Health Links "Meeting on the Bridge"

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Module 4 – The Collaborative Mindset
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Introduction

The following is a summary and reflection of Module 4 – the Collaborative Mindset – in the IMHL program held in Bangalore, India in February, 2013. While the class visited a number of settings that demonstrated collaboration in action, particularly in serving the poor and vulnerable in India, the following were the readings and sessions with most applicability to my current position as Lead, Health Link Implementation at the Toronto Central LHIN. The impact and translation of learning into the practical work setting in the TC LHIN Health Link project are embedded in the body of this paper. This format allows the paper to be shared directly with the TC LHIN and Health Link leadership within the LHIN.

The Collaborative Mindset - Engaged Management

In the "Five Minds of a Manager", Mintzberg and Gosling establish the collaborative mindset as simply "working with people – not just as bosses and subordinates, but more importantly, as colleagues and partners". [1]

Unfortunately, due to the deductive foundations of mainstream scientific and economic theory, managers and leaders in health care have often followed the example from other science based disciplines and taken a more narrow view of 'collaboration'.

This often means health organizations and the people within them are often seen by health managers as detached "resources or assets" that can be moved, transitioned, restructured and engineered, combined, or even downsized and out placed to achieve the vision and goals developed by government leaders, upper management and Boards.[2] As Mintzberg and Gosling point out, this is far from achieving the collaborative mindset required for change and transformation in health systems around the globe.

Mintzberg and Gosling maintain a truly collaborative mindset does not involve managing people so much as managing *relationships* among people, in teams and projects, as well as across divisions and alliances[3]. For leaders, it means moving away from more traditional forms of heroic management and moving toward a more engaging style. According to the work of Mintzberg and Gosling, engaged management in health care is based on the following principles[4]:

- Viewing leaders and managers as important to the extent they help other people do the important work of delivering health services;
- Viewing the organization as an interacting network, not a detached or vertical hierarchy. Effective leaders work throughout a network or its community. They do not sit on top of or act on behalf of only one organization.
- Out of this interacting network emerge strategies, as engaged and committed people solve little problems that grow into big initiatives.
- Implementation of strategy cannot be separated from strategy formulation. Therefore, committed insiders are necessary to come up with and implement key strategies and changes;
- To manage is to bring out the positive energy that exists naturally within people. Managing thus means inspiring and engaging, based on judgement that is rooted within context.

- Human values matter – many of which are difficult or impossible to measure precisely, but rather are experienced by those serving and being served. Rewards for making the organization a better place are returned to everyone – in particular to patients and the community being served – not to leaders or shareholders.

- Leadership is a sacred trust *earned* through the respect of others.

Leaders in health care rarely actually provide the services offered by their organizations to patients and their community, but they do shape the context – establishing the conditions, attitudes and structures through which high quality, cost effective health services can be provided. This requires leaders and management to work *with* people and this, in turn, requires leaders and managers to work from a collaborative mindset.

The Relationship between Doers and Helpers

To work collaboratively also requires an understanding of the relationship between "doers and helpers" in health system development[5].

As Mintzberg and Srinivas set out in their article "Juxtaposing Doers and Helpers in Development" , activities in development initiatives can be roughly divided between people and organizations rooted locally that reach out based on 'need' – the insiders - and organizations that more globally support local initiatives, and push 'help' – the cosmopolitan outsiders. [6]

One might describe these perspectives as "grassroots" – smaller localized organizations - and "umbrellas" – larger policy, planning and advocacy organizations that can protect local activities or conversely block or redirect them. Mintzberg and Srinivas refer to them as *"roots and roofs"*.[7] However, within this paper, these organizations will be called "*doers (roots) and helpers (roofs)".*

While 'doers' face the day to day problems within their communities and often provide direct health services, 'helpers' offer expertise and general solutions to helpers that can be translated into a particular application that fits local context. Both skills and perspectives of doers and helpers add value and are required to implement change. However, typically there are significant gaps between the doers (local management, health care workers and patients) and the helpers (government policy, planning and management staff). Mintzberg's and Srinivas framework helps elucidate these roles.

Doers

"Doers" are often loose groupings of people or organizations within an identified community who recognize the benefits of working together toward some shared need or more often, provoked by a crisis. They often operate with rudimentary structures and focus normally on a single cause or project. Strong member involvement enhances mutual trust within the group. In lieu of structures, hierarchies or clear divisions of responsibility, they tend to coordinate by informal, face to face communication most likely using mutual adjustment and perhaps some forms of direct supervision[8]. There are strong incentives for doer organizations to remain decentralized since they are pulled by the need for help from the community and local providers within their communities.

Staff specialists and managers can and do join doer organizations in the role of helper, mainly in activities such as fundraising and community organizing. But one fundamental difference is unique to local 'helpers' within doer organizations that prevent them from crossing over to the helper

organizations. They are viewed and treated by doer organizations as if indigenous to their communities. If not, they often become ineffective in their roles within the local community.

Helpers

On the other hand, 'helper' organizations intervene or work on behalf of the larger public good. Their activities, origins or ownership often have limited or no doers on the ground, in local communities. Their emphasis is bringing expertise that drives solutions at the local level for the broader public.

Helper organizations are generally comprised of professionals and people educated in solutions to problems encountered during the development process. They channel finances, broker or provide technical solutions and conceptual or policy support to meet grassroots needs. Thus, they link specific local problems with established, more global solutions.

Helper organizations tend not to be owned but are often associations or government sponsored organizations. Non ownership confers helper organizations with particular advantage. They generally have the increased freedom to attract and work with more diverse stakeholders. This includes public sector institutions, private businesses and other levels of government.

Helpers tend to work within more formal structures and procedures which support activities such as training/education, technology planning and deployment, and financing directed through local doer organizations.

Tension and Possible Dysfunction between Doers and Helpers

Compelled by the need to help the broad public, the helpers develop or translate general solutions into a particular application at the local level – often a policy or change initiative. In that respect, they tend to use deductive reasoning, from concept to specific initiative. In contrast, the doers, compelled by the pull of need from local communities, seek solutions to local problems. In that respect, doers tend to use inductive reasoning or bottom up thinking. Mintzberg and Srinivas argue that best practice in development of transformation initiatives, will arise when inductive and deductive reasoning are combined[9].

The radically different perspectives and aims of doers and helpers can create tension and possible dysfunction as they try to work together. The following template developed by Mintzberg and Srinivas articulates these two aspects of the relationship in broad terms.

Doers	Helpers
• Local Insiders	• Cosmopolitan Outsiders
• Indigenous doers	• Exogenous helpers
• Collaborative Action	• Altruistic Support
• Work inside up	• Work outside in
• Connected	• Constructed
• The Pull of Need from Communities	• The push to Help Broad Public

• Have Local Problems	• Offer Broad/Global Solutions
• Rooted in local context	• Offer Concepts
• Owned Organizations	• Non Owned Organizations
• Blended into communities	• Coordinated through networks
• Need for local engagement	• Need for transparency and consistency to achieve broad goals
• Danger of incestuous involvement, cooptation by local organizations and political interests	• Danger of excessive control or detachment, abstract dogma or cooptation by political biases

These two sides – doers and helpers – are often drawn in opposite directions leading each to its own potential dysfunction[10] .

Doer organizations risk being drawn down toward local interests that can co opt them and leave them serving narrow agendas rather than the broader community. Doer organizations tend to use mainly informal or political means to achieve goals. This approach can risk alienating not only helpers, but portions of their local communities as well.

In contrast, helper organizations risk becoming detached from operating activities on the ground and specific communities served by doer organizations. The result is that helpers can create an overly conceptual agenda which lacks local credibility for implementation. In other cases, this can mean helper organizations over control or develop inappropriate formalized and centralized approaches toward those needing help. Full of good intentions, helper organizations can become insulated from the real world consequences associated with implementation of their solutions.

Application to Ontario's Health Links

Ontario's Health Links provides a useful provincial transformation initiative for application of the principles of engaged management and the framework of "doers and helpers". Both approaches are required for success of health system transformation. In this section, these two frameworks will be applied to the development and implementation of Health Links, particularly within the Toronto Central Local Health Integration Network.

What are Health Links in the TC LHIN?

The Toronto Central LHIN is proposing the creation of nine Health Links consistent with provincial health policy. The idea of Health Links is simple: *"**providers supporting providers to deliver the best possible care for people and communities". [11]***

Health Links will be created to support local needs and be guided by local leadership with LHIN oversight. Participation by physicians and health organizations is voluntary. The LHIN will leverage existing partnerships and build on current successful collaborative initiatives already underway in

forming Health Links which will be planned and operated as self organized entities. Each Link will follow a six step implementation guide during development and will have commonality in terms of access to core services and expected outcomes. However, there will be local customization on the "local initiatives and implementation processes" based on provider input and community need.

Specialized services not available in each Link will be available to all Health Links through a formal, easy to access intake and referral process. Finally, each Link will be supported by robust local and provincial information management practices to identify and track improvements related to the patient experience, quality of care, timely access to services and cost.

The Health Links will be implemented through a series of phases over the next 2-3 years and each phase will build on the lessons learned from early phases. Every area of the LHIN and every provider will be "engaged" or invited to be part of their local Link – it is just a matter of when. Strategies for physician and patient/community engagement, reflecting best practices, have been provided by the TC LHIN to guide the efforts of Health Links in these areas.

Rollout of the Health Links in Toronto Central will include patients and providers in four key health sectors. The first wave and starting point for building the Link will be creating a foundational partnership with **Primary Care Providers and the CCAC.** International evidence exists to demonstrate the health systems built on a strong foundation of primary care yield improved health outcomes for the population service, less health inequities at lower overall cost.[12] Extensive work has already been completed and four health Links are moving to implementation, based on business plans, in Q1 of 2013.

The four subsequent sectors of Health Link development include:

- **A focus on Community Support and Mental Health and Addictions services** that extend beyond primary health care with a goal of aligning these services with the Link and revising current service delivery models to promote easy access of these services for primary care providers;
- **A focus on Hospitals** including acute, specialty and mental health to provide a seamless transition to and from primary care when a higher level of care is required;
- **A focus on Academic Institutions** with a goal of creating opportunities for educating and training our future providers of care in support of our vision; and
- **A focus on Social and other key Support Services** in each Link to further advance achievement of our vision and objectives for the population served.

In planning for changes within each sector, the TC LHIN is facilitating a broad engagement of sector providers, primary care providers, patients and other stakeholders for each wave of development and change.

Health Links across the Province, and more locally, the Links within Toronto Central LHIN, are designed to have the following positive impacts, starting with the 1 and 5% of complex patients identified as high users of our health system accountable for approximately two third of health care expenditure in the province. While there are nine clear outcome indicators for Health Links evaluation, all indicators are aimed at achieving these overall goals:

- increased access to primary care,
- improvements in care delivery by all providers,
- improvements in the patient experience at better value,
- increased accountability for patient care and outcomes.

As the TC LHIN Health Links are implemented, patients will be involved to manage their own care and to make informed choices in collaboration with their primary health care team. The Links will work toward meaningful patient centred care and involvement by patients and caregivers in Health Link planning and operation is encouraged.

In sum, Ontario's Health Links provides a useful provincial transformation initiative for application of the principles of engaged management and the framework of "doers and helpers". Both approaches are required for success of health system transformation being sought through Health Links. How can these approaches be successfully implemented within this important provincial health initiative?

Engaged Management in Health Links

Based on the description of Health Links, it is apparent they are aligned with the definition of complex adaptive systems requiring the principles of engaged management in order to achieve success. Using Mintzberg and Gosling's framework shown earlier, the principles of engaged management can be more specifically applied and tailored to Health Links as follows:

- Leaders and managers within the system including the Ministry of Health and Long Term Care (MOHLTC), the TC LHIN, physician groups and health and social service organizations will be important to the extent they help Health Links achieve their goals.
- Each Health Link is an interacting network, requiring leaders to work throughout the Health Link, collaborate with other Health Links and to reach beyond organizational boundaries and out into the community.
- Out of each Link and collectively through all provincial Health Links, will emerge an implementation and change strategy as each Health Link and each LHIN engages its committed core team and working groups to tackle smaller problems that will grow into larger scale initiatives that can be leveraged to achieve broader provincial goals.
- It will take "committed insiders" to develop and implement strategies and key changes appropriate within the local context of a Health Link.
- It is the job of the MOHLTC, TC LHIN and local leaders to bring out or unleash the positive energy that exists naturally within each Health Link and within each sector. Management and leaders must inspire and engage, based on judgement about what is appropriate within the context of local Health Links and sectors.
- The culture and human values brought to bear within this initiative will matter significantly – the values and culture will drive the experience of those doing the work within Health Links and receiving services. The culture and values need to be clearly articulated from the outset in order to motivate and sustain change. Rewards for making the organizational and personal changes required, including resource reallocation and reinvestment decisions, need to be well articulated and transparent.
- Certainly, in this initiative, distributed, consistent and cohesive leadership can generate the trust and respect required to establish and sustain the environment for such a transformation. Leaders must resist the temptation of thinking too narrowly and putting self-interest, organizational interests or the interest of local Health Links before the collective goals of the Health Links and people in the Province.

These principles may serve as a useful starting point to guide Health Link development and explain the role and approach to be taken by leaders and managers in the project.

Doers and Helpers – Meeting on the Bridge

Having articulated the need for engaged management based on the need for collaboration within Health Links, how can the relationship between doers and helpers best be leveraged for the success of Health Links at both the local and provincial/regional levels? How can doers and helpers effectively collaborate in Health Links?

As articulated earlier, the natural pull of doers and helpers, in excess, can lead to tension, dysfunction and can impede collaboration. To be successful, Mintzberg and Srinivas argue that doers and helpers must connect in tangible forums[13]. On the ground knowledge of doers has to combine with the abstract expertise of helpers. When this happens, problems deeply understood on the ground in local communities will meet with solutions carefully constructed with input from both local insiders and external experts. Mintzberg and Srinivas describe three ways doers and helpers relate over time: 1) by handing over 2) by crossing over or ideally by 3) collaborating or meeting on the bridge.[14]

The first way – handing over - occurs when helpers stand to one side and merely hand over something of use, normally money, equipment or information, to the indigenous doers. This is the most common way doers and helpers bridge the gap. However, the danger is there may be no real appreciation of the capabilities of the doers to utilize the resources to actually solve local problems nor is there often broad appreciation by the doers of the needs within a community beyond their immediate focus.

The second way - crossing over – occurs when helpers involve themselves more directly in the activities of doers, even if temporarily. This often occurs through training or support provided during initial start up. However, the danger with 'crossing over' is that, while well intended, it may be taken as interference by those who know more about the local community than the community itself. Cooptation is another risk – those who cross over get co opted by the doers and therefore, do not perform their roles effectively to achieve the broader public goals.

The third and most effective situation occurs when the two types of organizations, doers and helpers, develop a formal, balanced relationship – on the bridge – either as a team, task force or through some formal alliance. Under these circumstances doers and helpers can share knowledge, skills and resources in an authentic partnership with minimal disparity in power. This can begin with handing over resources to doers while helpers train, support and monitor application of funds to achieve the desired goals or actions.

Therefore, to be successful, Mintzberg and Srinivas would propose that Health Links need to establish formal forums where sharing of unique skills and knowledge between doers and helpers happens frequently and effectively within the project structure.[15]

In Health Links, the *helpers* likely include the MOHLTC, LHINs, provincial professional or advocacy bodies such as the Ontario Medical Association, the Ontario Hospital Association or professional Colleges. They might also include government-supported organizations including the Health Quality Ontario or the Change Foundation.

The doers likely include individual health care providers including physicians, lead organizations or managing partners of local Health Links and management and Boards of health organizations within local Health Links, particularly smaller community based organizations such as community health

centres, community support service organization, community care access centres and family health teams.

For Health Links, 'standing on the bridge' means building strong relationships and then working in formal teams that include representatives from both doers and helper organizations. As Health Links move from planning to implementation, it's seems critical that helpers not "withdraw" or "crossover". While the TC LHIN has been engaged and active during sector planning, this framework would suggest TC LHIN stay actively engaged with Health Links during the stages of implementation, operation, and evaluation. Similarly, this framework also suggests that while the MOHLTC and LHINs provide support and possible solutions for Health Links, it not "crossover" into operational management or control of the Health Links or impede their ability to meet local needs.

Building forums for doers and helpers to work together in formal teams will be critical to future success of Health Links. Examples of teams that currently meet on the bridge in the TC LHIN include the current monthly Cross Link forums for Early Adopters Health Links attended by LHIN staff and Health Link teams. Another example of information sharing on the bridge was the Early Adopter Day held by the Ministry attended by the MOHLTC, LHINs and Health Link leads from across the province. Joint TC LHIN and Health Link working groups are being considered to address such issues as technology or e health projects and performance measurement and monitoring.

The accountability for "bridging" might also be formally integrated into key project roles. Responsibility for 'bridging' has been formally assigned to TC LHIN roles such as the TC LHIN Health Link Lead, primary care outreach roles in diabetes and physicians advisors. At the Health Link level, responsibility for bridging can be assigned to roles within the lead organization or managing partner including physician ambassadors, project directors and managers.

Bridging can also be formally incorporated into key processes or functions of Health Links development. Currently, bridging models were used in sector planning of the TC LHIN for Mental Health and Addictions Services as well as Community Support Services. This will ensure that sector changes required to integrate with Health Links are designed with expertise from both doers and helpers.

Developing Skills of Doers and Helpers in Health Links

Bridging will require both doers and helper in the project to learn together and apply new skills effectively within Health Links – a complex adaptive system. What then are the skills and approaches needed to be successful in health redesign and integration in the form of Health Links implementation? Some of these skills include dialogue, systems thinking, building relationships and mutual trust, and creating a mental model for change.

Dialogue and Listening

Creating meaningful change in complex environments requires the skill of listening and engaging in dialogue. Creating an environment for "dialogue" is cited in the literature as a core competency for creating meaningful change in complex environments[16]

Dialogue is a stream of meaning or discussion flowing through a group out of which flows new meaning or understanding[17] . Creating shared meaning is the "glue or cement" that will hold doers and helpers together and allow change to evolve or emerge.

Often team meetings in healthcare allow for discussion and debate, as opposed to dialogue. In a discussion, the group presents different viewpoints for the purpose of analysis and breaking up ideas to come to a dominant viewpoint or conclusion. In true dialogue, the prevailing spirit is that "everybody wins if anybody wins" – there is no attempt to have an individual or dominant viewpoint prevail. The outcome of dialogue is aimed at airing an entire thought process and collectively changing the way the thought process occurs. In dialogue, the aim is to gain new insights or perspective about a process or issue, not necessarily to make decisions or change in the immediate term.[18]

As far back as early 1900s, Mary Parker Follett pointed out three ways to deal with dispute or conflict – 1) domination – one side "wins" over the other; 2) compromise – each side gives up a little to have peace; or 3) integration – a solution in which neither side has to sacrifices anything. Parker Bowles says integration involves 'invention' – not letting one's thinking stay within the boundaries of two alternatives which are mutually exclusive. In other words, finding or developing a 'third way'. [19]

Dialogue is based on the assumption that all humans have an untapped wealth of knowledge and experience. "Hosting" dialogue activates the collective intelligence of doers and helpers to find new approaches and ways to respond to the increasing challenges in health care today. The purpose is to activate collective intelligence, to use diversity within the group to transform conflict/divergence into collective clarity and wise action moving forward.

Dialogue often requires developing a common language and practicing the art of listening to others – taking in, asking insightful and meaningful questions, providing a framework for thought, as opposed to giving advice or stating opinions.

For doers and helpers in Health Links, to enter into dialogue means *letting go* of one's expertise and experience and *letting in* the words and thoughts of others to create new meaning to a topic or question. It is very much based on coming to the table with an open mind and respect for the diverse benefits brought by both doers and helpers, as well as by the multiple perspectives of professional disciplines and patients/community members.

Systems Thinking and Building Relationships

Understanding and managing the connections or relationships within and between parts of a health system will be of paramount importance for both doers and helpers to work effectively in complex systems.

The focus within complex system is recognizing the interdependence and connections that need to be fostered to change or transform a system. Even small changes within complex systems can have a disproportionate or non linear impact. This means that any action taken needs to be carefully thought through and examined with respect to impact – both anticipated and unanticipated.

In working within complex systems, harnessing the power of relationships will be critical to achieve and sustain change over time. Transformational work will occur through positive relationships with a system – shared purpose, shared goals, shared knowledge and mutual respect for one another [20]

Often from a traditional management mind set, people within a system are seen as individuals who are a means to an end. Management often ceases to consider relationships or put much effort into building solid relationships unless people were performing a task. However, in Health Links, taking time to understand and appreciate individual, professional, organizational and team relationships will be of paramount importance to understand the complexity of the system. Rather than merely focussing on

immediate tasks, Health Link teams will need time to build relationships, particularly between doers and helpers.

From a complexity theory perspective, Health Link teams must embrace systems thinking to closely observe the relationships within health system sectors and examine the impact of changing these relationships. In Health Link teams, both doers and helpers need to grasp the patterns and interrelationships within the present health system and to envision how these relationships might be altered. What is the strange attractor that might unleash change? What are the unintended consequences of relationship changes? With this deeper understanding, when individual Health Links initiate their initiatives and design, it will unleash action based on wisdom from both insiders (doers) and outsiders (helpers).

The relationship between doers and helpers, if harnessed, can provide mutual benefits to the change process required in Health Links. Helpers can serve as a calming presence for local Health Links providing options, expertise and experience required to solve local problems. While the LHIN and other helper organizations will not necessarily provide "answers", they can serve as a sounding board to discuss options and the path forward rather than offering opinions or even imposing a solution. Doers, on the other hand, can serve to "keep things real" providing options, expertise and experience on what will be most effective in the local context – a context sometime not fully understood and often overlooked by outsiders. This is particularly true for engaged patients, caregivers and community members within the doer teams.

If positive relationships are not fostered between doers and helpers, doer organizations may become mired in local relationships and lack the political will to move past what exists to build new relationships with helpers or change existing relationships within their local communities. Helper organizations may not recognize the strength of existing relationships within local communities and how these relationships can be harnessed to initiate and sustain change.

In sum, in order to embark on this difficult and complex journey, doers and helpers need to build a solid platform to sustain positive working relationship over time. Creating shared purpose and a genuine feeling of connectedness and relationship will result in the mutual support and trust required to initiate and sustain change. Gradually, as teams and individuals understand the true nature of relationships, they can develop trust in one another and an appreciation of the mutually beneficial roles played by doers and helpers.

Mental Models

Greater understanding of one's mental model leads one to a more complete view of oneself, one's environment and helps develop understanding of the mental model of others in order to embrace change and transformation.

Our mental model is made up of our values, beliefs, assumptions, attitudes and experiences. Each person's mental model, consciously or unconsciously, influences their ability to be open and adapt to change. Many health managers and health care providers, trained in the sciences, have developed a "can do" or "right/wrong" mental model which focuses on achievement of tangible goals and solving problems within an acceptable range of solutions. From this perspective, the health care system is viewed as a broken machine with problems to be fixed. In this context, health teams often search for "right answers" to solve immediate problems.

One could view the health system as a series of problems to be fixed or one big daunting problem. Health Links could approach their mandate from this perspective. However, in Health Links, creating an environment built on "finding an answer" may drown out the important conversations and new voices that could lead to new paradigms and radically different paths forward.

In Health Links, doers and helpers will need to embrace a mental model that is framed by inquiry, not certainty. To be successful, Health Links must learn to embrace and encourage multiple perspectives and paradox[21] . As a major health system transformation, both doers and helpers within the Health Link project need to recognize there will be no right way. For helpers, this will mean adapting proposed solutions to local conditions and responding with approaches relevant to that specific situation.[22] It may even require abandoning known solutions to allow a new path forward. For doers, this will mean being open to the solutions proposed and the supports being offered by exogenous helpers and welcoming them into local Health Links. It may even required putting aside ideal local solutions to embrace less ideal solutions for the greater good of the public being served.

Conclusion

A collaborative mindset does not involve managing people as much as managing relationships among people in teams and projects, as well as across divisions and formal alliances. For managers and leaders, this means moving away from more traditional forms of heroic management and moving toward engaged management.

To work collaboratively also requires an understanding of the important relationship between "doers and helpers". The framework developed by Mintzberg and Srinivas is useful in highlighting the unique perspectives that underlies the work of doers and helpers and provides some possible ways in which doers and helpers can effectively work together – on the bridge. This framework can be applied to the Health Link initiative in the Province of Ontario.

To be successful, Health Links in Ontario require a 'collaborative mindset' to achieve goals. The project involves both doers – local Health Link communities and patients, organizations, and providers – as well as helpers – the MOHLTC, LHINS and professional association and advocacy groups.

By understanding the principles of engaged management and the relationships between doers and helpers in health system development and laterally, through skills development appropriate for complex adaptive systems, Health Link teams, including doers and helpers, can become more thoughtful and effective in taking appropriate actions within their local health systems.

Health Links need to "meet on the bridge" where the needs of the local community can be addressed by the adapting the expertise and solutions offered by regional and provincial helpers.

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[1] Mintzberg, Henry and Jonathan Gosling, "The Five Minds of a Manager," *Harvard Business Review* (November, 2003): Reprint ROC11C pp. 5-6.

[2] Ibid.

[3] Ibid.

[4] Ibid.

[5] Mintzberg, Henry and Nidhi Srinivas. "Juxtaposing doers and helpers in development". Oxford University Press and Community Development Journal. 2009.

[6] Ibid.

[7] Ibid.

[8] Dr. Henry Mintzberg ppresentation on "Organizing" to IMHL class at McGill University. June, 2012.

[9] Mintzberg, Henry and Nidhi Srinivas. "Juxtaposing doers and helpers in development". Oxford University Press and Community Development Journal. 2009.

[10] Ibid.

[11] Health Links Backgrounder. Toronto Central Local Health Integration Network website. 2013.

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[13] Mintzberg, Henry and Nidhi Srinivas. "Juxtaposing doers and helpers in development". Oxford University Press and Community Development Journal. 2009.

[1414] Ibid.

[15] Ibid.

[16] Theory U: Leading from the Future as It Emerges. C. Otto Scharmer. Foreward by Peter Senge. Berrett-Koehler Publishers. 2009; Source: The Inner Path of Knowledge Creation; Joseph Jaworski. Berrett-Koehler Publishers, 2012.; Parker Palmer, *Let your Life Speak, Listening for the Voice of Vocation, (John Wiley and Sons, 2000);* Boehm, David. *On Dialogue*. New York, New York: Routledge, 1996.

[17] Boehm, David. *On Dialogue*. New York, New York: Routledge, 1996. pp. 6-7.

[18] Ibid.

[19] Parker Follett, Mary. Dynamic Administration. H.C. Metcalf and L. Urwick, eds. New York: Harper and row. 1940.

[20] Hoffer Gittell, Jody. *Health Performance Healthcare: Using the Power of Relationships to Achieve Quality, Efficiency and Resilience.* McGraw Hill USA. 2009.

[21] Westley, Frances, Brenda Zimmerman and Michael Quinn Patton. *Getting to Maybe*. Random House Canada. 2006. pp 21 and 22.

[22] Mintzberg, Henry and Jonathan Gosling, "The Five Minds of a Manager," *Harvard Business Review* (November, 2003): Reprint ROC11C pp. 5-6.