Director and Physician Lead
Entire Staff	<ul style="list-style-type: none"> – Monthly rounds – Quarterly newsletter – FHT intranet – Department heads meeting 	Individual meetings on key issues and updates
Specific Staff Groups	<ul style="list-style-type: none"> – Staff meetings – Staff focus groups 	Individual meetings on key issues and updates

In contrast to the FHT, within the sub-region amongst the FHT’s external partners, communication requirements are more complex, requiring finesse and a focus on relationship-building and developing shared meanings related to the goals and implementation of specific partnerships. Table 7 summarizes the communication and relationship-building status of several key FHT partnerships originally noted in Chapter One. As suggested by this table, while there

are some communication structures in place, more formalized communication strategies are required and constitute implementation challenges to be further explored in Chapter Three.

Type of Partnership	Formal Communications	Informal Communications
Shared Psychiatrist (FHT and Hospital)	<ul style="list-style-type: none"> – Memorandum of Understanding – Formal meetings with Hospital Director (irregular but formal touch bases) 	<ul style="list-style-type: none"> – Interactions with psychiatrist on their work-days at FHT – Feedback from team members working with psychiatrist – Updates from staff dedicate to liaising with psychiatrist
Shared staff between FHT and local soup kitchen	<ul style="list-style-type: none"> – Two Memorandums of Understanding 	<ul style="list-style-type: none"> – Updates from participating staff – Meetings with Soup kitchen related to other initiatives
Community Refugee Health Clinic and FHT	<ul style="list-style-type: none"> – Memorandum of Understanding – Formal reporting requirement (RHC to FHT) 	<ul style="list-style-type: none"> – Updates from participating staff – Updates from dedicated staff liaison working with CRHC
Developing Inner City Collaboration	<ul style="list-style-type: none"> – Letter of intent 	<ul style="list-style-type: none"> – Meetings as needed
Health Links	<ul style="list-style-type: none"> – Funding agreement from MOHLTC – Sub-regional Project plan 	<ul style="list-style-type: none"> – Project meetings
Sub-regional planning	<ul style="list-style-type: none"> – Terms of Reference – Bi-monthly meetings 	<ul style="list-style-type: none"> – Meetings through other initiatives (with same representatives)

Mobilization and Acceleration

Similar to the other phases, SCM's Mobilization and Acceleration stages borrow from Cawsey, Deszca, and Ingols Change Path Model (2016) and consolidate and initiate a vision for change. This includes solidifying and implementing strategies based on additional analyses, for example related to formal structures and processes, understanding power dynamics, mapping

stakeholder relationships, identifying change agents and recipients of change, and developing communication and relationship building strategies.

As described in Chapter One, there are three priorities related to the change being pursued in this OIP that would require additional analyses and consolidation: 1) Synthesizing the current state of evidence related to partnerships, particularly in complex systems; 2) adapting and integrating the evidence to make it applicable to the healthcare context, specifically the FHT; and 3) engaging with stakeholders, particularly institutional partners, to pilot and implement best practices in partnership. The first two priorities were addressed in Chapter One and will be revisited in the upcoming *Potential Solutions* section. Of the third priority, engaging with stakeholders, there are several sub-priorities: 1) relationship management within the FHT; 2) stakeholder engagement with partner institutions, including around change management; and, underpinning the first two sub-priorities, 3) evidence uptake and implementation. Sub-priorities 1 and 2 have been addressed in Chapters One and Two and are briefly consolidated and summarized in Table 8 below, while the third requires further exploration. The third sub-priority, evidence uptake, is a particular type of communication strategy and is the purview of knowledge translation, known as implementation science in Europe, and is a discipline that broaches the chasm between evidence and implementation of new knowledge to improve health outcomes and efficiencies in health care (Graham et al., 2006). This will be further developed as part of the implementation plan in Chapter Three through a test of change project.

Table 8 <i>Elements of an Organizational and Sub-regional Analysis</i>		
Elements	FHT	Sub-Region
Formal structures, systems and processes	<ul style="list-style-type: none"> – Informal organizational structure (Adhocracy) – Manager has significant scope and autonomy within portfolio 	<ul style="list-style-type: none"> – MOHLTC and LHIN requirements (evolving) – Sub-regional planning table and Health links
Power and culture dynamics in organizations	<ul style="list-style-type: none"> – Diffuse across the organization although Physician Board is final decision maker 	<ul style="list-style-type: none"> – LHIN has been healthcare decision maker in sub-region <ul style="list-style-type: none"> – LHIN’s power is waning based on decisions by provincial government
Stakeholders	<ul style="list-style-type: none"> – Executive Director, Physician Lead, Physician Board, Staff 	<ul style="list-style-type: none"> – LHIN and MOHLTC – Community partners – Healthcare partners
Recipients of change	<ul style="list-style-type: none"> – Organization in that it has new frameworks and tools 	<ul style="list-style-type: none"> – Partnership by Partnership
Change agents	<ul style="list-style-type: none"> – Partnership-specific 	<ul style="list-style-type: none"> – Partnership-specific
Communication and relationship-management	<ul style="list-style-type: none"> – Push communications (reports, updates etc.) to organizational stakeholders 	<ul style="list-style-type: none"> – Relationship building – Developing shared meanings

Systematization

Within the Change Path Model, the final phase is called Institutionalization as change is assumed to be taking place within a single organization (Cawsey, Deszca, & Ingols, 2016). However, given the system-level context implicit to SCM, the fifth phase has been reconceived as Systemization. During this phase, activity is characterized by developing new processes, structures, knowledge and abilities to systematize the change, and bring system-spanning stability. From the perspective of this critical organizational analysis, this phase constitutes a significant gap for the FHT and is the motivation for this OIP: developing strategies to provide evidence-based structure to FHT partnerships to achieve improved patient outcomes through system-level partnerships. The next section, *Potential Solutions*, proposes several possible ways to address the PoP. Chapter Three will further develop one of these solutions and apply it to the test of change project and implementation plan.

Summary of Critical Organizational Analysis

In summary, SCM frames key change considerations for this OIP, including:

- an identified gap in the FHT’s partnership work, and a clear vision for change;
- a differentiation between the communication requirements within the FHT, and external to the FHT, including identification of pre-existing communication channels, and identifying opportunities for developing new communication, relationship building and system-spanning opportunities and vehicles;
- a summarized organizational analysis of the FHT and sub-region, addressing
 - formal structures, systems and processes,
 - power and culture dynamics in organizations,
 - stakeholders,

- recipients of change,
 - change agents, and
 - communication and relationship management; and
- a compelling gap and need for systematization of the FHT findings to its partnership work.

Possible Solutions to Address the PoP

The critical organizational analysis identified gaps and opportunities that underpin the PoP. This section builds on the organizational analysis, and explores four possible solutions to address the PoP. These include: 1) adopting and adapting an evidence-based partnership framework designed for interorganizational and system-level partnerships; 2) adopting a healthcare-specific partnership framework; 3) implementing relational coordination, a strategy developed by Gittell (2016) for, “coordinating [complex] work through high-quality communication, supported by relationships of shared goals, shared knowledge, and mutual respect” (p. 4); or 4) a combination of the preceding solutions. This section briefly outlines each proposed solution and presents the Plan-Do-Study-Act (PDSA) cycle as a way of testing the preferred solution.

Solution One: Adopting and Adapting Generalized Partnership Frameworks

As the PoP identifies the need for evidence-informed tools to support the FHT’s partnership portfolio, adopting or adapting a generalized partnership framework constitutes a potential, if unsurprising, solution for this OIP. There are a number of evidence-based partnership frameworks employed in a variety of sectors. For example, three areas that are exploring the benefits and outcomes of inter-organizational partnerships are private sector-public sector collaborations; private sector-non-governmental organizational partnerships; and cross-

sectoral partnership frameworks to address system-level issues. It should be noted that given the prevalence of partnerships amongst many sectors, these constitute only a brief sample of options.

Of the first type, private sector-public partnerships (PPPs), these are a growing kind of inter-sectoral partnership endeavour that, as suggested by the descriptor, brings the private sector into public undertakings. Within PPPs, the *private sector* usually denotes a for-profit commercial enterprise while the *public* refers to municipal, state/provincial or national governments, often represented by governmental agencies mandated to deliver and manage public goods (Nishtar, 2004). These types of PPPs are predominantly large infrastructure initiatives, for example related to transportation, housing, education, water and prisons (Siemiatycki, 2012). Although there are examples of partnership frameworks that encourage communications, relationship-building, system-spanning and evaluation, for example Mohummad and Johar (2017), these frameworks - like the infrastructure initiatives themselves, are largely focused on capital considerations such as procurement and engineering requirements. Given the scope of these PPPs, the frameworks and supporting tools are not highly applicable to the FHT's context which has little to do with large-scale infrastructure development.

A second type of PPP occurs when the public sector partners with non-governmental organizations, philanthropic initiatives and/or other not-for-profits (Nishtar, 2004). This is a common type of arrangement in global health aimed at achieving a variety of goals, including: product development, increasing access to healthcare products, global coordination mechanisms, strengthening health services, public advocacy and education endeavours, and regulation and quality assurance initiatives (Nishtar, 2004). However, similar to other types of PPPs, the scale and international dimension of these types of collaborations make them an awkward fit, and largely inapplicable to the FHT, its subregion and this OIP.

Of the third type of partnership, multi-sectoral collaboration, there is an increasing variety of tools and supports for partnerships that span sectors. For example, collective impact is a burgeoning field that recognizes the strength of a structured, cross-sectoral coalition over the more limited impact of working for change through a solitary organization (Kania & Kramer, 2011, 2013). In its formative years, collective impact initiatives were characterized by five conditions shared by multiple players in a communal endeavour: a common agenda, shared measurement, mutually reinforcing activities, continuous communication, and backbone support (Kania & Kramer, 2013). However, as communities have engaged in, and learned from collective impact endeavours, these conditions have become more nuanced and include community aspirations, strategic learning, high leverage activities, inclusive community engagement, and containers for change (Cabaj & Weaver, 2016).

While not explicitly identified as a collective impact framework, the Randle and Anderson (2017) *Building Collaborative Places* model reflects the evolved conditions of collective impact, but provides a bit more structure. The public sector framework is based on two principles: that social problems are complex and interrelated, meaning solutions require the contributions of multiple actors; and that complex problems often have a local or geographic dimension in that solutions can be driven by communities. Thinking about problems in this way requires several shifts in thinking that are consistent with collective impact. First, public services like healthcare and municipal services need to be recast from stand-alone solutions, to participants in a broader system that includes local residents, businesses, community services, healthcare etc. Second, intentional consideration needs to be made about how the collective power of a system can be mobilised to address a shared and complex issue. And third, public funds should be invested in system-level strategies. To support a multi-sectoral approach to

problem solving and change, Randle and Anderson identified nine considerations for practitioners engaged in cross-system collaborations to bring about change. These “building blocks” of systems-collaboration are:

1. place-based strategies;
2. governance;
3. outcomes and accountability;
4. funding and commissioning;
5. culture change and people development;
6. delivery;
7. data, evidence and evaluation;
8. collaborative platforms (digital and physical); and
9. communications and engagement.

The rationale behind, and elements of this framework are all highly adaptable to healthcare and the FHT’s context, and will be further developed in the *Integrating Options for a Potential Solution*.

Limitations to Generalized Partnership Frameworks.

While generalized partnership frameworks are a strong potential solution for this OIP, by their nature they are generic and require adaptation to a local context. In fact, this is the first building block of Randle and Anderson’s (2017) framework that acknowledges the imperativeness of place-based strategies. Despite this recognition, or perhaps because of it, there is significant conceptualization work required to actualize place-based strategies that are beyond the scope of a generalized framework. For this reason, a health-specific framework may be more applicable to the FHT and this OIP.

Solution Two: Healthcare Partnership Frameworks

While the first solution requires adapting a generalized framework to the FHT's context, there are also frameworks that are targeted directly at healthcare. Healthcare partnerships are predominantly focused on improving health outcomes through team-based care. These may be through interprofessional partnerships between healthcare providers (for example Butt, Markle-Reid, & Browne, 2008; D'Amour, Ferrada-Videla, Rodriguez, & Beaulieu, 2009); or partnerships between healthcare providers and their patients (for example, Montague, 2006).

As this OIP is focused on macro-level partnerships between organizations, the frameworks of primary interest are not at the team-level, but institution-to-institution, at the system level. For example, Boydell and Rugkasa (2007) described multi-institutional collaborations in the United Kingdom aimed at reducing health inequity. Similarly, an interesting health system framework is the Bailie, Matthews, Brands, & Schierhout (2013) Partnership Learning Model (PLM) depicted in Figure 5. This model is particularly relevant to the FHT given the model's emphasis on comprehensive PHC, and PLM's embedded concepts related to systems thinking, health systems strengthening and knowledge translation, all of which are of interest to, and have been acknowledged in this OIP.

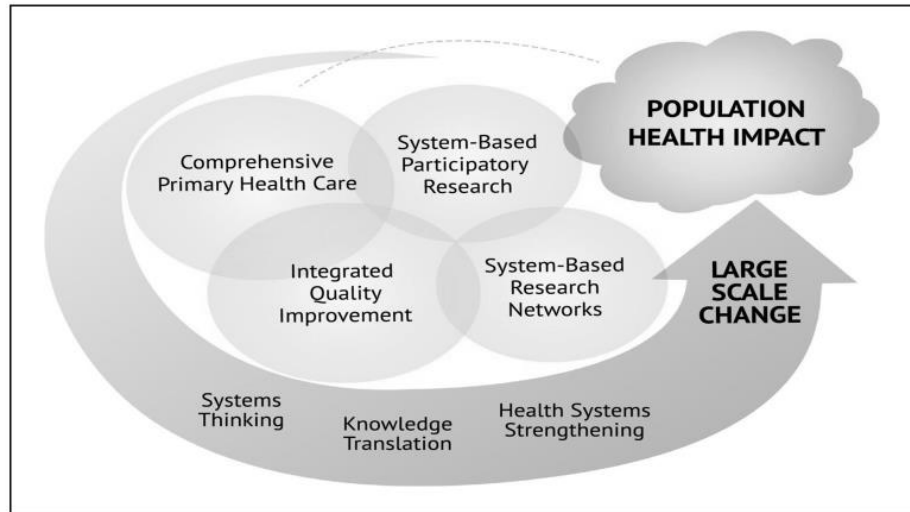


Figure 5. Partnership Learning Model (from Bailie, Matthews, Brands, & Schierhout, 2013).

PLM encompasses many elements of interest to the FHT's engagement in system-level partnerships, however it is difficult to know how to apply the framework to accomplish day-to-day partnership work, making it more conceptual than operational.

Limitations to Healthcare Frameworks.

While a healthcare-specific framework seems to be an obvious strategy for this OIP, the predominant examples in the literature are either too granular, being focused on the teams directly supporting patients, or too conceptual and high-level, as exemplified by the Bailie, Matthews, Brands, and Schierhout (2013) PLM. The FHT requires more operational support for developing and implementing multi-agency collaborations to improve healthcare outcomes for its patients and community, suggesting a healthcare partnership framework is not an appropriate standalone solution for this OIP.

Solution Three: Relational Coordination

Partnership frameworks, generalized or healthcare-specific, help conceptualize and provide scaffolding for integration work amongst multiple organizational stakeholders, however they tend to emphasize *what* elements to think about, more than *how* to accomplish the work. An

alternative then to frameworks is a consideration of methods for operationalizing integration collaboration work. An interesting option may arise from Gittell's (2016) relational coordination (RC) theory, a "mutually reinforcing process of communicating and relating for the purpose of task integration" (Brandeis University, 2018, para 1). Originally observed in the aviation industry, RC is now being implemented in sectors such as healthcare that are characterized by work with many moving parts, and multiple players, all of whom are impacted by and involved in the same task.

How does RC work?

The RC Research Collaborative at the Heller School for Social Policy and Management, Brandeis University describes RC as part theory of performance, part theory of change and part validated construct, and directs RC research in five sectors: private industry, education, public safety, community health and health innovation (Brandeis University, 2018). Figures 6 and 7, derived from Gittell (2016), and Gittell, Edmondson, and Schein (2011), together provide more insight into how RC is implemented in these sectors. First, Figure 6 outlines seven dimensions of RC, particularly as they pertain to relationships and communication - RC's special sauce. Four communication dimensions (frequency, timeliness, accuracy, and problem-solving orientation), are mutually reinforcing of three relationship dimensions related to shared goals, shared knowledge, and mutual respect. In comparison, without these dimensions, collaborations are mobilized around disaggregated functional goals, and thus perpetuate specialized or siloed knowledge, a lack of respect for others' work, and infrequent, delayed, inaccurate or unproductive communication.

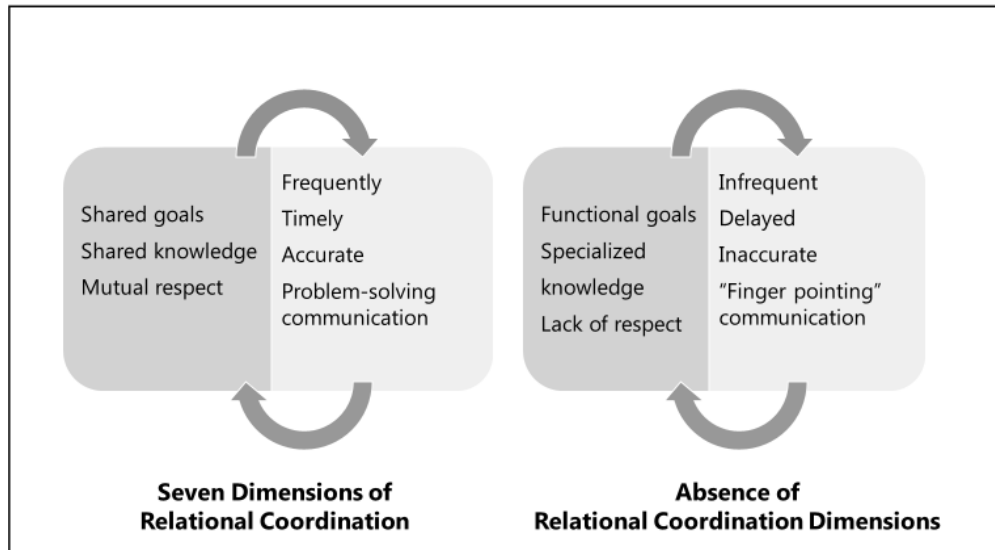


Figure 6. Seven dimensions of relational coordination (left) (from Gittell, 2016).

Figure 7 builds on Figure 6 and depicts the operationalization of RC by placing the seven relationship and communication dimensions at the centre of an implementation model under the influence of a number of workplace phenomena, including structure, performance outcomes, workplace (process) interventions, and relational interventions. Two key elements of Figure 7 are the structural and workplace process interventions boxes (at left) that are necessary to create and enable an optimal organizational environment for RC, particularly interventions that support high-quality relationships and communications. Structuring communication opportunities instead of relying on charismatic individuals with excellent communication skills, ensures that the relationships integral to RC are scalable, replicable and sustainable across an organization or initiative (Gittell, 2016).

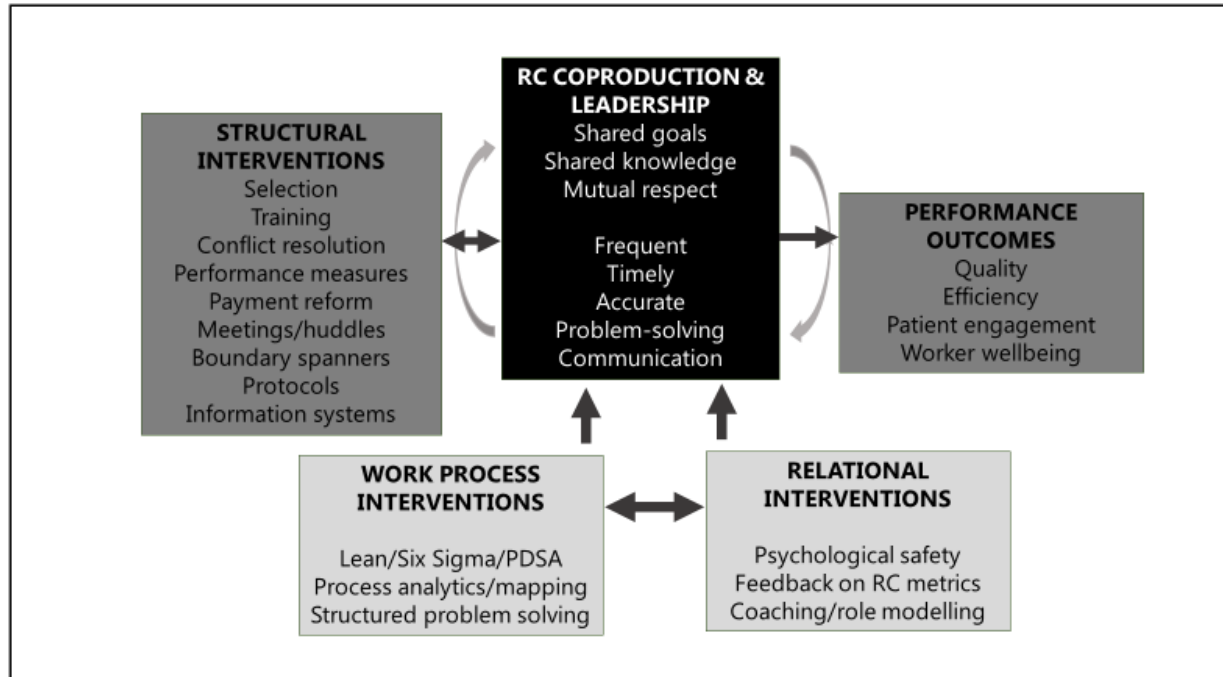


Figure 7. Relational coordination model of high performance (from Gittell, Edmondson, & Schein, 2011).

Leadership and RC.

RC's reliance on structured relationships and communications to facilitate shared tasks is as much people work as organizational restructuring. As Gittell (2016) explained: "There are no shortcuts. Simply put, there can be no organizational transformation ... without personal transformation" (p. 12). Leadership, then, is recognized as important to RC in how it influences the development or co-production of shared goals, shared knowledge and mutual respect both *with* and *among* others (Gittell, 2016). "At the heart of relational leadership is [recognition of] the authority within each role...rather than vesting authority in one person over another based on his or her position in the hierarchy, authority is shared" (Gittell, 2016, p. 51). So, leadership within RC is not only focused on relationships, but shifts the power dynamics underpinning these relationships.

The two leadership theories introduced earlier in this chapter (ALT and CLT) are consistent with relational leadership and support an RC approach. Follett (1949), on whose early ideas Gillett based RC, characterized reality as constructed through relating, a way of filling the ‘spaces in between.’ Gillett (2016) elaborated on this to describe what this looks like in an RC workplace: “Just as our identities are created in relationship with each other, so is our work most effectively coordinated in relationship with each other. If human identity is relations, then [RC] is ... an expression of our nature as human beings” (p. 29). These paired notions of co-creating reality as fundamentally human, and the spaces in between, align well with CLT and ALT, particularly as an integrated approach to leadership. CLT’s focus on interactions in a complex system shares a pre-occupation with RC’s ‘spaces in between’; while ALT sheds light on the nature of some of these interactions, particularly leader-follower relationships and, in the context of this OIP, relationships between partner-organizations.

Limitations to RC.

Despite its potential, RC has almost exclusively been implemented and observed within individual organizations for the purposes of task integration; there is limited evidence of its inter-organizational effectiveness, and the author of this OIP is unaware of any attempts to implement RC to support partnerships. Despite this lack of targeted evidence, this OIP will take advantage of RC learnings, and explore the adaptation of RC tenets to support an integrated solution to the PoP, briefly considered in the next section, and more fulsomely in Chapter Three.

Solution Four: Integrating Options for a Potential Solution

Elements of all three proposed solutions are applicable to this OIP. The generalized partnership frameworks, particularly Randle and Anderson (2017), use multi-sectoral collaborations to address complex issues beyond the scope of any one organization. This is of

particular interest when considering the FHT’s sub-regional partnerships; however, these frameworks do not necessarily address the healthcare context. In comparison, the healthcare frameworks, obviously, target healthcare, but are either too granular and focused on teams, or are so high level and conceptual they are difficult to apply and operationalize within the FHT’s context. Finally, Gittel’s RC theory provides tangible strategies for using communication and relationship building to help individuals accomplish shared tasks, for example within a given partnership, but has not been tested on inter-organizational collaborations. So, while all three solutions have elements that would support the FHT’s partnership portfolio, no single solution fully addresses the needs of this OIP.

In keeping with the spirit of integration that characterizes both this OIP and partnerships more generally, it may be that the most robust solution draws on elements of several solutions. Chapter Three will take this approach and adapt the generalized Randle and Anderson (2017), *Building Collaborative Places* framework to the FHT’s context, and apply RC where communication and relationship-building could support task integration. Implementation of this preferred strategy will be supported by a test of change project that includes the incorporation of a Plan-Do-Study-Act (PDSA) cycle, briefly explained in the next section and further explored in Chapter Three.

Using Plan-Do-Study-Act to Support Implementation of a Potential Solution

The Plan-Do-Study-Act (PDSA) tool is a quality improvement tool to support strategic and other planning processes (Varkey, Reller, & Resar, 2007). Within Ontario’s healthcare system, PDSA is well-established (Health Quality Ontario, 2018); and, as depicted in Figure 7, is a common process intervention when implementing RC (Gittel, Edmondson, & Schein, 2011). Figure 8 summarizes the four steps that comprise a PDSA cycle. The “Plan” step is the initiation

of a test with a clearly defined improvement goal, supporting tasks and accountabilities (Varkey, Reller, & Resar, 2007). According to Moen and Norman (2009), this step also involves predicting what will happen as a result of the intervention that is being studied. Following planning, the “Do” step includes the actual implementation and documentation of the test outlined in the first step. During this step, unexpected results, for example deviations from predictions, are documented and preliminarily analyzed. The preceding “Study” step is, in many ways, the learning stage during which the first two steps are analyzed. The results of the test are studied, including questions related to what went right, what went wrong, and what could be changed. Finally, the fourth step, “Act” lays the foundations for the next PDSA cycle by applying the lessons and ideas acquired throughout the cycle, and making adaptations for the next one. This basic PDSA cycle will be adapted to support the implementation plan for a Test of Change project in Chapter Three.

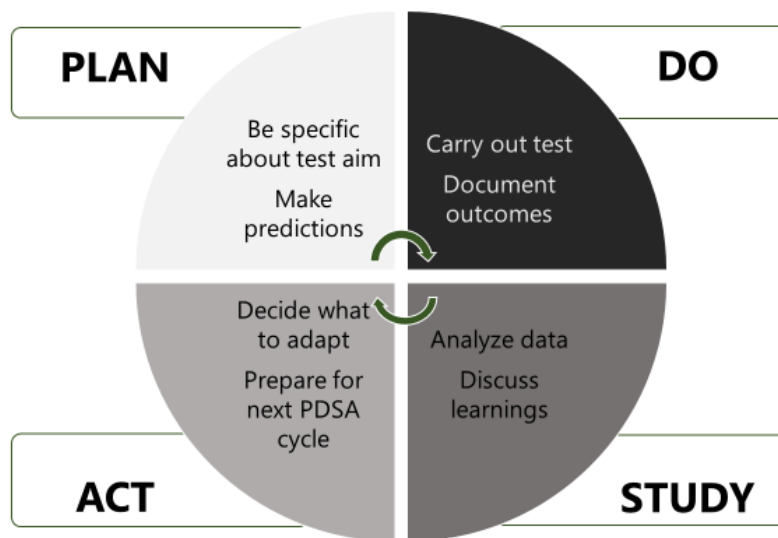


Figure 8. PDSA cycle in healthcare (Health Quality Ontario, 2018).

Leadership Ethics and Change

Thus far, this OIP has largely focused on the mechanics of FHT operations, its partnerships and system-level change. However, ethics is an additional consideration to leadership and change work. This section will briefly explore ethics as it pertains to the FHT's healthcare context; and the ethical leadership implications of the author's practice, and implementing the OIP.

As a PHC organization, the FHT is inherently an organization that is rooted in, and concerned with ethics. Ethical behaviour is identified as a pre-requisite to practice for Ontario's regulated healthcare professionals. For example, ethical practice is one of five areas in the College of Nurses of Ontario jurisprudence exam that nurses must pass to qualify for a certificate of practice (College of Nurses of Ontario, 2018). Similarly, the College of Physician's and Surgeons of Ontario's *Practice Guide* equates ethics with medical professionalism, "the translation of the values of the profession — compassion, service, altruism, and trustworthiness — into action" (College of Physicians and Surgeons of Ontario, 2018). The *CanMEDs 2015* medical education framework first introduced in Chapter One, also identifies adherence to high ethical standards as a key competency for physician practice (Frank, Snell, & Sherbino, 2015). These ethical obligations for individual practitioners are not just required by overseeing professional and regulating bodies, but the organizations for which they work. For example, in healthcare organizations such as the FHT, ethical considerations are institutionalized into policies and guidelines, ethics education for employees, and/or interprofessional reviews around specific patient cases.

So, ethics is endemic to the practice of healthcare, the external context to this OIP. Similarly, ethics is a leadership consideration generally, and for the Manager's practice and

execution of this OIP. As an act of influence that impacts those who are led, leadership is imbued with ethical implications (Northouse, 2016). Angus (2006) described ethical leadership as a social, relational practice concerned with the moral purpose of an endeavour. For example, as discussed previously, in the case of the FHT the ‘endeavour’ refers to healthcare delivery and patient care; in the case of this OIP, the change associated with addressing the PoP. According to Northouse (2016), there are five behaviours or principles that help operationalize ethical leadership in practice: respect for others; service to others; showing justice; manifesting honesty; and building community. The application of these behaviours may be as varied as the landscapes and contexts in which leaders operate.

For the author of this OIP, ethical leadership considerations are at play through the Manager’s direct management of FHT staff, her relationships with representatives of partner organizations, and implementation of this OIP. Of the first, direct reporting relationships, Northouse’s (2016) ethical principles complement ALT, one of the two leadership theories informing this OIP. For example, Luthans and Avolio (2003) described ALT as a ‘root construct’ that could incorporate other leadership theories including ethical. More explicitly, Brown and Treviño (2006) identified key similarities between ethical leadership and ALT - primarily individual characteristics - including concern for others, ethical decision-making, integrity, and role modeling. These align well with the first four of five principles of ethical leadership identified by Northouse (2016) (respect for others, service to others, showing justice, and manifesting honesty), and provide a supporting lens for the Manager in her day-to-day work with FHT staff.

In addition to working with direct reports, the Manager’s day-to-day practice includes interactions with partner-organizations. Northouse’s (2016) fifth principle of ethical leadership,

building community, is foundational to this work. As stated by Northouse (2016): “An ethical leader is concerned with the common good in the broadest sense” (p. 346). For the Manager, endeavouring to balance the needs of a given partnership and its contribution to the broader healthcare system, say over the specific needs of the FHT only, is an ongoing ethical consideration. While the Manager can control her own behaviours and contributions to interactions with partners, leadership amongst organizations within a complex system are beyond any one individual’s control. Leadership and ethics in CLT, the second leadership theory informing this OIP, are manifested non-hierarchically. All players within a system, or between organizations, have equivalent opportunity to assume leadership roles and display leadership characteristics - including ethics. A strategy for enabling ethics in this type of diffused environment can be found in collective impact, a means of facilitating multi-sectoral partnerships that was introduced as part of Solution One. ‘Creating containers’ or what Weaver (2014) described as ‘holding space,’ is a function that can be played by an individual or institution by providing ongoing organization, communications and even physical space for partners engaged in shared work. This *is* a function the Manager can play, and will be part of the test of change project in Chapter Three.

Finally, in addition to general partnership work, implementation of the OIP as a research endeavour has a specific ethical dimension for consideration. The application of ethical principles in biomedical and behavioural research has long been a research requirement for those conducting research with humans. For example, the 1978 Belmont Report codified three ethical principles for such research (The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1978). The first, *respect for others*, ensures autonomy of participants and protections for those with reduced autonomy. The second, *beneficence*, aims at

minimizing risk and harm to those participating in a research endeavour, and maximizing benefit. And, the third, *justice*, ensures that the benefits, and the burdens of a research initiative are shared equitably, and no particular group is exploited. While implementation of the OIP is not a primary research endeavour, and its stakeholders are not research participants, partnerships by their nature involve humans and will require ongoing consideration of the application of these and Northouse's (2016) ethical leadership principles.

Conclusion

This chapter further developed SCM introduced in Chapter One by integrating two well-known organizational change models, and operationalizing it with authentic and complexity leadership theories. SCM is then used to frame a critical organizational analysis to better understand the FHT's current state and gaps related to its partnership work; considered several possible solutions to the PoP; and proposed an integrated solution. The identified strategy includes adopting and adapting Randle and Anderson's (2017) framework for system level partnerships, and integrating Gittel's (2016) RC to buttress the communication and relationship building components of the framework as it is applied to specific partnerships. The chapter concluded with a recognition and brief review of ethical considerations associated with the healthcare context and leadership components of this OIP, including its implementation. Chapter Three will revisit several of the ideas and concepts introduced in Chapters One and Two, and develop an implementation plan for a test of change project that includes communication and evaluation considerations.

Chapter Three: Implementation, Communication and Evaluation

The identified strategy for this OIP draws on elements of the solutions proposed in Chapter Two, specifically adopting and adapting Randle and Anderson's (2017) framework for system-level collaboration; and integrating Gittel's (2016) RC to bolster the communication and relationship-building components of the framework, particularly where task coordination could be beneficial. This chapter re-visits the change priorities and considerations introduced in the first two chapters, and describes a plan to implement, communicate and evaluate the proposed solution through a test of change (TOC) project. In keeping with the critical organizational analysis outlined in Chapter Two, this implementation plan will be framed using SCM.

Change Implementation Plan

To be effective, a change implementation plan needs to be clear about its vision and the nature of the change it is supporting. So, to ensure clarity, this section will re-visit the change priorities, organizational analysis and theme of integration described in the first two chapters, before outlining a TOC project using a FHT partnership of significant importance and timeliness.

Re-visiting the Change Priorities and Organizational Analysis

Three change priorities were previously introduced in Chapter One: 1) To synthesize the current state of evidence related to partnerships, particularly in complex systems; 2) to adapt and integrate the evidence to make it applicable to the healthcare context, specifically that of the FHT; and 3) to engage stakeholders, particularly institutional partners, to pilot the incorporation of evidence into FHT partnerships. Chapter One addressed the first priority through a brief review of partnership literature that informed the potential solutions presented in Chapter Two, and the evaluation plan later this chapter. The *Possible Solutions* section in Chapter Two spoke to the second priority and introduced several potential frameworks and collaboration strategies,

two of which will be integrated as the preferred solution. And the third priority, stakeholder engagement, is a key element of the proposed partnership framework (Randle & Anderson, 2017) and Gittel's (2016) RC collaboration strategy that together comprise the identified solution, but also facilitating the change associated with this OIP.

The organizational analysis conducted in Chapter Two identified additional considerations. What follows is a re-cap of these findings that, along with the change priorities in the previous paragraph, will inform the implementation plan.

1. In addition to legacy funding incentives and directives still in place, there are significant external motivators, including new, provincially-directed healthcare system transformations that are compelling the FHT to initiate and participate in partnerships.
2. There is a strong evidence-base related to partnerships and coordinating work that, while not always targeted at healthcare, can be adapted to the FHT's context.
3. Within the FHT there is clear opportunity, including important drivers, that will support the Manager in bringing evidence and intentionality to the organization's partnership portfolio. These include:
 - an adhocratic culture within the FHT that empowers the Manager to participate in partnerships that support and enhance the FHT's programming for non-FHT patients;
 - the FHT's current repertoire of partnerships, particularly those that are sub-regional in nature, and its leadership position within the sub-region;
 - a FHT governance transition that, among other things, is centralizing and co-locating FHT programs for non-FHT patients (the majority of which are enacted or supported through partnerships);

- formal structures, systems and processes that already exist, and/or could be enhanced to support partnership work;
- power dynamics within the sub-region that support (although in some cases impede) meaningful collaboration; and
- an appreciation for, and prioritization of communication and relationship management activity.

Finally, in addition to the change priorities and the organizational analysis, two leadership theories described in Chapter Two support implementation of the proposed solution: CLT and ALT. Both leadership theories address relationships, albeit in different ways. Neither theory could fully support facilitation of this implementation plan, so this OIP proposes an integrated leadership approach that both acknowledges the complexity inherent to inter-organizational collaborations (CLT), and values and prioritizes human relationships (ALT).

Integration as a Theme.

Integration is a recurring theme in this OIP. For example, the preferred change model (SCM) described in Chapter Two integrates two well-known change models (Cawsey, Desczca, & Ingols, 2016; Kotter, 1996) to create a system-level model more applicable to the change required by this OIP. SCM itself is supported by an integrated approach to leadership; and the identified strategy for this OIP, further developed in the next section, is the integration of two organizing frameworks, one that allows for a broad conceptualization and approach to multi-sectoral system collaborations (Randle and Anderson, 2017), and RC that provides more concrete tactics for operationalizing shared work through communications and relationships (Gittell, 2016).

The author of this OIP is not alone in adopting integrative thinking, an approach that allows for conceptualizing and addressing complex problems with creative resolutions, in part by liberating over-reliance on single models for problem definition and solution (Riel, & Martin, 2017). According to Riel and Martin (2017), integrative thinking recognizes that problems and situations are interpreted differently by collaborators, and conceptual models are best understood as dynamic, situation-specific opportunities for clarifying a collective's thinking about both a problem and its potential solutions. The most powerful of these types of models are those that “resolve tension between opposing ideas and create new value for the world” (Riel, & Martin, 2017, p. 212). Within this OIP, the two frameworks comprising the identified solution are not diametrically opposed, but approach collaboration from different perspectives. In addition, both models assume and enable the opposition and tensions that naturally occur when partners attempt shared endeavours.

Overview of the Identified Solution

The change targeted by this OIP is to ensure the FHT has a strategy for implementing partnerships that are evidence-informed, and improve service delivery and patient outcomes. Based on the literature review in Chapter One, and a consideration of possible solutions in Chapter Two, the identified solution integrates an evidence-informed, yet pragmatic framework for system-partnerships, and a supporting collaboration and coordination theory. The basic analogy of the former, Randle and Anderson's (2017) *Building Collaborative Places*, equates cross-sectoral partnerships to building infrastructure for system-level collaboration. This echoes Penuel, Coburn, and Gallagher's (2013) aforementioned idea of research partnerships as co-created places and communities unique from those of the contributing partner organizations. This type of construction or place-making metaphor is inherently compatible with RC's approach to

structuring relationships and communications into everyday tasks (Gittell, 2016). So, both prongs of the strategy proposed for this OIP share a core premise related to building communications and relationships into the day-to-day work of partnerships and collaborations. This natural convergence is an opportunity to integrate the two into a single, organized approach depicted in Figure 9, specifically by identifying where five of the nine building blocks that comprise Randle and Anderson's (2017) conceptual framework could benefit from RC for task integration (governance, outcomes, culture, delivery and communications). This will be explained in more detail in the remainder of this section.

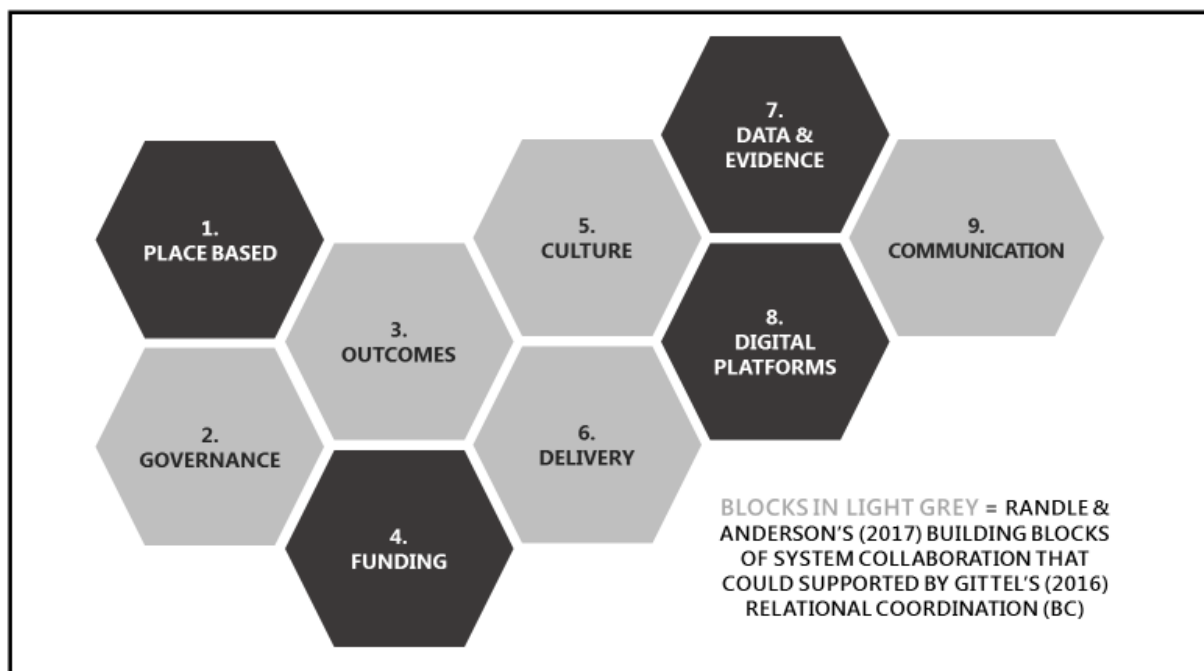


Figure 9. The Test of Change to be implemented is the adoption of Randle & Anderson's (2017) framework, supported by Gittell's (2016) Relational Coordination in five of nine building blocks (in light grey).

The Randle and Anderson (2017) framework is, in some ways, in and of itself, applicable to the complexity and system-nature of healthcare. The framework recognizes that social problems, for example SDHs and their impact on health outcomes, are complex, inter-related,

and best understood (and solved) within local systems. Although several of Randle and Anderson’s (2017) building blocks have communication and relationship-building elements (for example the governance, delivery and communications building blocks), given the relationship needs of healthcare, the communication and collaboration strategies embedded in these stages lack sufficient insight into operationalization.

Complementing the Randle and Anderson (2017) framework, Gittell’s (2016) RC theory is process-oriented, and includes specific activities for collaborators with shared tasks. For example, Figure 10 re-produces a model from Gittell (2009) that situates RC’s central tenets of relationship- building and communications in relation to key elements of a high-performance work environment; and depicts how they may mediate and contribute to quality, efficiency, and job satisfaction.

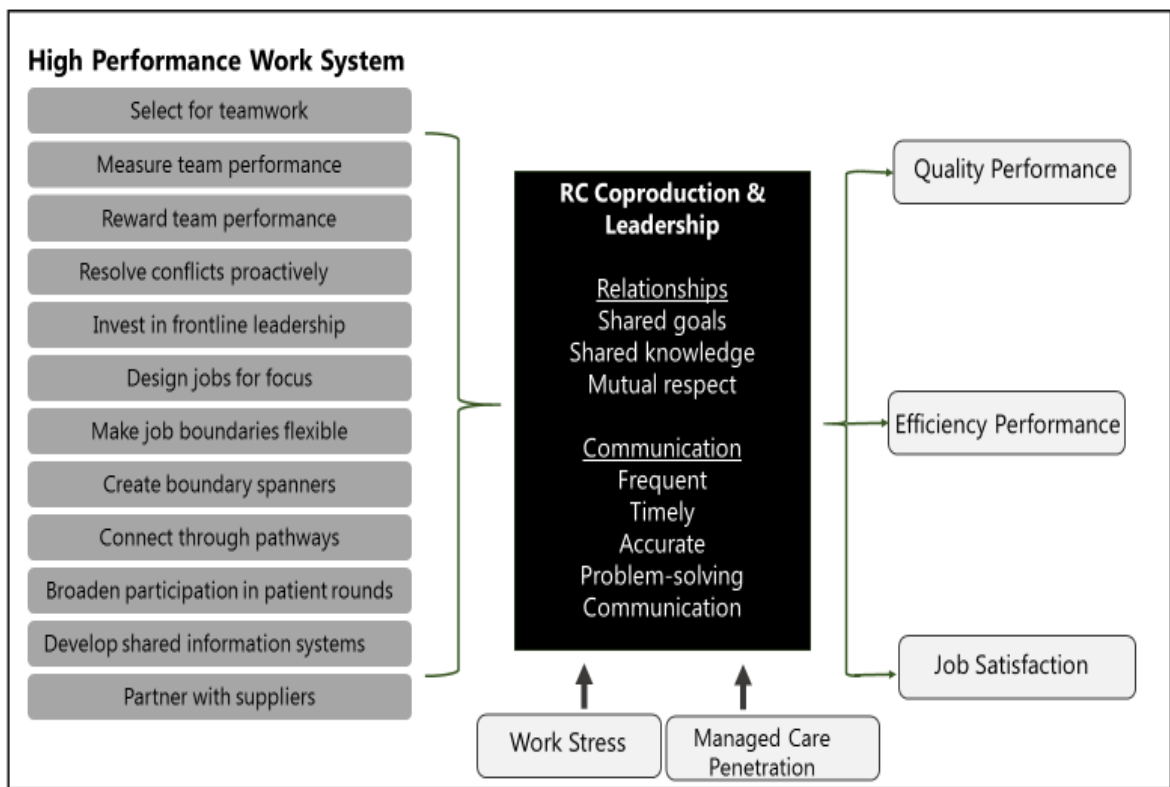


Figure 10. Achieving high performance healthcare under pressure (from Gittell, 2009).

Although RC focuses on *intra*-organizational collaboration, this OIP is concerned with collaborations and shared tasks that are *inter*-organizational, requiring adaptations for the FHT’s context. Table 9, developed by the author, therefore builds on the high-level intersections between RC and Randle and Anderson’s (2017) framework previously depicted in Figure 9, and provides more detail and insight into how RC’s elements of a high-performance work system (for example, “select for teamwork”) could be adapted to reinforce or enhance five of Randle and Anderson’s collaboration building blocks to support the OIP’s inter-organizational context.

Building block of Randle & Anderson (2017) framework	Adaptations and considerations for healthcare/FHT	– Opportunity to integrate Relation Coordination (Gittell, 2016)
Governance (2)	There are pre-existing system-level governance structures that could be leveraged; most likely to support a sub-regional partnership is sub-regional leadership table	Create mechanisms to: <ul style="list-style-type: none"> – Empower teamwork – Create boundary spanners – Resolve conflicts
Outcomes and accountability (3)	Organization-specific <i>and</i> shared outcomes to be identified per partnership	Develop shared inter-organizational measures
Culture change and people development (5)		<ul style="list-style-type: none"> – Invest in front-line participation – Make organizational boundaries flexible
Data, evidence and evaluation (7)		Develop shared data and information systems; and collaborative platforms
Collaborative platforms: Digital and physical (8)		
Communications and engagement (9)		Communications should be frequent, timely, accurate and focused on problem solving

Note. Developed by author using Gittell (2016) and Randle & Anderson (2017).

Test of Change – Sub-regional Planning and an Ontario Health Team

Within healthcare, large-scale change is often initiated through small TOCs to see if they result in the desired improvement (Institution for Healthcare Improvement, 2019). If successful, these pilots are adapted and scaled for larger contexts, often through the incorporation of, and learning from PDSA cycles. While this suggests it might make sense to target one of the FHT's less complex partnerships for a TOC, for example a bilateral agreement around a particular program, for several reasons this OIP proposes to test Gittel's (2016) RC, and Randle and Anderson's (2017) framework with a more ambitious FHT collaboration, the FHT-led sub-regional planning table. The rationale for this larger pilot is two-fold. First the planning partnership is a multi-lateral collaboration of over 25 partner organizations including health-service providers, community-based organizations, and patient groups. The scope and governance of the players at this planning table represent different jurisdictions and sectors making the partnership an apposite test of the Randle and Anderson (2017) framework. Second, there is an immediate need for cross-sectoral, system-level collaboration within the FHT's sub-region. Provincial changes to the legislation governing Ontario's healthcare system are upending operations across the FHT and the province, and compelling an urgent, and coordinated, sub-regional response, making sub-regional planning a timely TOC.

To provide further context to this second impetus, rumours, that at the initiation of this OIP were vague concerns, were substantiated in February 2019 when the Minister of Health announced imminent healthcare transformations (Ministry of Health and Long-Term Care, 2019a). This announcement confirmed key content in a leaked draft of the 2019 *People's Health Act*, originally the *Health Systems Efficiency Act*, that was published by Ontario's opposition

party in January 2019 (Crawley & Boisvert, 2019). While the legislation is not yet fully enacted, the provincial priorities it supports are already impacting healthcare in Ontario.

At the time of writing, the most significant change for this OIP is the dissolution of the province's 14 LHINs (Longwoods, 2019); and an accompanying announcement introducing the idea of Ontario Health Teams (OHTs) (Ministry of Health and Long-Term Care, 2019b; Ministry of Health and Long-Term Care 2019c). The dismantling of the LHINs is moving quickly. In mid-March, with little advertisement, provincial Order-in-Council appointments of Board chairs and members of the province's 14 LHINs were revoked with one day's notice, amounting to a firing of all LHIN Board members in the province (Payne, 2019). Concurrent to this dismantling is an equally fast-moving amalgamation of 20 Ontario healthcare agencies – including some LHIN divisions, into a new 'super agency,' called Ontario Health. This new organization will centralize funding, and set healthcare strategy and direction for 30-50 new OHTs.

Like Ontario Health, OHTs do not yet exist, but are described in the tabled legislation as healthcare providers organizing themselves to deliver integrated care to a defined geographic population or patient segment (Ministry of Health and Long-term Care, 2019a). In early April 2019, the Minister of Health provided some guidance including a formal call for expressions of interest (Ministry of Health and Long-Term Care, 2019c). The call asks healthcare providers, for example primary care providers, long-term care facilities, hospitals, home and community care services, palliative care programs and institutions receiving funding for mental health and addictions, to come together within their geographical regions⁷ and develop proposals for

⁷ These do not have to respect the regional and sub-regional boundaries denoted by the province's 14 LHINs, but as will be described later in this section, the FHT *is* participating in conversations within its current sub-region (a subdivision of the LHIN).

integrated care for their local populations (approximately 300,000 patients per OHT) (Ministry of Health and Long-Term Care, 2019c). While not expected in the short-term, a long-term provincial expectation is that OHTs will eventually have more streamlined, reduced infrastructure and governance than currently exists in healthcare, including the removal of LHINs as an intermediary between MOHLTC and healthcare providers. This means collaborations amongst multiple organizations could, eventually, become impelled amalgamations into single organizational structures. In the meantime, how communities are meant to come together to propose, establish and govern an OHT is not well defined, and will likely look different across the province. However, in response to the April, 2019 announcements, communities across Ontario are wrestling with these ideas, and have plunged into planning and proposal development. This is occurring in the FHT's sub-region through the FHT-led planning table that, in late February was re-purposed as the vehicle for local OHT discussions and decisions.

Expanding on the Identified Solution

So, there are compelling reasons to test the proposed solution for this OIP with the FHT-led sub-regional planning table. This section builds on the TOC introduced in Figure 9 and elaborated in Table 9, and re-visits the SCM model described in Chapter Two to outline an implementation plan that includes communication and evaluation strategies.

An anticipated challenge for the reader is the potential to confuse applying the Randle and Anderson (2017) framework and Gittell's (2016) RC to the planning partnership, to the broader implementation of change associated with this OIP. As a reminder, there are two types of change addressed in this OIP: 1) The OIP change related to bringing more evidence to the FHT's partnership work, for which this chapter describes a TOC; and 2) the change inherent to

the TOC, bringing evidence-informed frameworks to the sub-regional planning table, an example of a FHT partnership. This confusion may be further confounded by shared concepts across the change processes. For example, as noted several times previously, communication and relationship building are integral to the selected partnership framework, RC *and* SCM. To better situate the relationship between these change processes and associated concepts, Figure 11 depicts the Randle and Anderson (2017) framework and Gittell's (2016) RC as the TOC that will be implemented using SCM. The remainder of this and the following sections describe the implementation of TOC using SCM; while this chapter's final section will describe how the specific TOC itself may be evaluated.

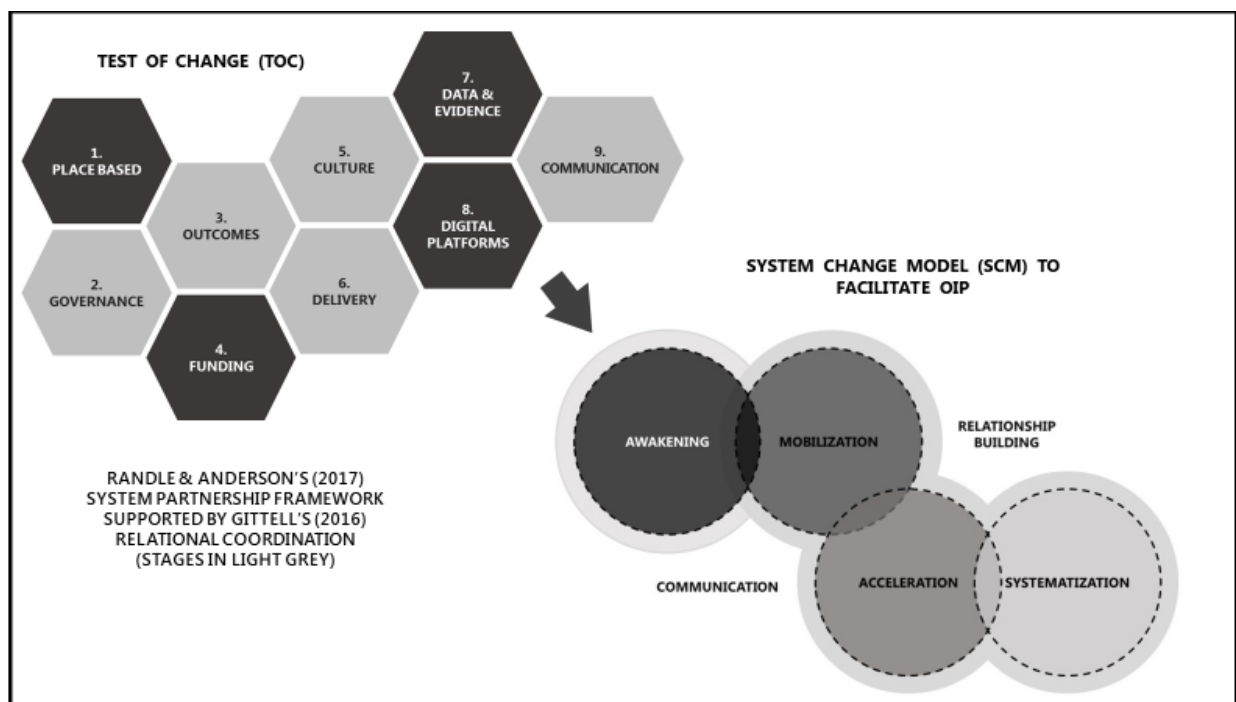


Figure 11. The Test of Change (TOC) to be implemented is the adoption of Randle & Anderson's (2017) framework, supported by Gittell's (2016) Relational Coordination in five of nine stages. The TOC will be implemented using the integrated System Change Model developed for this OIP.

Using SCM to Implement the TOC

As discussed previously, SCM is a model developed for this OIP by layering two change models, the Cawsey, Deszca, and Ingols (2016), and Kotter (1996) organizational change models, to create a model more suited to inter-organizational partnerships for system-level change. The TOC is the application of the Randle and Anderson (2017) *Building Collaborative Places* framework, and Gittell's RC to one of the FHT's most significant partnerships, a sub-regional planning table. The planning table is tasked with responding to a call from the provincial government to propose and develop an OHT for its community. This section outlines an implementation plan for this TOC using SCM.

Communication and Relationship-building: Start with the Stakeholders.

Communication and relationship-building are activities necessary to all stages of a system-level change initiative. In fact, the sustained importance of communication and relationship-building throughout a change program was an impetus for developing SCM to support this OIP. Before addressing communication and relationship-building activities within each SCM phase, an important foundational activity is the identification and prioritization of stakeholders connected to the TOC. While, it would not be unusual to describe this activity within SCM's Awakening phase, given the situation the FHT finds itself in – a pre-existing planning table with a quickly evolving mandate, some consideration will be given to the TOC stakeholders before addressing the Awakening phase.

It would be impractical, and undermining of the anonymization of this OIP, to list each interested party with a stake at the sub-regional planning table and a potential sub-regional OHT. Approximately thirty-five individuals representing over 25 organizations and their respective constituents currently sit at the table; and the table does not yet know who may end up having a

stake in the final OHT proposal. Despite the evolving nature of OHT discussions, this OIP will focus only on *current* members of the sub-regional planning table as they are already involved in a FHT collaboration. To provide structure and a generalized approach for managing, and transitioning this stakeholder engagement, Figures 12 and 13 depict two complementary ways of organizing and engaging stakeholders to ensure meaningful, and achievable, relationship-building and communications during the TOC. These organizations are identified by type or general focus to protect their anonymity and that of the sub-region.

Figure 12 depicts the application of Mendelow's (1991) Power Interest Grid to the sub-regional planning-table as it faces a pressing mandate around whether and how to propose an OHT in its community. The Power Interest Grid categorizes stakeholders, and associates the required intensity of relationship-building to stakeholders' level of interest and power around a given initiative (Mendelow, 1991). According to the grid, the most vital of the four categories, key players, are those individuals or institutions holding the highest power *and* interest, thus requiring the greatest intensity of communication and relationship-building. The second group, stakeholders with high power but low interest should be kept satisfied, and may require targeted, pro-active communication and engagement given their ability to influence an initiative's outcomes (interested or not). The third group, those with low power and high interest will be naturally easy to engage and should be kept informed on an ongoing basis. And finally, those with both low interest and power require a minimal level of engagement. Stakeholders may start in one category and shift over the course of a given initiative, and new stakeholders may emerge over time (Mendelow, 1991).

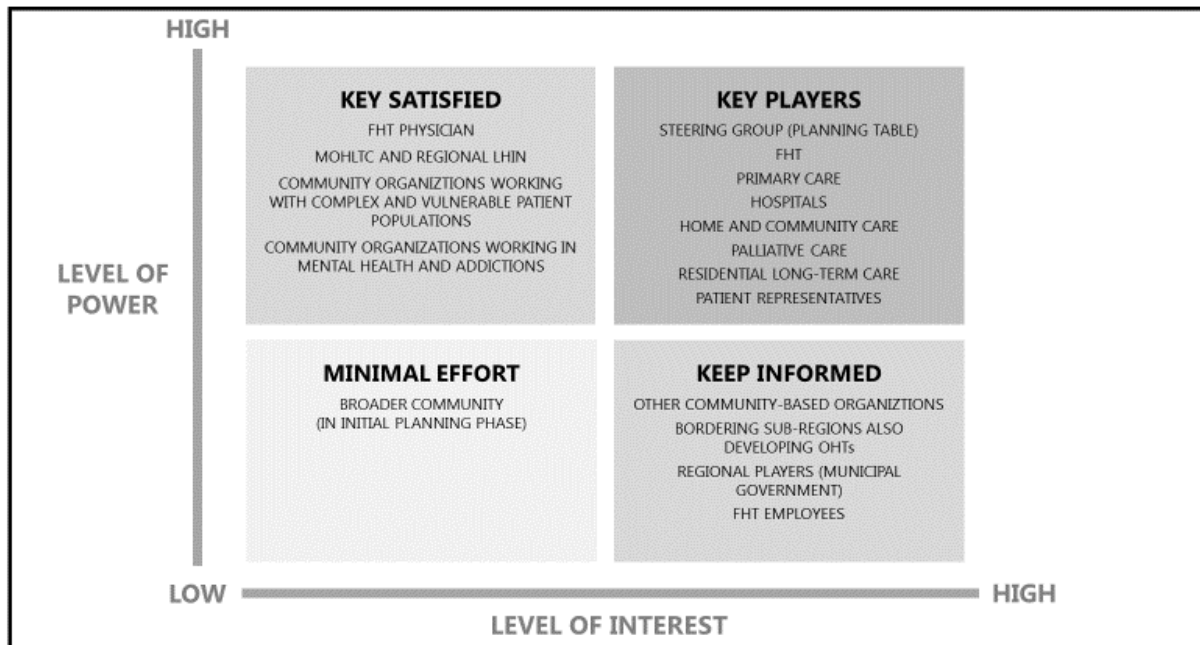


Figure 12. Applying Mendelow's (1991) Power Interest Grid to TOC stakeholders.

The TOC stakeholders with the highest level of power and interest are institutions funded by MOHLTC already at the planning table. These types of organizations were identified in the Minister of Health's February 2019 announcement as necessary participants in *any* proposed OHT (Ministry of Health and Long-Term Care, 2019a). In addition to strong intimations from their shared funder that they participate in an OHT, many of these organizations have been privy to the tabled *People's Health* legislation that includes future provisions for potentially forcing institutions to amalgamate at the discretion of MOHLTC (Ministry of Health and Long-Term Care, 2019a). This constitutes strong incentive for key players at the planning table to actively participate in the initiation and design of a possible sub-regional OHT, so they are not eventually forced into one.

In addition to high interest, MOHLTC-funded stakeholders hold significant and entrenched powers that could influence the success of an OHT conversation, and thus this TOC. Within the community, key players represent a variety of established organizations backed by

different constellations of history, constituency, resourcing, boards, working relationships with MOHLTC, and programs and services. Institutions with particularly strong reputational power in most provincial OHT discussions will be hospitals. In some Ontario communities the hospital is like a self-contained city state, managing significant budgets, human resources and capital, and serving as the sole urgent care provider in a geographic area. The 2015/2016 Auditor General's report provides insight into the scale of some Ontario hospitals. For example, within the 7.89 billion dollars of MOHLTC's 2015/2016 annual budget for 157 hospitals, the three largest comprised 16% (1.26 billion dollars) of that total (Office of the Auditor General, 2016). This constitutes significant power for those hospitals engaged in OHT discussions, including the FHT's sub-region, particularly when realignment of resources and even governance structures will be a future consideration (Ministry of Health and Long-term Care, 2019a).

In addition to their reputational power(s), the TOC's key players have leverage within the FHT initiated collaboration. The FHT currently finds itself in a de facto, interim, leadership role around potential OHT discussions given its pre-established role with the sub-regional planning table. To be successful in coming to a decision about whether to initiate an OHT proposal, and its content, it needs the majority of the key players to meaningfully participate in these discussions. It should be noted that the FHT and members of the planning table's Executive have additional influence. While this power may be transient, given their collective role in shaping the planning table's agendas, including the OHT topic, they are influencing the trajectory of whether or not there will be a sub-regional proposal; and what it might look like. This also makes the Executive natural early adopters or change agents for the TOC - an idea that will be re-visited during the *Awakening and Mobilization* section.

While the interest and power of the TOC's key players are relatively uniform (with the exception of the Executive and FHT), those of stakeholders in two of Mendelow's (1991) three other categories, Keep Satisfied and Keep Informed, are more heterogenous and will require stakeholder by stakeholder consideration. For example, a recent budget announcement by the provincial government included an increased commitment to mental health and addictions, suggesting community counselling agencies may have a degree of power in OHT discussions different from their historic, lower-profile situations (Canadian Mental Health Association, 2019).

The FHT's pre-existing relationships with the individual players at the planning table, regardless of category, are variable requiring more detailed stakeholder mapping. This is an area where SCM can borrow from RC theory that is interested in relationships and how they support, or impede, shared goals (Gittell, 2016). Figure 13 builds on the Power Interest Grid outlined in Figure 12, and shows the results of an adapted RC exercise in which the FHT's current relationships at the planning table are mapped and depicted as strong, weak (but existing), or non-existent. Understanding the strength of these relationships, and where relationships need to be established, further nurtured or even used to support next steps will help direct specific communication and relationship-building activities, some of which are outlined later in this section (Table 10).

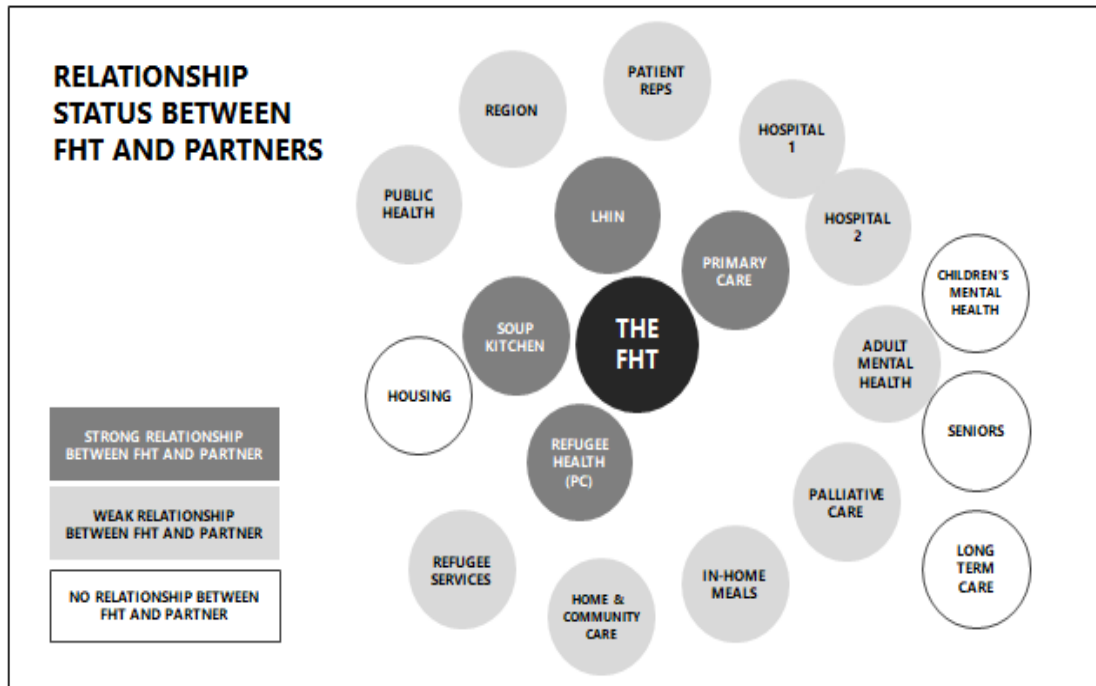


Figure 13. Mapping TOC relationships by adapting Gittel's (2016) principles of Relational Coordination (RC).

Understanding a stakeholder base is an important communication and relationship-building strategy, however within SCM communication is an ongoing and multi-faceted activity that occurs throughout a change initiative. Similar to the organizational analysis in Chapter Two, communication and relationship-building activities are included in the descriptions of each SCM phase that follows.

Awakening and Mobilization.

SCM's Awakening phase initiates a system change process; and the Mobilization phase consolidates a vision for change and begins moving it forward. In the real world, these phases are often concurrent, and overlap with other SCM phases including Communication and relationship-building, but they will be considered independently in this implementation plan for ease of reading.

In the context of the TOC, Awakening is the initiation of the OHT proposal discussion – already underway, and includes the introduction of Randle and Anderson’s (2017) nine building blocks of collaboration to facilitate the initiation, and assumed development of an OHT proposal. Given the pressing nature of the OHT conversation, and pre-existing planning table, incorporation of the framework will not be explicitly explained as a TOC for the FHT and this OIP, but an evidence-based strategy for organizing the complex work required by the OHT discussion.

Readiness is a concept yet to be explored in this OIP, but is an important enabler to the Awakening phase. Within the TOC, it is not an issue of whether or not the planning table *is* ready, but how to *get* the table ready and engaged in a response to the provincial call for expressions of interest in an OHT. This readiness conversation will be facilitated by a companion framework to Randle and Anderson (2017), Billiald and McAllister-Jones’ (2015) *Behaving Like a System*, that identifies six preconditions for a system collaboration using the Randle and Anderson framework: vision, learning, infrastructure, delivery, impact and learning. These preconditions may be used in several ways, including as an introductory language to support system-partners as they evaluate “how well they are placed for future system changes, what they need to do to build capability and what role they can play to enable a systems approach” (Billiald & McAllister-Jones, 2015, p. 27). Within the TOC, the preconditions will focus on the “how” of building capability to respond to the government’s call.

Largely concurrent with the Awakening phase, the Mobilization stage includes solidifying and implementing strategies based on additional analyses, for example related to formal structures and processes, understanding power dynamics, mapping stakeholders, identifying change agents and recipients of change, and developing communication and

relationship building strategies. The inherent overlap with the Awakening phase is particularly pertinent in this TOC, given the pre-existing planning table, and the tight provincial timeline for OHT proposals; and in the case of this TOC, much of the Mobilization work pertains to communications and relationship building initiated before and during the Awakening phase.

Communications during Awakening and Mobilization.

The communication and relationship-building activities during Awakening and Mobilization will focus on stakeholder engagement within the FHT, and at the planning table. While much of this TOC is externally directed, ongoing communication within the FHT is important throughout implementation. As a reminder, the FHT's institutional vision includes a focus on evidence; and its culture has been assessed as adhocratic (Chapter One). This has provided the Manager significant scope around initiating this OIP, and partnership work more generally. So, within the FHT, relationship-building is less about engagement and influence, and more on ensuring the organizational leadership is kept updated with "push" communications previously described in Table 8 (Chapter Two).

Communicating with Change Agents and Early Adopters.

External relationship-building and communications will be far more complex than those within the FHT. Communications about initiating a sub-regional proposal are already underway. OHTs are a very new, high-stakes and time-sensitive idea, and the FHT is not in a position to undertake an OHT alone. A key group to engage early and actively is the Executive of the planning table, composed of many of the key players depicted in Figures 12 and 13. Early adopters are well established in the literature as important enablers to facilitating and disseminating change in healthcare (Berwick, 2003; Varkey, Horne, & Bennet, 2008; Weber &

Joshi, 2007). For example, Berwick (2003) identified seven recommendations for healthcare executives facilitating change, including:

- identifying worthwhile change;
- finding, and then investing time and resources in early adopters;
- ensuring the work of initial change-makers is made public and acknowledged;
- trusting and enabling early adopters to take change forward;
- facilitating opportunities and connections to a change initiative; and
- leading by example.

Within this OIP, many such strategies are being employed with the Executive. For example, members of the Executive group have already agreed on the importance, in principle, of a sub-regional proposal (identified as a necessary, and worthy change). In addition, the Manager and a supporting consultant are spending significant time engaging the Executive, and enabling their participation in key elements of the proposal development process, such as facilitating and organizing community-based information and consultation sessions.

Other Communication Activity.

Communication with all stakeholders during the Awakening and Mobilization phases will set the stage for relationships throughout the change process. The FHT needs to facilitate productive working relationships with not only the Executive, but all players at the planning table, and potentially additional stakeholders as the proposal develops. Table 10 re-visits Figure 13 and identifies communication and relationship-building activities by stakeholder types (key players, stakeholders to keep satisfied, stakeholder to keep informed, and stakeholders who require minimal engagement). In addition, within each type, where individual stakeholders were

depicted as having weak or non-existent relationships in Figure 13, the FHT is making time for face-to-face meetings regardless of whether a stakeholder is categorized as a key player or not.

Table 10 <i>TOC Communication and Relationship-building Activity by Stakeholder Type</i>	
Stakeholder Category (Based on Mendelow, 1991)	Communication and Relationship Building Activities
FHT	<ul style="list-style-type: none"> – Keep FHT Board updated and ask for additional representation in OHT discussions
Key Players	<ul style="list-style-type: none"> – Build on pre-existing planning table communication tools (including Terms of Reference (TOR), scheduled meetings, meeting summaries, decision framework, and Executive that advises the larger planning table) – Ensure key players have representation on Executive – Conduct individual face-to-face meetings with representatives, prioritizing institutions with which FHT does not have a relationship
Keep Satisfied	<ul style="list-style-type: none"> – Maintain good communications via push communications – Conduct individual face-to-face meetings with representatives, prioritizing institutions with which FHT does not have a relationship
Keep Informed	<ul style="list-style-type: none"> – Fast track development of a sub-regional planning communications and website that all members can access
Minimal Effort	<ul style="list-style-type: none"> – Make process relatively transparent for pull communications (e.g., website)

Acceleration: Using PDSA Cycles.

After the Awakening and Mobilization phases, Acceleration furthers a change by speeding things up and/or diffusing the change initiative. In the case of this OIP and the OHT proposal, both speed and diffusion are required given the tight proposal deadline and scope of a potential OHT. Deconstructing what needs to be done and conducting PDSA cycles is a trusted implementation strategy in healthcare that could support moving the TOC forward.

As described in Chapter Two, PDSA is a trial and learn approach that hypothesizes a solution, and tests it on a small scale before implementing wide-spread change (Varkey, Reller,

& Resar, 2007). The four PDSA steps previously depicted in Figure 8 (Chapter Two) will be used to test the implementation of Randle and Anderson's (2017) partnership framework with embedded RC supports. While PDSA is more commonly used for rapid and incremental tests of change in healthcare (Varkey, Reller, & Resar, 2007), a unique application is reflected in the work of Headrick, Moore, Alemi, Hekelman, Kizys, Miller, & Neuhasuer (1998). The Ohio-based team applied PDSA to a series of community-academic partnerships, essentially using a PDSA cycle per partnership, while maintaining a connection between the partnerships. This OIP proposes to employ a comparable application of PDSA by using it to support two, interconnected building blocks within Randle and Anderson's (2017) framework: outcomes (3) and data (7). These two building blocks are closely interconnected, and have been suggested not only for their relationship to each other, but because of their applicability to using PDSA: they are relatively apolitical; and amenable to an incremental approach to development. (Say, in comparison to the governance and culture building blocks that will require different development strategies, further explored in the next section). Figure 14 depicts how PDSA may be employed to inform the development of these two, interconnected building blocks.

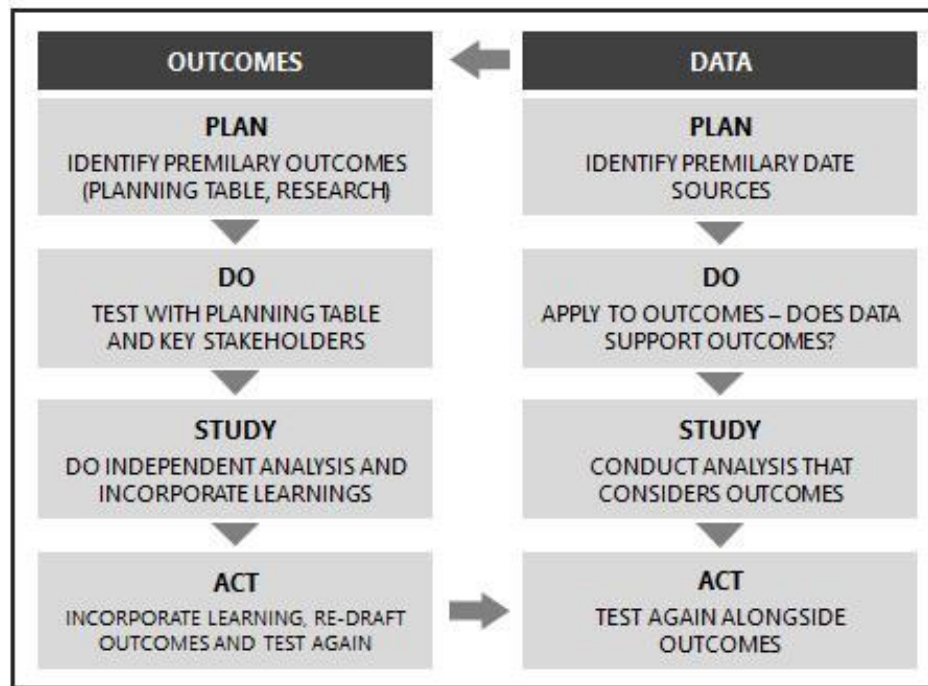


Figure 14. Using PDSA to support development of two building blocks in the Randle and Anderson (2007) framework (outcomes and data).

In addition to applying PDSA to achieve the TOC, additional analyses and activities will be initiated during the Acceleration phase. For the most part, these are specific to the Randle and Anderson (2017) building blocks, and in some cases the incorporation of RC. As with the other SCM phases, communication and relationship-building are ongoing throughout this phase and will build on many of the activities initiated during Awakening and Mobilization.

Systematization.

During systematization within SCM, activity is characterized as developing new processes, structures, knowledge and abilities to systematize a change and bring system-spanning stability. For the purposes of this OIP, this phase is not so much about the TOC and OHT proposal, but what comes after – assumedly a sub-regional OHT. The Randle and Anderson (2017) framework initiated during the TOC naturally provides a ‘container’ or way of ‘holding

space,’ a key characteristic of collective impact described as part of Solution One (Chapter Two). For example, many of the building blocks initiated during the TOC, including outcomes, governance, data and evidence, and a communal digital platform, will all contribute to a sustained space for continued multi-sectoral accomplishments even after the TOC is completed.

Resourcing and Timeline

The resourcing and timeline for this TOC are not within the control of the author of this OIP, and both are challenging. Of the latter, the timeline is dictated by the provincial call for expressions of interest announced in April 2019 for proposal submissions in late July 2019 (Ministry of Health and Long-Term Care, 2019c). The TOC will follow these timelines, but, in a manner similar to the Acceleration phase where two PDSA cycles are informing each other, learnings from the TOC will inform OHT implementation (assuming the proposal is successful).

Similarly, the resourcing for this initiative is iterative and unplanned. There is not a set budget and the predominant resourcing consideration is related to human resources, by the FHT – including the Manager, and other members of the Executive and planning table. For these reasons, there is not a timeline or budget included in this implementation plan.

Additional Implementation Challenges

Successfully implementing a change initiative is as much science as art. An entire academic discipline is dedicated to considering how to facilitate change and incorporate evidence into healthcare: in Canada this field is known as Knowledge Translation; and in Europe, Implementation Science to better reflect the growing body of evidence that supports systematic implementation of evidence into healthcare (Hanan, 2016). Among other things, Implementation Science has dedicated significant consideration of barriers, particularly to behavioural change, and how to address them. Early studies developed generalized descriptions of barriers; however,

more recent research suggests that barriers, and mitigation strategies, should be specific to the undertaking (Kajermo, Bostrom, Thompson, Hutchinson, Estabrooks, & Wallin, 2010).

Implementing this TOC has no limit of barriers as suggested by the previous resourcing and timeline discussion. Some further challenges are anticipated and intuitively addressed through SCM, for example anticipating resistance to change through a focus on communication and relationship-building and identifying early adopters. In addition to behavioural barriers, there are other logistical and operational challenges that pose practical barriers to implementing the TOC. These and mitigating activities are summarized in Table 11.

<i>Table 11 Anticipated implementation challenges and mitigation activities</i>	
Barrier	Mitigating Activity
Scope of TOC	Incorporation of Randle and Anderson (2017) and RC (Gittell, 2016) to provide structure to process.
Large Planning Table	
Tight timeline	
Large Executive Group	Employ Berwick (2003) strategies for early adopters.
Competing Priorities (including other OHT proposals)	Ongoing communication and relationship-building. Use stakeholder relationships depicted in Figure 14.
Power Dynamics	Use of Bolman and Deal (2017) Four Frame Model to understand and navigate alternative perspectives.

Evaluating Implementation of the TOC

Evaluation is an important component of any change initiative. Similarly, the need for evaluation, including understanding what works and what does not, is focal throughout the partnership literature. The PDSA cycles described previously contribute to a developmental evaluation approach that has been selected for this OIP. Developmental evaluation is similar to

the better-known formative evaluation approach that is used to refine initiatives already underway, and then ready them for a summative decision (Patton, 2009). In comparison, Patton (2009) describes the purpose of developmental evaluation as supporting an initiative so new, within an environment so complex, it is unclear how to proceed. This approach aligns well with the VUCA environment of healthcare, and the environment in which the FHT, and its sub-regional partners, are attempting to develop an OHT proposal, making it a good fit for the TOC. The remainder of this section will describe how several evaluative tools consistent with developmental evaluation will be used to support and evaluate the TOC.

When evaluation is done well it is initiated during program development, or in the case of partnership work, at the inception of a collaboration; and it is guided by what a given initiative is meant to achieve. Two types of evaluation were identified in the brief literature review in Chapter One as predominant in the partnership literature: theories of change, and realist evaluation. The former, theories of change, are evaluation tools best incorporated during the inception of an initiative (Funnell & Rogers, 2011). This is because theories of change are models that depict the relationship and rationales, including theoretical bases, for how an initiative's inputs and activities interact with an external context to bring about planned outcomes (Blamey & Mackenzie, 2007). Essentially, they visualize what, and more importantly *how*, an endeavour is meant to accomplish its goals. In the case of this OIP, a theory of change will not be used to conceptualize the partnership, but the product of the collaboration, the OHT proposal. Such a theory of change is already in development as part of the planning table's readiness work. This includes consideration of the proposed OHT's vision, key components and activities, and the theoretical bases for how they are meant to interact and contribute to patient care. This is consistent with Patton's (2009) developmental evaluation approach, particularly

given the creation of a new, initiative-specific conceptual model or theory of change underpinning the proposed OHT. It also aligns with an assertion by Parry, Carson-Stevens, Luff, McPherson, and Goldmann (2013) that the guiding evaluation questions of healthcare should be informed by theory.

The second evaluation tool commonly identified in the partnership literature, is realistic evaluation, originally developed by Pawson and Tilley (1997), and later elaborated on by Pawson (2002). Realist evaluation occurs during or after an endeavour has been undertaken, and attempts to understand and describe the unique features of a program or initiative and its interactions with a specific environment. This evaluative process can be summed up in a well-known equation for realist evaluation: context + mechanism = outcome. For example, within healthcare, Parry, Carson-Stevens, Luff, McPherson, and Goldmann, (2013) ask how and in what contexts a new model works and whether, and how, it can be amended to other contexts. This approach aligns well with the development of an OHT, which will be highly specific to the FHT's community.

Theories of change and realist evaluation are specific activities that can be undertaken to support a developmental evaluation approach. In addition, utilization evaluation, also a support, is a specific lens through which an evaluation is undertaken. According to Patton (2003), utilization-focused evaluation is concerned with how participants experience an evaluation process, and apply the findings in practice. Utilization-focused evaluation is concerned with honouring the intended use of an evaluation, and for whom, and is a consideration during all stages of an evaluation. This will be an important lens for the FHT and this TOC given the pressing and quick-moving speed of its implementation. Like the PDSAs described in the SCM,

it is important that the evaluation is practical, quick, and informing the ongoing development of the TOC and its partners.

Summarizing the TOC

Figure 15 depicts a summarized version of the implementation plan for the TOC using the SCM model described in Chapter Two. As suggested by the model, communication and relationship-building are activities required throughout the TOC, not isolated to a specific stage. Similarly, given the unique, complex and ambiguous nature of the TOC, a developmental evaluation approach underpins its entire implementation, using evaluation supports such as theories of change, realist evaluation and a utilization lens. However, an evaluation is not necessary to understand some of the inherent limitations and challenges to undertaking the TOC from the outset; this will be the focus of the next section.

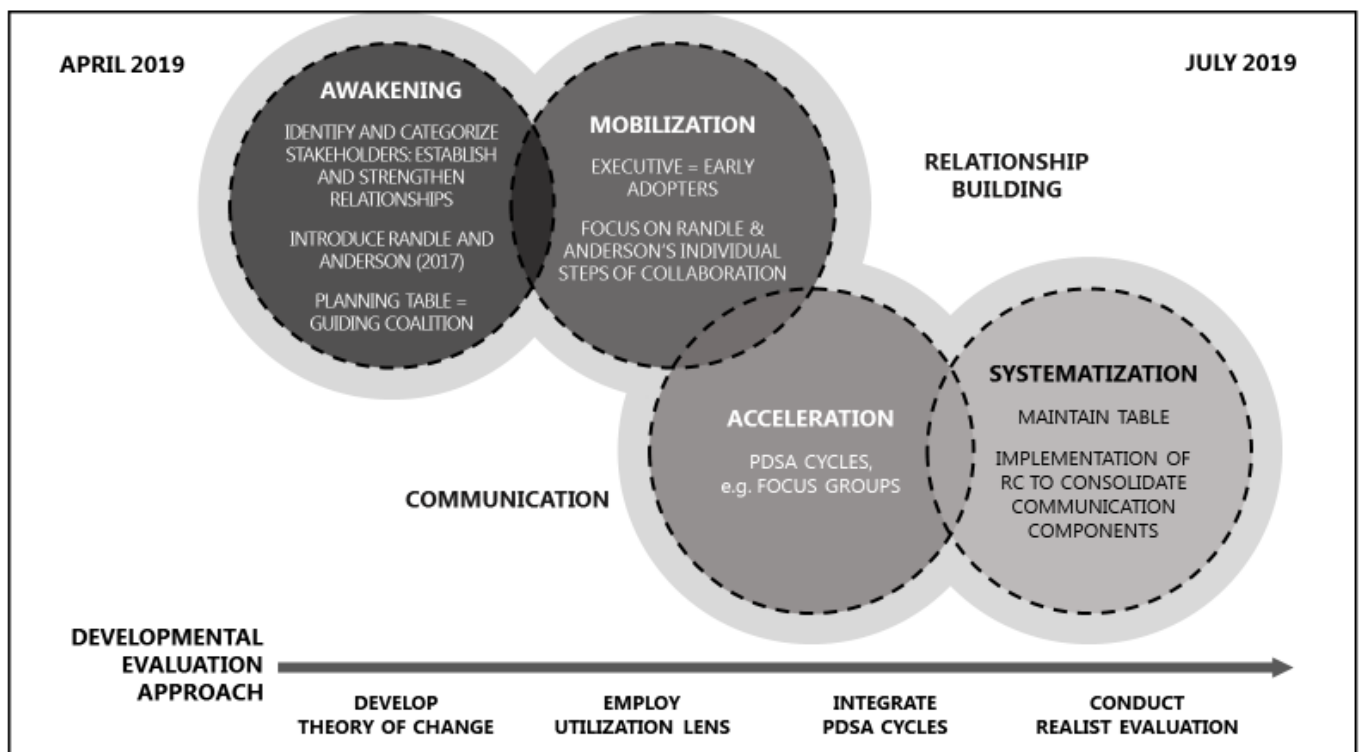


Figure 15. Summary of TOC Implementation using SCM.

Limitations to TOC

While the TOC for this OIP is a timely opportunity to incorporate evidence into the formation and implementation of a FHT partnership, it is only one FHT partnership, and its most complex. The application of Randle and Anderson (2017) and Gittell (2016) to other FHT partnerships, for example a bilateral partnership related to shared care teams, is likely overkill - a strategy misaligned to context. Despite this, the TOC is developing quickly and lessons are being learned every day, providing a rich repository of ideas for other FHT partnerships.

A second, interrelated challenge for this implementation plan is the VUCA environment in which the writing process has occurred. Since January 2019, Ontario patients and healthcare providers have been privy or subject to a series of government leaks, proposed legislative changes and formal provincial announcements that, while sometimes contradictory in specifics, all reflect large-scale change across the healthcare system. Given the immediacy and incessance of these changes, writing this OIP has often felt more like field-reporting than an academic pursuit. This means that much of the content described in this OIP, and the TOC in particular, is subject to rapid change, rendering the ideas and concepts more applicable to the author's practice than any specific details in the implementation plan.

Additional Considerations and Next Steps

Given the current flux of healthcare in Ontario, and the FHT's partnership needs that extend beyond the sub-regional planning table and TOC, this section presents a final consideration for the FHT's broader partnership portfolio. Figure 16 depicts a supplementary tool that may enable the FHT to better sort and support its partnerships, the Snowden and Boone (2007) decision framework. Named for the Welsh word *cynefin* that denotes the factors and experiences that impact people in ways that cannot be articulated, the Snowden and Boone

(2007) matrix sorts leadership challenges into four different environmental contexts: simple, complicated, complex, and chaotic. These designations are framed around cause and effect relationships at play in an environment, and are aimed at supporting decision-making by matching the types of decisions available to a leader, to the context in which decisions are being made.

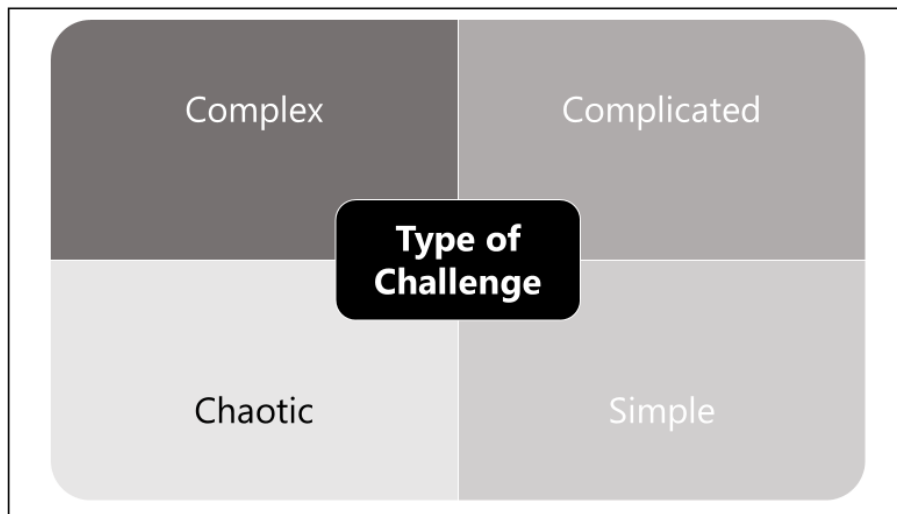


Figure 16. Decision Framework for Different Types of Challenge (Snowden & Boone, 2007).

Issues and problems in the first two domains occur in known or readable environments and are amenable to packaged or pre-existing solutions. In the first domain, *simple* context like the existence of a medical condition with a known treatment, is an issue that can be addressed through a ‘best-practice’ or previously trialed approach. Or, more succinctly, an issue with a known cause and effect relationship benefits from a standardized solution easily identified and applied by a leader. Of a similar ilk, the second domain, *complicated* context, denotes a situation or challenge with discernible cause and effect relationships, but the possible solutions may vary and are not obvious to all. Leaders working in this context may choose from several potential solutions. When thinking about FHT partnerships, the context and nature of some of its bilateral partnerships could be described as *simple* and/or *complicated*, suggesting that some of the

healthcare frameworks considered in Solution Two (Chapter Two) may fit, particularly those partnerships involving shared care teams.

The third and fourth domains reflect increasing unpredictable or VUCA environments. Within the third domain, *complex* contexts are dynamic, varied and in flux, and cause and effect relationships may not appear to exist. In addition, unlike the first two domains there are unknown unknowns. In these scenarios, leaders cannot simply select and apply a known solution, but need to probe further, sense what is happening, respond... and then probably fail and try again. This unpredictability is even more pronounced within the fourth domain, where context is *chaotic* and discerning *any* relationships or predictable patterns is impossible. Leadership strategies employed in chaotic scenarios tend to be short-term and focused on minimizing damage; yet visionary leaders may also take advantage of the chaos as an opportunity to innovate. Arguably, the FHT-led, sub-regional planning partnership falls between the third and fourth domains, supporting the proposed integrated strategy developed for the TOC.

So, while the TOC implementation plan is limited, ironically, by the large scope of its collaboration that is not indicative of other FHT partnerships, a stratified approach to sorting its other partnerships could be an additional opportunity to support the FHT's partnership portfolio with evidence-based tools.

OIP Conclusion

This OIP considered the experience of the FHT, an Ontario family health team whose growing portfolio of partnerships requires evidence-based structure, particularly during a time of growing instability and flux in healthcare. Chapter One outlined the FHT's organizational context, described the author's leadership influences, and introduced and developed a PoP that envisions a future state in which the FHT is participating in intentional, evidence-based partnerships. Given the healthcare system context in which the FHT operates, the author layered two organizational change models to create a system-level change model (SCM) more suited to the FHT's inter-organizational collaborations.

Chapter Two further described SCM, animated it with authentic and complexity leadership theories, and used it to frame a critical organizational analysis of the FHT's partnership portfolio. Building on this analysis, four potential strategies to address the PoP were presented. The first was to adopt an evidence-based, multi-sectoral partnership framework for the FHT's system-level partnerships. The second was to adopt a more targeted healthcare partnership framework. And the third was to implement Relational Coordination, a way of integrating tasks across multiple players through structured communication and relationship-building activities. While all three solutions have elements that would support the FHT's partnership portfolio, no single solution fully addresses the FHT's needs and a fourth, integrated solution was proposed.

In keeping with the spirit of integration that characterized both this OIP and partnerships, Chapter Three further developed the preferred solution: adopting and adapting a framework for multi-sectoral, system-level partnerships (Randle & Anderson, 2017) by integrating Gittel's (2016) Relational Coordination where communication and relationship-building could support

shared tasks. To animate this solution, a test of change pilot was identified using one of the FHT's most pressing, and complex collaborations - a sub-regional planning table with over 25 organizational partners. The rationale for a large pilot was two-fold. First, the planning partnership is a multi-lateral collaboration that represents different jurisdictions and sectors, making the partnership an apposite test of the Randle and Anderson (2017) framework. Second, given pressing changes in Ontario's healthcare system, there is an immediate and ongoing need for cross-sectoral, system-level collaboration within the FHT's community.

While timely and well underway, there are several limitations to the TOC, including its broad scope, tight timelines, limited resources and potential lack of transferability to other FHT partnerships. In recognition that the proposed solution is limited in its applicability, the Snowden and Boone (2007) decision framework was introduced as an additional evidence-based tool to support the FHT in sorting and applying solutions to other partnerships. In addition, there will be opportunity to extract lessons learned from the TOC and implement them with other FHT partnerships regardless of their scope. This constitutes ongoing work for the FHT that will extend beyond the OIP and TOC.

Finally, as noted in the *Limitations* section, the OIP writing process has taken place during a time of transformation across Ontario's healthcare system. This has many implications for the FHT and its partners, including a possible future state in which organizational structures are significantly altered over the next several years. For this OIP, it means the ideas and concepts developed through the writing process are likely more applicable to the FHT's institutional future and the author's practice, than any specific details in the implementation plan.

References

- Ackerly, D.C., Sangvai, D.G., Udayakumark, K., Shaw, B.R., Kalman, N.S., Cho, A.H., Schulman, K.A., Fulkerson, W.J., & Dzau, V.J. (2011). Training the next generation of physician-executives: An innovative residency pathway in management and leadership. *Academic Medicine*, 86(5), 575-579. doi: 10.1097/ACM.0b013e318212e51b
- Advancing Access to Team-Based Care. (2018). *AA-TBC program guide*. AA-TBC project, Toronto, ON.
- Angus, L. (2006). Educational leadership and the imperative of including student voices, student interest, and students' lives in the mainstream. *International Journal of Leadership in Education*, 9(4), 369-379.
- Ansari, W.E., Phillips, C.J., & Hammick, M. (2001). Collaboration and partnerships: Developing the evidence base. *Health and Social Care in the Community*, 9(4), 215–227. <https://doi.org/10.1046/j.0966-0410.2001.00299.x>
- Association of Family Health Teams of Ontario. (2018). *Governance fundamentals*. Retrieved from http://www.afhto.ca/wp-content/uploads/AFHTO_Fundamentals-of-Governance_Introduction_Apr14.pdf
- Association of Ontario Health Centres. (2009). *Community-governed family health teams: Looking back, looking forward*. Retrieved from http://www.aohc.org/index.php?ci_id¼9789&la_id¼41
- Avolio, B.J., & Gardner, W. (2005). Authentic leadership development: Getting to the root of positive forms of leadership. *Leadership Quarterly*, 16(3), 315–338. <https://doi.org/10.1016/j.leaqua.2005.03.001>

Avolio, B.J., Walumbwa, F.O., & Weber, T.J. (2009). Leadership: Current theories, research, and future directions. *Annual Review of Psychology*, *60*, 421-449.

<https://doi.org/10.1146/annurev.psych.60.110707.163621>

Bailie, R., Matthews, V., Brands, J., & Schierhout, G. (2013). A systems-based partnership learning model for strengthening primary healthcare. *Implementation Science*, *8*(143).

Retrieved from <https://implementationscience.biomedcentral.com/articles/10.1186/1748-5908-8-143>

Bak, P. (1996). *How nature works*. New York, NY: Copernicus Publishers.

Baltaci, A., & Balci, A. (2017). Complexity leadership: A theoretical perspective. *International Journal of Educational Leadership and Management*, *5*(1), 30-58. doi:

10.17583/ijelm.2017.2435

Beech, R., Henderson, C., Ashby, S., Dickinson, A., Sheaff, R., Windle, K., Wistow, G., & Knapp, M. (2013). Does integrated governance lead to integrated patient care? Findings from the innovation forum. *Health and Social Care in the Community*, *21*(6), 598–605.

doi: 10.1111/hsc.12042

Berwick, D. (2003, April 16). Disseminating innovations in health care. *JAMA*, *289*(15), 1969-1975. doi:10.1001/jama.289.15.1969

Billiald, S., & McAllister-Jones, L. (2015). *Behaving like a system: The preconditions for place based systems change*. Lankelly Chase Foundation. Retrieved from [https://ccednet-](https://ccednet-rcdec.ca/en/toolbox/behaving-system-preconditions-place-based-systems-change)

[rcdec.ca/en/toolbox/behaving-system-preconditions-place-based-systems-change](https://ccednet-rcdec.ca/en/toolbox/behaving-system-preconditions-place-based-systems-change)

Blamey, A., & Mackenzie, N. (2007). Theories of change and realistic evaluation: Peas in a pod or apples and oranges? *Evaluation*, *13*(4), 439-455. doi: 10.1177/1356389007082129

- Blendon, R., & SteelFisher, G.K. (2009). Commentary: Understanding the underlying politics of health care policy decision-making. *Health Serv Res, 44*(4), 1137-1143.
doi:10.1111/j.1475-6773.2009.00979.x
- Bolman, L.G., & Deal, T.E. (2017). *Reframing organizations: Artistry, choice & leadership* (6th ed.). San Francisco, CA: Jossey-Bass.
- Boydell, J., & Rugkasa, J. (2007). Benefits of working in partnership: A model. *Critical Public Health, 17*(3), 217–228. <https://doi.org/10.1080/09581590601010190>
- Brandeis University (2018). *Relational coordination research collaborative*. Retrieved from <https://heller.brandeis.edu/relational-coordination/index.html>
- Brown, M.E., & Treviño, L.K. (2006). Ethical leadership: A review and future directions. *The Leadership Quarterly, 17*, 595-616.
- Butt, G., Markle-Reid, M., & Browne, G. (2008). Interprofessional partnerships in chronic illness care: A conceptual model for measuring partnership effectiveness. *International Journal of Integrated Care, 8*. Retrieved from <http://www.ijc.org/>
- Cabaj, M., & Weaver, L. (2016). *Collective impact 3.0: An evolving framework for community change*. Retrieved from https://cdn2.hubspot.net/hubfs/316071/Events/Multi-Day%20Events/Community%20Change%20Institute%20-%20CCI/2016%20CCI%20Toronto/CCI_Publications/Collective%20Impact%203.0%20Liz%20Weaver%20Mark%20Cabaj%20Paper.pdf
- Cameron, K.S., & Quinn, R. (2011). *Diagnosing and changing organizational culture*. San Francisco, CA: John Wiley and Sons.
- Canadian Medical Health Association. (2018). *Social determinants of health*. Retrieved from: <https://ontario.cmha.ca/provincial-policy/social-determinants/>

- Canadian Medical Health Association. (2019, April 11). *CMHA Ontario applauds province's commitment to mental health and addictions care in 2019 budget*. Retrieved from <https://ontario.cmha.ca/news/cmha-ontario-applauds-provinces-commitment-to-mental-health-and-addictions-care-in-2019-budget/>
- Carnegie Project on the Education Doctorate (CPED) (2016). *Western's Doctor of Education (EdD) Problems of Practice for an Organizational Improvement Plan*. Retrieved from <http://www.cpedinitiative.org/page/AboutUs>
- Caron, D. (2009 February 8). *It's a VUCA world*. Retrieved from <http://www.slideshare.net/dcaron/its-a-vuca-world-cips-cio-march-5-2009-draft>
- Cawsey, T.P., Deszca, G., Ingols, C. (2016). *Organizational change: An action-oriented toolkit*. Los Angeles, CA: SAGE.
- Cinaroglu, S. (2016). Complexity in healthcare management: Why does Drucker describe healthcare organizations as a double-headed monster? *International Journal of Healthcare Management*, 9(1), 11-17. <https://doi.org/10.1179/2047971915Y.0000000016>
- Closing the Gap. (2018, May 30). *Healthcare in Ontario: How does it work and how is it funded?* Retrieved from <https://www.closingthegap.ca/guides/healthcare-in-ontario-how-does-it-work-and-how-is-it-funded/>
- College of Nurses of Ontario. (2018). *Jurisprudence examination (CNO)*. Retrieved from <http://www.cno.org/en/become-a-nurse/entry-to-practice-examinations/jurisprudence-examination/>
- College of Physicians of Ontario. (2018). *The practice guide (CPSO): Medical professionalism and College policies*. Retrieved from <https://www.cpso.on.ca/Policies-Publications/The-Practice-Guide-Medical-Professionalism-and-Col/Introduction>

- Conference Board of Canada. (2014). *Final report: An external evaluation of the family health team (FHT) initiative*. Retrieved from: <https://www.conferenceboard.ca/e-library/abstract.aspx?did=6711>
- Cooper, C.D, Scandura, T.A., & Schriesheim, C.A. (2005). Looking forward but learning from our past: Potential challenges to developing authentic leadership theory and authentic leaders. *The Leadership Quarterly*, 16(3), 475-493.
- Crawley, M. (2019, January 17). *Ford government poised to dissolve regional health agencies, sources say*. Retrieved from <https://www.cbc.ca/news/canada/toronto/lhin-ontario-doug-ford-local-health-integration-networks-1.4980509>
- Crawley, M. (2019, February 10). *Why privatization is not the biggest issue with Ontario's health reforms*. Retrieved from <https://www.cbc.ca/news/canada/toronto/ontario-health-changes-privatization-doug-ford-1.5007957>
- Crawley, M., & Boivert, N. (2019, January 31). *Ontario government responds after NDP leaks draft bill to scrap regional health agencies*. Retrieved from <https://www.cbc.ca/news/canada/toronto/ontario-health-system-efficiency-act-1.5000546>
- Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage Publications Inc.
- D'Amour, D., Ferrada-Videla, M., Rodriguez, L.S.M., & Beaulieu, M. (2009). The conceptual basis for interprofessional collaboration: Core concepts and theoretical frameworks. *Journal of Interprofessional Care*, 19, 116-131.
<https://doi.org/10.1080/13561820500082529>

- Davies, J. (2002). Regeneration partnerships under new Labour: A case of creeping centralization. In C. Glendinning, M. Powell & K. Rummery (Eds.), *Partnerships, new labour and the governance of welfare*. Bristol: Policy Press.
- Davies, P. M., Popescu, A., & Gunter, H. M. (2011). Critical approaches to education policy and leadership. *Management in Education, 25*(2), 47-49.
- Deber, R.B. (2018). *Treating health care: How the Canadian system works and how it could work better*. University of Toronto Press: Toronto, Ontario.
- Denis, J.L., Baker, G.R., Black, C., Langley, A., Lawless, B., Leblanc, D., Lusiani, M., Hepburn, C.M., Pomey, M.P., & Tre, G. (2013). *Exploring the dynamics of physician engagement and leadership for health system improvement: Prospects for Canadian healthcare systems*. Retrieved from <https://pdfs.semanticscholar.org/4b77/18c9fab9118db731170e5e8e32578cdb5ab8.pdf>
- Denis, J.L., & van Gestel, N. (2016). Medical doctors in healthcare leadership: Theoretical and practical challenges. *BMC Health Services Research, 16*(158), 45-56.
<http://dx.doi.org/10.1186/s12913-016-1392-8>
- Dhillon, J. K. (2005). The rhetoric and reality of partnership working. *Journal of Further and Higher Education, 29*(3), 211-219. doi: 10.1080/03098770500166769
- Dowling, B., Powell, M., & Glendinning, C. (2004). Conceptualizing successful partnerships. *Health and Social Care in the Community, 12*(4), 309–317.
- Drucker P. (1980). *Managing in turbulent times*. New York, NY: Butterworth-Heinemann.
- Ehrich, L.C., Klenowski, J.H., & Spina, J.S. (2015). The centrality of ethical leadership, *Journal of Educational Administration, 53*(2), 197–214. Retrieved from

- <http://www.emeraldinsight.com.proxy1.lib.uwo.ca/doi/pdfplus/10.1108/JEA-10-2013-0110>
- Elias, S. (2008). Fifty years of influence in the workplace: The evolution of the French and Raven power taxonomy. *Journal of Management*, *14*(3), 267-285.
doi.org/10.1108/17511340810880634
- Evans, J.M., Grudniewiz, A., Wodchis, W., & Baker, G.R. (2014). Leading the implementation of Health Links in Ontario. *Healthcare Papers*, *14*(2), 21-25.
- Federation of Health Regulatory Colleges of Ontario (2018). *Fostering healthy regulatory collaboration in Ontario*. Retrieved from
<http://www.regulatedhealthprofessions.on.ca/index.html>
- Field, J.E., & Peck, E. (2003). Public–private partnerships in healthcare: The managers’ perspective. *Health and Social Care in the Community*, *11*(6), 494-501.
- Financial Accountability Office of Ontario (2019). *Ontario health sector: 2019 update assessment of Ontario health spending*. Retrieved from <https://www.fao-on.org/en/Blog/Publications/health-update-2019>
- Follett, M.P. (1949). *Freedom and co-ordination: Lectures in business organization*. London; Management Publications Trust.
- Frank, J.R., Snell, L., & Sherbino, J. (Eds.). (2015). *CanMEDS 2016: Physician competency framework*. Ottawa, ON: Royal College of Physicians and Surgeons of Canada.
- Fullan, M. (2008). *The six secrets of change: What the best leaders do to help their organizations survive and thrive*. San Francisco, CA: Jossey-Bass Publishers.
- Funnell, S.C., & Rogers, P.J. (2011). *Purposeful program theory: Effective use of theories of change and logic models*. San Francisco, CA: Jossey-Bass Publishers.

- Fusco, T., O'Riordan, S., & Palmer, S. (2016). Assessing the efficacy of authentic leadership (group-coaching). *International Coaching Psychology Review, 11*(2), 118-128.
- Gary, K. (2006). Leisure, freedom, and liberal education. *Educational Theory, 56*(2), 122-136.
<https://doi.org/10.1111/j.1741-5446.2006.00007.x>
- George, B. (2003). *Authentic leadership: Rediscovering the secrets to creating lasting value*. San Francisco, CA: Jossey-Bass.
- Gittell, J.H. (2016). *Transforming relations for high performance: The power of relational coordination*. Stanford, CA: Stanford University Press.
- Gittell, J.H., Edmondson, A., & Schein, E. (2011). *Learning to coordinate: A relational model of organizational change*. San Antonio, TX: Academy of Management Meetings.
- Gittell, J.H., Godfrey, M., & Thistlethwaite, J. (2013). Interprofessional collaborative practice and relational coordination: Improving healthcare through relationships. *Journal of Interprofessional Care, 27*, 210-213.
- Glazier, R.H., Hutchinson, B., & Kopp, A. (2015). *Comparison of family health teams to other primary care models, 2004/05 to 2011/12*. Retrieved from
<https://www.ices.on.ca/Publications/Atlases-and-Reports/2015/Comparison-of-Family-Health-Teams>
- Glendinning, C. (2002) Partnerships between health and social services: Developing a framework for evaluation. *Policy and Politics 30*, 115–127.
<https://doi.org/10.1332/0305573022501601>
- Globe and Mail. (2018, June 7). *Ontario election results 2018: A map of the results*. Retrieved from <https://www.theglobeandmail.com/canada/article-ontario-election-results-2018-a-map-of-the-live-results/>

- Gocan, S., Laplante, M., & K., Woodend. (2014, January). Interprofessional collaboration in Ontario's family health teams: A review of the literature. *Journal of Research in Interprofessional Practice and Education*, 3(3). Retrieved from: <https://www.jripe.org/index.php/journal/article/view/131/84> DOI: <http://dx.doi.org/10.22230/jripe.2014v3n3a131>
- Grady, C.M. (2016). Can complexity science inform physician leadership development? *Leadership in Health Services*, 29(3), 251-263. <http://dx.doi.org/10.1108/LHS-12-2015-0042>
- Graham, I.D., Logan, J., Harrison, M.B., Straus, S.E., Tetroe, J., Caswell, W., & Robinson, N. (2006). Lost in knowledge translation: Time for a map? *Journal of Continuing Education in Health Professions*, 26(1), 13-24.
- Grudniewicz, A., Tenbenschel, T., Evans, J.M., Gray, C.S., Baker, G.R., & Wodchis, W. (2018). Complexity-compatible policy for integrated care? Lessons from the implementation of Ontario's Health Links. *Social Science & Medicine*, 198, 95-102. <https://doi.org/10.1016/j.socscimed.2017.12.029>
- Hanan, K. (2016). Knowledge translation and implementation science: What is the difference? *International Journal of Evidence-Based Healthcare*, 14(2), 39-40.
- Haydt, S.M. (2018). Politics and professions: Interdisciplinary team models and their implications for health equity in Ontario. *International Journal of Health Services*, 48(2), 302-327. doi: 10.1177/0020731417717384
- Headrick, L.A., Moore, S.M., Alemi, F., Hekelman, F., Kizys, N., Miller, D., & Neuhaser, D. (1998). Using PDSA to establish academic-community partnerships: The Cleveland experience. *Quality Management in Healthcare*, 6(2), 12-20.

Health Quality Ontario. (2018). *Health Links approach to care maturity model: Operational definitions and resource guide (Final draft for consultation)*. Toronto, Ontario.

Hopkins, M.H., & O'Neil, D.A. (2015). *Authentic leadership: application to women leaders*. *Frontiers in Psychology*, 6 (959). <https://doi.org/10.3389/fpsyg.2015.00959>

Hunter, D.J., Perkins, N., Bambra, C., Marks, L., Hopkins, T. & Blackman, T. (2011). *Partnership working and the implications for governance: Issues affecting public health partnerships* (Final report). NIHR Service Delivery and Organisation Programme. Retrieved from <http://nihr.ac.uk>.

Huynh, H.P., & Sweeny, K. (2014). Clinician styles of care: Transforming patient care at the intersection of leadership and medicine. *Journal of Health Psychology*, 19(11), 1459-1470. doi:10.1177/1359105313493650

International Institute for Healthcare Improvement. (2019). *Using change concepts for improvement*. Retrieved from <http://www.ihl.org/resources/Pages/Changes/UsingChangeConceptsforImprovement.aspx>

James, B. (2018). *Leadership skills clinical training doesn't teach*. Institute for Healthcare Improvement. Retrieved from <http://www.ihl.org/communities/blogs/what-your-clinical-training-didn-t-teach-you-about-leading-improvement?>

Kajermo, K.N., Bostrom, A., Thompson, D.S., Hutchinson, A.M., Estabrooks, C., & Wallin, L. (2010). The BARRIERS scale – the barriers to research utilization scale: A systematic review. *Implementation Science*, 5 (23). <https://doi.org/10.1186/1748-5908-5-32>

Kania, J., & Kramer, M. (2011). Collective impact. *Stanford Social Innovation Review*. <https://www.everychildcq.org/wp-content/uploads/2018/06/Collective-Impact-Stanford-Social-Innovation-Review-2011.pdf>

- Kania, J., & Kramer, M. (2013, January 21). Embracing emergence: How collective impact addresses complexity. *Stanford Social Innovation Review*. Retrieved from https://ssir.org/articles/entry/social_progress_through_collective_impact#
- Kernis M. H. (2003). Toward a conceptualization of optimal self-esteem. *Psychol. Inq.*1, 1–26. 10.1207/S15327965PLI1401_0
- Kingsinger, P. & Walch, K. (2012, July 9). *Living and leading in a VUCA world*. Thunderbird University Retrieved from <http://knowledgenetwork.thunderbird.edu/research/2012/07/09/kingsinger-walch-vuca/>
- Kiran, T., Kopp, A., Moineddin, R., & Glazier, R.H. (2015). Longitudinal evaluation of physician payment reform and team-based care for chronic disease management and prevention. *CMAJ*, 187(17), E494-E502. doi: 10.1503/cmaj.150579
- Kotter, J.P. (1996). *Leading change*. Boston, MA: Harvard Business School Press.
- Lavis, J. (2016). *Ontario's health system: Key insights for engaged citizens, professionals and policymakers*. Hamilton, ON: McMaster.
- Lawrence, K. (2013). *Developing leaders in a VUCA environment*. UNC Keenan-Flagler Business School. Retrieved from <http://laszlo-zsolnai.net/sites/default/files/3/documents/Reading%203%20Developing-leaders-in-a-vuca-environment.pdf>
- Leape, L., Berwick, D., Clancy, C., Conway, J., Gluck, P., Guest, J., Lawrence, D., Morath, J., O’Leary, D., O’Neill, P., Pinakiewicz, D., & Isaac, T. (2009). Transforming healthcare: A safety imperative. *Qual Saf Health Care*, 18, 424–428. doi:10.1136/qshc.2009.036954

- Lichtenstein, B.B., Uhl-Bien, M., Marion, R., Anson, S., & James, D. (2006). *Complexity leadership theory: An interactive perspective on leading in complex adaptive systems*. Management Department Faculty Publications - University of Nebraska. Retrieved from <http://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1007&context=managementfacpub>
- Lillemoen, L., & Pedersen, R. (2012). Ethical challenges and how to develop ethics support in primary health care. *Nursing Ethics*, 20(1), 96-108.
- Longwoods (2019). *Ontario health system efficiency act, 2019 (DRAFT)*. Retrieved from <https://www.longwoods.com/newsdetail/13175>.
- Loriggio, P. (2018, August 1). Ontario government defends move to axe basic income pilot project. *Globe and Mail*. Retrieved from <https://www.theglobeandmail.com/canada/article-ontario-government-defends-move-to-axe-basic-income-pilot-project-2/>
- Luthans, F., & Avolio, B. (2003). Authentic leadership: A positive development approach. In K. S. Cameron, J. E. Dutton, & R.E. Quinn (Eds.), *Positive Organizational Scholarship*. San Francisco: Berrett-Koehler.
- Marchildon, P., & Hutchison, B. (2016). Primary care in Ontario, Canada: New proposals after 15 years of reform. *Health Policy*, 120(7), 732-738. Retrieved from <https://doi.org/10.1016/j.healthpol.2016.04.010>. doi: 10.1016/j.healthpol.2016.04.010
- Mendelow, A. (1991). *Mendelow's Power-interest grid*. Kent, OH: Kent University Press.
- Merlino, J. (2017). Communication: A critical healthcare competency. *Patient Safety and Healthcare Quality*. Retrieved from <https://www.psqh.com/analysis/communication-critical-healthcare-competency/>

Meuser, J., Bean, T., Goldman, J., & Reeves, S. (2006). Family health teams: A new Canadian interprofessional initiative. *Journal of Interprofessional Care, 20*(4), 436-438. DOI:

10.1080/13561820600874726

Mikkonen, J., & Raphael, D. (2010). *Social determinants of health: The Canadian facts.*

Retrieved from: http://thecanadianfacts.org/the_canadian_facts.pdf

Ministry of Health and Long-term Care. (2016a). *Bill 41, Patients First Act.* Retrieved from

http://www.ontla.on.ca/web/bills/bills_detail.do?locale=en&BillID=4215

Ministry of Health and Long-term Care. (2016b, January 22). *Family health teams.* Retrieved

from <http://www.health.gov.on.ca/en/pro/programs/fht/>

Ministry of Health and Long-term Care (2017, May 10). *Ontario boosting access to primary care for people across the province: Province expanding and enhancing*

interprofessional health care teams. Retrieved from

<https://news.ontario.ca/mohlhc/en/2017/05/ontario-boosting-access-to-primary-care-for-people-across-the-province.html>

Ministry of Health and Long-term Care (2018, August 23). *Transforming Ontario's health care system: Community Health Links provide coordinated, efficient and effective care to*

patients with complex needs. Retrieved from

<http://www.health.gov.on.ca/en/pro/programs/transformation/community.aspx>

Ministry of Health and Long-term Care. (2019a). *Ontario's government for the people to break down barriers to better patient care.* Retrieved from

<https://news.ontario.ca/mohlhc/en/2019/02/ontarios-government-for-the-people-to-break-down-barriers-to-better-patient-care.html>

- Ministry of Health and Long-term Care. (2019b, April 3). *Ontario taking next step in building a connected public health care system for patients*. Retrieved from https://news.ontario.ca/mohltc/en/2019/04/ontario-taking-next-step-in-building-a-connected-public-health-care-system-for-patients.html?utm_source=ondemand&utm_medium=email&utm_campaign=p
- Ministry of Health and Long-term Care. (2019c, April 3). *Ontario Health Teams: Guidance for health care providers and organizations*. Retrieved from http://health.gov.on.ca/en/pro/programs/connectedcare/oht/docs/guidance_doc_en.pdf
- Moen, N., & Norman, C. (2009, January). *Evolution of the PDCA Cycle*. Retrieved from <http://www.idemployee.id.tue.nl/g.w.m.rauterberg/lecturenotes/DG000%20DRP-R/references/Moen-Norman-2009.pdf>
- Mohammad, Z., & Johar, F. (2017). A conceptual framework for evaluating the success of public-private partnership (PPP) projects. *Journal of Built Environment, Technology and Engineering*, 2 (March), 89-98. Retrieved from <https://www.researchgate.net/publication/320762746>
- Monaghan, B., Malek, A., & Simson, H. (2001). Public-private partnerships in healthcare: Criteria for success. *Healthcare Management Forum*, 14(4), 44-49.
- Montague, T. (2006). Patient-provider partnerships in healthcare: Enhancing knowledge translation and improving outcomes. *Healthcare Papers*, 7(2), 53-61.
- Munroe, E.A, Borden, L., Orr, A.M, Toney, D. & Meader, J. (2013). Decolonizing aboriginal education in the 21st century. *McGill Journal of Education*, 48(2), 317-337. doi 10.7202/1020974ar

- Nishtar, S. (2004). Public-private ‘partnerships’ in health – a global care to action. *Health Research Policy and Systems*, 2(5). <https://doi.org/10.1186/1478-4505-2-5>
- Northouse, P. G. (2016). *Leadership: Theory and practice (7th ed.)*. Los Angeles, CA: Sage Publications.
- Office of the Auditor General of Ontario. (2016). *2016 annual report of the office of the Auditor General of Ontario (Chapter 3, Section 3.8)*. Retrieved from http://www.auditor.on.ca/en/content/annualreports/arreports/en16/v1_308en16.pdf
- Ontario Medical Association. (2015). *Ontario has 800,000 “unattached” patients: What does that mean?* Retrieved from: <http://www.ontariosdoctors.com/ontario-has-900-000-unattached-patients-what-does-that-mean/>
- Osborn, C. (Ed.). (2009). *Public-private partnerships: Theory and practice in international perspective*. London: Routledge.
- Pabico, C. (2015). Creating supportive environments and thriving in a Volatile, Uncertain, Complex, and Ambiguous World. *The Journal of Nursing Administration*, 45(10), 471-473.
- Parry, G., Carson-Stevens, A., Luff, D.F., McPherson, M.E., & Goldmann, D. (2013). Recommendations for evaluation of health care improvement initiatives. *Academic Paediatrics*, 13(6), S23-S30. <https://doi.org/10.1016/j.acap.2013.04.007>
- Patton, M. Q. (2009). *Developmental evaluation as alternative to formative assessment*. [Web Video]. Retrieved from http://www.youtube.com/watch?feature=player_embedded&v=Wg3IL-XjmuM

- Patton, M.Q. (2011). Utilization-focused evaluation. In T. Kellaghan, & D.L. Stufflebeam (Eds.), *International handbook of educational evaluation* (223-244). Dordrecht: Kluwer Academic Publishers.
- Pawson, R. (2002). Evidence-based policy: The promise of ‘realist synthesis’. *Evaluation*, 8(3), 340–358.
- Pawson, R., & Tilley, N. (1997). *Realistic Evaluation*. London: Sage Publications.
- Payne, E. (2019, March 15). *Ontario begins dismantling local health integration system*. Retrieved from <https://ottawacitizen.com/news/politics/ontario-begins-dismantling-local-health-integration-system>
- Penuel, W. R., Coburn, C. E., & Gallagher, D. J. (2013). Negotiating problems of practice in research-practice design partnerships. *National Society for the Study of Education Yearbook*, 112(2), 237–255.
- Picard, A. (2018, June 27). Doug Ford needs to rein in Ontario’s bureaucratic health-care mess. *Globe and Mail*. Retrieved from: <https://www.theglobeandmail.com/opinion/article-doug-ford-needs-to-rein-in-ontarios-bureaucratic-health-care-mess/>
- Pietrzak, M., Paliszkiwicz, J. (2015). Framework of strategic learning: The PDSA cycle. *Management*, 10(2), 149–161
- Plsek, P.E., & Wilson, T. (2001). Complexity, leadership, and management in healthcare organizations. *BMJ*, 323(7315), 746-749.
- Pollack, J., & Pollack, R. (2015). Using Kotter’s eight stage process to manage an organisational change program: Presentation and practice. *Systemic Practice Action Research*, 28, 51-66. doi 10.1007/s11213-014-9317-0

- Quality Assurance in Medicine Act, Canada statutes. (1991). Retrieved from <https://www.ontario.ca/laws/statute/91r18>.
- Randle, A., & Anderson, H. (2017). *Building collaborative places: Infrastructure for system change*. Retrieved from <https://collaboratecic.com/building-collaborative-places-infrastructure-for-system-change-50329af06498>
- Raven, B. (1993). The bases of power: Origins and recent developments. *Journal of Social Issues*, 49(4), 227-251. <https://doi.org/10.1111/j.1540-4560.1993.tb01191.x>
- Raven, J. (2005). Liberal education and Liberalism in modern society. *The Good Society*, 14(3), 29-37.
- Regine, B., & Lewin, R. (2000). Leading at the edge: How leaders influence complex systems. *Emergence: A Journal of Complexity Issues in Organizations and Management*, 2(2), 5–23.
- Riel, J., & Martin, R. (2017). *Creating great choices: A leader's guide to integrative thinking*. Boston, MA: Harvard Business Review Press.
- Rosser, W., Colwill, J.M., Kasperski, J., & Wilson, L. (2011). Progress of Ontario's family health team model: A patient-centered medical home. *Annals of Family Medicine*, 9(2), 165-171. <https://doi:10.1370/afm.1228>
- Rottmann, C. (2007). Leadership and change for social justice: Mapping the conceptual terrain. *Journal of Educational Administration and Foundations*, 18(1/2), 52-91.
- Siemiatycki, M., 2012. The global experience with infrastructure public—private partnerships. *Planning & Environmental Law*, 64(9), pp.6–11.

- Snowden, D.J., & Boone, M.E. (2007). A leader's framework for decision making. *Harvard Business Review*, November. Retrieved from <https://hbr.org/2007/11/a-leaders-framework-for-decision-making>
- St. Michael's Hospital. (2018). *Exploring the relationship between primary care and health equity in Ontario*. Retrieved from: <http://stmichaelshospitalresearch.ca/research-programs/urban-health-solutions/our-projects/building-healthy-policy-and-practices/exploring-the-relationship-between-primary-care-and-health-equity-in-ontario/>
- Steinert, Y., Naismith, L., & Mann, K. (2012). Faculty development initiatives designed to promote leadership in medical education. A BEME systematic review: BEME Guide No. 19. *Medical Teacher*, 34, 483-503. doi: 10.3109/0142159X.2012.680937
- Stintz, L.J., & Stoller, J.K. (2014). A systematic review of physician leadership and emotional intelligence. *Journal of Graduate Medical Education*, March. <http://dx.doi.org/10.4300/JME-D-13-00012.1>
- Sullivan, J. (2012a, January 16). VUCA: The new normal for talent management and workforce planning. Retrieved from <http://www.ere.net/2012/01/16/vuca-the-new-normal-for-talent-management-and-workforce-planning/>.
- Sullivan, J. (2012b, October 22). Talent strategies for a turbulent VUCA world—shifting to an adaptive approach. Retrieved from <http://www.ere.net/2012/10/22/talent-strategies-for-a-turbulent-vuca-world-shifting-to-an-adaptive-approach>.
- The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. (1978). *The Belmont report: Ethical principles and guidelines for the protection of human subjects of research*. Bethesda, Md: The Commission.

- Tobias, J., Scott, T., Davies, H.T.O., Bower, P., Whalley, D., McNally, R., & Mannion, R. (2009). Instruments for exploring organizational culture: A review of the literature. *Public Administration Review*, 69(6), 1087-1096. <https://doi.org/10.1111/j.1540-6210.2009.02066.x>
- Uhl-Bien, M., & Arena, M. (2017). Complexity leadership: Enabling people and organizations for adaptability. *Organizational Dynamics*, 46(1), 9-20. <http://dx.doi.org/10.1016/j.orgdyn.2016.12.001>
- Uhl-Bien, M., & Marion, R (2001). Leadership in complex organizations. *The Leadership Quarterly*, 12(4), 389–418.
- Uhl-Bien, M., Marion, R., & McKelvey, B. (2007). Complexity leadership theory: Shifting leadership from the industrial age to the knowledge era. *The Leadership Quarterly*, 18, 298-318. <https://doi.org/10.1016/j.leaqua.2007.04.002>
- Varkey, P., Reller, M.K., & Resar, R.K. (2007). Basics of quality improvement in health care. *Mayo Clinic Proceedings*, 82(6), 735-739.
- Varkey, P., Horne, Al., & Bennet, K. (2008). Innovation in health care: A primer. *American Journal of Medical Quality*, 23(5), 382-388. <https://doi.org/10.1122/1062860608317696>
- Waldman J.D., & Cohn, K. H. (2008). Chapter two: Mending the gap between physicians and hospital executives. In K.H. Cohn & D.E. Hough (Eds.) *The Business of Healthcare*. USA: Greenwood Publishing Group, Inc. Retrieved from http://www.healthcarecollaboration.com/docs/physhospgap_waldman.pdf
- Walshe, C., Caress, A., Chew-Graham, C., & Todd, C. (2007). Evaluating partnership working: Lessons for palliative care. *European Journal of Cancer Care*, 16, 48–54. doi: 10.1111/j.1365-2354.2006.00702.x

Weber, V., & Joshi, M.S. (2007). Effecting and leading change in health care organizations. *The Joint Commission Journal on Quality Improvement*, 26(7), 388-399.

Wittkuhn, K. D. (2012). Think: What does disciplined inquiry mean for our profession? *Performance Improvement Quarterly*, 25(1), 69-74. doi: 10.1002/piq.20138.

World Health Organization. (2010). *A conceptual framework for action on the social determinants of health (Social determinants of health discussion paper 2)*. Retrieved from http://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf