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Building Capacity: A Cycle of Change for a Non-Profit Clinical Service Organization

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WESTERN UNIVERSITY

Building Capacity: A Cycle of Change for a Non-Profit Clinical Service Organization

by

Sarah L. Drexler

AN ORGANIZATIONAL IMPROVEMENT PLAN

SUBMITTED TO THE SCHOOL OF GRADUATE AND POSTDOCTORAL STUDIES

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Abstract

Families of children with intellectual and developmental disabilities (IDD) need clinical behavioural services. A lack of capacity within non-profit agencies results in children and families often waiting for long periods of time to receive services. This Organizational Improvement Plan (OIP) aims to address a Problem of Practice (POP), namely, a lack of capacity within a clinical service agency to provide sufficient behavioural support to the number of children with IDD in its service area. The OIP includes an examination of the organizational context, factors influencing wait times for service, and the organization's ability to implement change. Multiple solutions to address the POP are considered, highlighting the need to address organizational culture and ensure that evidence-based services are being utilized. The use of transformational and distributed leadership, supported by the concurrent implementation of Kotter's (1996) and Lewin's (1947) change path models provides leaders of this service agency with a framework to enact change. This OIP recognizes that political ideologies are subject to change, and will have a strong influence on an agency's capacity to provide service. Through this OIP, a process will be developed to build capacity from within an organization with limited resources in order to provide more families and children with needed behavioural service, and respond to environmental change.

Key Words: intellectual and developmental disability, service delivery capacity, organizational culture, evidence-based practice, distributed leadership, transformational leadership, non-profit agency

Executive Summary

Background and Purpose

Champion Branch (CB) is a non-profit organization providing clinical services to children with intellectual and developmental disabilities (IDD). This Organizational Improvement Plan (OIP) examines methods of changing the culture and model of service delivery to increase service delivery capacity, decrease the wait times, and prepare for future change. CB is a traditional organization, hierarchically structured, and exhibits both conservative and liberal tenets. Leaders employ a variety of leadership models including situational, transactional, and transformational. The problem of practice (POP) addressed is the lack of service delivery capacity of a clinical service organization for children with intellectual and developmental disabilities (IDD). Currently, over 400 children are waiting for services, the waitlist having increased in four of the last five years. In 2018, the number of children receiving services, and the number of cases closed, both reduced from 2017. This trend will only continue.

Change Vision

CB's vision is to increase the quality of life for children with IDD by providing clinical support to ensure that children with IDD and their families have access to high quality clinical services. CB shares a social constructivist and disability lens with other agencies within the disability and educational sectors, and is focused on increasing social inclusion for children with IDD, enhancing their ability to fully participate in school and community.

The POP is framed using recognized models, primarily Bolman and Deal's (2013) organizational frames with a focus on human resources. The Congruence model (Nadler & Tushman, 1989) is used as a supplemental guide to frame the POP. A PESTE analysis outlines the political, economic, structural, technological and environmental factors. A gap analysis, using the Beckhard and Harris framework (1987), contrasts the current state with the preferred

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future state, namely one in which clinicians have the capacity to provide a greater volume of service, are meeting the needs of children and families, and the organization has developed a mechanism for adapting to continuous change. This led to the development of five priorities for change: (1) meeting the needs of clientele; (2) fulfilling the needs of the funding source; (3) the requirements of the affiliated pediatric health clinic; (4) fostering a positive organizational climate; and (5) modifying organizational procedures to create a standard of practice.

Lewin's (1947) Three Stage Theory of Change and Kotter's (1996) Eight Step Model are presented as change frameworks to help leaders within CB facilitate the change. Lewin's (1947) three-step model provides an approach to change based on the belief that clinicians should evaluate and see the value of changing their own behaviour. Kotter's eight step model is used concurrently to provide leaders with a more detailed step by step process for implementing change. The granular steps in both models will provide structure for CB which has limited experience with change. Leaders should begin to view the process of change as a cyclical part of their ongoing leadership.

The Plan/Do/Study/Act (PDSA) model, with a successful history enabling change in healthcare environments, provides for CB a scientific methodology for evaluating procedures, demonstrating the value of the changes trialed, and increasing buy in from team members (NHS Improvement, 2018), as well as creating a culture that will promote continuous change.

Solutions

Four possible solutions are presented for CB, and the benefits and risks of each are identified. These are: (1) maintaining the status quo; (2) developing a more positive organizational culture; (3) modifying the structure of services delivered; and (4) implementing integrated service delivery teams (ISDT). The recommended solution is the creation of both a

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positive culture and modifying the structure of services. Together the solutions offer the greatest immediate leverage to increase capacity, reduce wait times, and maintain service quality.

Change Plan

The OIP includes a comprehensive change implementation plan, identifying key roles, leadership tasks, and specific assignments. A number of change leadership roles are established, including clinical service leaders (CSL). CSL's are clinicians who, on an ongoing basis, will own the new evidence-based structured services; providing deep clinical expertise, distributing clinical leadership, and offering a career development role for clinicians. All organizational members will have a documented change role. There is a twelve month change plan, including 90-day checkpoints. Evaluation of the changes will be measured on progress against core baseline measurements including duration of service, cases closed, wait list metrics, and service quality. Recognized tools for evaluating the quality of behavior support plans, leadership effectiveness, and culture change will be implemented. Communication plans are internal and external throughout, formal, informal, and multi directional. Formal and informal recognition is a priority. Also identified are future change cycle opportunities which include an Integrated Service Delivery Team (ISDT) model and streamlined clinical supervision.

Summary

Implementation of this OIP could increase CB's effectiveness, increasing its service delivery capacity, and improving its employee retention and morale. Implementation also creates opportunities to integrate additional new service delivery innovations and to respond to changes in its external environment. This will allow CB to increase value to its clients, differentiate CB in its field, establish CB as a leader in its field, and enable its partners as well as other agencies to leverage these changes, all for the good of the clients and stakeholders they serve.

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Acronyms

BACB:	Behaviour Analyst Certification Board
BCBA:	Board Certified Behaviour Analyst
CB:	Champion Branch, pseudonym for the organization
CSL:	Clinical Service Leader
EBSS:	Evidence Based Structured Services
IDD:	Intellectual and developmental disabilities
ISDM:	Integrated Service Delivery Model
ISDT:	Integrated Service Delivery Teams
OCAI:	Organizational culture assessment instrument
OCAT:	Organizational capacity assessment tool
OIP:	Organizational Improvement Plan
PESTE:	Political, economic, social, technological, environmental analysis
PDSA:	Plan Do Study Act Model
POP:	Problem of Practice

Chapter 1: Introduction and Problem

Chapter 1 Introduction

This organizational improvement plan introduces the context of Champion Branch (CB) (a pseudonym), a mid-sized non-profit organization in Eastern Canada. The mission, vision, values, and goals for the organization will be outlined. The structure of the organization and key stakeholders will be identified. Chapter 1 outlines a leadership problem of practice (POP) that is occurring within CB and examines the factors framing and influencing the problem.

CB is a non-profit organization that provides clinical services to children with intellectual and developmental disabilities (IDD). CB employs over 50 people and provides services to children and families across approximately 15 regions. Roughly 30 of these employees provide clinical behavioural support. CB is affiliated with a large publicly funded pediatric health clinic. In addition to specialized health care, this clinic provides children with interdisciplinary clinical services, such as speech and language pathology, mental health services, physiotherapy, occupational therapy and behaviour therapy.

Organizational Context

The vision of CB is to increase the quality of life for children with IDD by providing clinical support (Champion Branch, 2016). CB's mission ensures that children with IDD, their families and other community agencies have access to high quality clinical services (Champion Branch, 2016). CB utilizes a consulting model whereby clinicians provide behaviour assessments and recommendations for children and their families, and to other service agencies who also provide support. CB strives to provide services that are outcome-based, utilizing evidence-based practices. Outcome-based services focus on observable gains for children who are receiving

services. For example, outcomes might include a child demonstrating new social skills or there may be a decrease in the frequency of physical aggression displayed by the child.

Clinicians exemplify the values of the organization, exhibiting passion for their role as well as great compassion, care, and ethics. CB's service model focuses on outpatient services, ensuring that clinical services are accessible to everyone within their catchment area. CB prides itself on ensuring that its clinicians are always as responsive to the needs of the client, family and community agencies as possible (Champion Branch, 2016).

Children with IDD and their families require a wide variety of clinical services, such as behaviour, occupational, and speech therapies. CB aims to provide high quality evidence-based services to decrease a child's need to engage in challenging behaviour, teach adaptive skills, and increase the quality of life for the child. While the foremost priority of CB is to provide high quality behavioural consultation, adjunct services are also available, including: dual diagnosis nursing; occupational therapy; and speech and language therapy. Additionally, CB strives to increase the capacity of families, educators and other service providers to respond to challenging behaviour and to teach the children new skills to help them attain greater independence and growth (Champion Branch, 2016).

Organizational structure and Leadership Approaches

CB has a hierarchical structure. Formal authority is assigned within CB by the executive director as well as the human resources department and leadership within the affiliated pediatric health clinic. CB has a senior management team, consisting of the executive director and clinical managers. Currently, all changes to procedures and policies are evaluated and formalized by the senior management team (Guttek, 1997).

The executive director and clinical managers incorporate traits from a variety of leadership models including transactional, situational and transformational approaches. The clinical managers also describe the organization as utilizing a collaborative leadership model, believing in the importance of soliciting feedback from organizational members, creating trust and empowering organizational. These beliefs are associated with collaborative and transformational leadership (Hurley, 2011; Northouse, 2018). While the senior leadership team promotes the use of these approaches, leader behaviour does not always reflect them. Leaders within CB often use positional power as they hold formal authority, maintain control of information, and allocate resources as they believe necessary. While leaders within CB will listen to the ideas of organizational members, collaborative leadership involves proactive encouragement to share ideas and brainstorm solutions (Hurley, 2011).

The primary role of a clinical manager is to provide first line supervision within the organization, ensuring that clinicians are fulfilling their roles and responsibilities in order for CB to be effective and efficient. This can lead to clinical managers utilizing transactional leadership when working with the clinicians, using a manage by exception approach and only intervening and providing guidance when correction is visibly needed (Bass, 1990; Northouse, 2018). The use of transactional leadership combined with the structure of the organization creates a hierarchical culture of leadership. This culture is promoted through the expectation that clinicians will follow standard procedures. Leadership often focuses on increasing efficiency, predictability and optimizing resources used to provide services (Cameron & Quinn, 2006).

While the structure of CB lends itself to the use of transactional leadership, some of the clinical managers do implement characteristics of transformational leadership. For example, some work with the clinicians to determine their personal goals and seek to collaborate with

them towards the goals of the organization (Yang, 2016). Situational leadership is demonstrated within the organization, as clinical managers modify their managerial style and the type or quantity of support that they offer to clinicians based on individual circumstances (McCleskey, 2014; Northouse, 2018). Additionally, distributed leadership is evident within the use of working groups and committees, which share responsibility for the development of new procedures (Avolio, Walumbwa, and Weber, 2009). However, work from all committees is brought to the senior management team for feedback and approval.

Political, Economic, Social and Cultural Context

The current political climate within CB includes tenets from both conservative and liberal cultures. Conservative cultures are illustrated by the strong hierarchical structure, as each organizational member has an assigned role (Guttek, 1997). Liberal organizational cultures are intertwined, incorporating horizontal decision making, peer coaching, and development of organizational members (Salancik & Pfeffer, 1974). Examples at CB of this liberal ideology include clinicians having autonomy to determine the types and amounts of services they provide clients. Committees and working groups have also been used to allow the clinicians to collaborate in organizational processes and topics such as accreditation, delivery of community skill development, and ethical practice (Raven, 2005).

CB is a non-profit organization, receiving public funding. The affiliated pediatric health clinic acts as a means of transferring funds from the provincial government to CB. Each year, CB receives an annualized budget in which to provide its services. In order to receive fiscal resources, CB provides the government department with statistics regarding number of children and families receiving services. Additional funding may be provided to the agency as a one-time resource, based on the priorities of the government. As an example, additional funding may be

given to provide additional consulting to families whose children have just received a diagnosis of Autism Spectrum Disorder (ASD). Services delivered by CB fall into the category of social services, which is funded by the provincial government. Funding for services such as behavioural supports offered by CB is dependent on the priorities of the provincial government. As government ideologies shift, changes in the funding structure are possible for organizations such as CB. The processes outlined in this OIP will assist CB with navigating these possible changes.

Organizational Culture and Climate

Organizational culture is defined as a combination of ideas, practices, attitudes, and beliefs within a workplace (Edelman, 2011; Bolman & Deal, 2013). The culture is impacted by the organizational structure, rules and policies also have an impact on organizational culture (Edelman, 2011). Within CB, the culture is built around shared beliefs and values regarding the promotion of children with disabilities, their ability to access the community, and their right of access to effective clinical services. The social climate of an organization is comprised of the perceptions, feelings, and behaviour of organizational members (Glisson & James, 2002). The climate within CB is influenced by the organizational members feelings and perceptions of leadership and the organizational culture both impacts and is impacted by the social climate within the organization, which in turn influences work performance and service delivery. As depicted in Appendix A, the organizational culture and climate impact the quality of services provided to children and families, as well as the likelihood for clinicians to implement evidence-based practice and fulfill all aspects of their role (Glisson, 2002).

The described organizational culture within CB places a strong emphasis on hierarchy and structure. Within CB all clinicians are expected to follow standard procedures. Leadership

often focuses on increasing efficiency, predictability, and ability to serve as many children as possible (Cameron & Quinn, 2006). In addition to the emphasis on structure, some managers within CB attempt to build a culture that nurtures employees, increases interpersonal skills, and building strong relationships with clinicians (Cameron & Quinn, 2006). For example, a clinical manager may work with a clinician to help develop a plan for self-care or provide positive feedback on the value of a clinician's clinical skillset.

According to Glisson (2002), organizational culture impacts the perceptions of individuals within the organization, and overall social context. Factors impacting the social context within CB include the interpersonal relationships within the organization, interactions between different hierarchies within the organization, relationships with other service agencies, and clinicians' motivation and attitudes about their work (Glisson, 2002; Grojean, Resick, Dickson, & Smith, 2004). In addition to internal factors influencing social context, CB's model of service delivery is also influenced by a social constructivist and disability theory perspective. This is illustrated by clinicians placing a strong focus on increasing social inclusion for children with IDD, enhancing their ability to fully participate school and community (Anastasiou & Kauffman, 2011; Creswell & Poth, 2018). CB shares this social constructivist and disability lens with other agencies within the disabilities services sector, schools and advocacy initiatives.

History of the Organization

The organization has a long history within community services. The care for children and adults with disabilities shifted from the prior medical treatment model to a community integration model in the 1990s. The focus has transitioned from fixing or curing the child to increasing their ability to participate in recreational and community activities (King et al., 2002). CB was developed in the late 1990s, as a means for providing the clinical support needed by

children with IDD and families to gain the skills necessary to integrate into communities, schools, and recreational programs (Champion Branch, 2015). These clinical services can help increase a child's ability to participate in their communities and schools by teaching new skills and by decreasing the child's need to engage in challenging behaviour.

In summary, CB is a clinical service provider with a long history of providing services to families of children with IDD. The organization holds a hierarchical structure and is led using a variety of leadership approaches. The following section outlines the author's scope and agency within the organization as well as personal perspectives on leadership theories.

Leadership Position and Lens Statement

The following section outlines the author's position within CB and reviews the scope, agency and power associated with that position. Personal perspectives on leadership methods and approaches will also be addressed. Additionally, potential biases of the author are examined to determine the impact they may have on this OIP.

Personal Position. As a behavioural clinician within CB, I provide behavioural support to children, families, and other community organizations. Included within this role is to provide education and skill development to other service providers. I have also become an emergent leader by providing education, support, and peer clinical feedback to other clinicians who also provide behavioural support (Northouse, 2018). Further, I am an active member of internal committees focusing on evaluating service delivery, overcoming barriers to providing service, and decreasing wait times.

While my role is not a position that holds assigned organizational authority, I am able to enact change within my current caseload and influence change throughout the organization. The Director of CB has approved the development of this OIP and has delegated to me, the

development of a change implementation plan that can be utilized by the entire organization. Therefore, it is within my scope and agency to develop an OIP including a detailed change implementation plan for the purposes of moving change forward. The change plan will be presented with the support of, and in collaboration with the Director and will be evaluated to determine the validity of the OIP within the context of the organization for possible implementation.

Leadership Values. Throughout my educational pursuits and my employment within CB, I have been able to identify leadership traits and characteristics which hold a strong value to me. These values include trust between leadership and clinicians, transparency within CB, collaboration amongst all organizational members, and empowerment of clinicians (Grojean et al., 2004). Transparency within CB is crucial for developing a trust between leaders and clinicians (Detert & Burris, 2007; Yang, 2016). Leaders need to utilize effective interpersonal skills to effectively collaborate with clinicians to meet the goals of their organization. In order to be an effective leader, one must have strong interpersonal skills, build strong trusting relationships, and share values with the people in which they are providing support and guidance (Grojean et al., 2004).

Leadership as a process. Emergent leaders are members of an organization who are viewed by others as holding leadership skills that others value, including transparency and trust. Emergent leaders may have influence over other organizational members based on the relationship developed between them and history of positive work contributions (Yoo & Alavi, 2004; Northouse, 2018). As an emergent leader, I have begun to view leadership as an ongoing process which includes the professional and personal growth of both leaders and followers. The leadership process is comprised of four main factors which influence one another, and impact

organizational outcomes (Fischer & Antonakis, 2017). From my perspective, these factors include leadership skills, environmental factors, leadership behaviour, and follower behaviour. These factors work together to contribute to leadership outcomes.

Leadership Skills. The skills a leader holds and their skill deficits impact how the leader responds to environmental factors that arise within CB (Fischer & Antonakis, 2017). Examples of valuable leadership skills include problem solving, interpersonal skills, and the ability to think critically.

Environmental Factors. Leaders must be flexible and maintain the ability to adapt to environmental changes impacting CB (Fischer & Antonakis, 2017; Northouse, 2018). For example, environmental factors may include funding changes, the changing needs of clients, changes in the direction of the affiliated pediatric clinic, and the changing needs of followers.

Leader Behaviour. Leader behaviour describes any action a leader takes in order in order to meet organizational goals, and can be either positive or negative (Fischer & Antonakis, 2017; Northouse, 2018). Examples of positive leader behaviour within CB include collaborating with and mentoring clinicians, providing coaching through work related tasks, providing constructive feedback, soliciting the opinions of clinicians, and ensuring transparency within CB (Detert & Burris, 2007). Some examples of negative leader behaviours include: little to no collaboration with clinicians, not eliciting feedback from clinicians, a lack of appreciation for clinician's work and commitment, and the use of coercive power (Detert & Burris, 2007; Northouse, 2018).

Follower Behaviour. Follower behaviour describes any action a clinician engages in to fulfil their role and enact change within an organization. A clinician's

behaviour may be affected by the actual behaviour of the leader, or based on an anticipation of what future leader behaviour may be (Detert & Burris, 2007). Examples of positive follower behaviours include increased productivity and efficiency with work tasks, taking initiative outside of assigned roles, providing peer support to other clinicians, and compliance with CB policies. Examples of negative follower behaviours include negative talk amongst clinicians, resistance to implementing procedural change, decrease in work productivity, and lack of collaboration (Gleeson, 2002).

Leadership outcomes. Leadership outcomes refer to the consequences that occur as a result of the leadership skills, operating environment, and the leader follower relationship and behaviors, and ultimately the behavior of the entire team. An example of a leadership outcome within CB would be the creation of a new policy through collaboration of a leader and a group of clinicians. The relationship between leaders and followers as well as the behaviour of both has an impact on whether or not leadership outcomes will be considered positive (Detert & Burris, 2007). If the leader views the leadership outcomes as positive, they will be more likely to use the same leadership behaviours in the future (Gleeson, 2002; Detert & Burris, 2007). Appendix B illustrates the relationship between the four factors and leadership outcomes, a process developed for the purposes of this OIP, and it has been revised throughout the OIP writing process.

Personal Leadership Lens and Bias

A critical part of the change process is for leaders and change agents to identify perspectives in which they view the POP, and bias that may impact the change process (Cawsey, Deszca, & Ingols, 2016). The section below describes my bias when acting as a change agent. A combination of my education in applied disability studies and my experience within community

services and the developmental services sector influence how I view the POP and CB as a whole. I view CB through Social Constructivist, Advocacy and Disability lenses (Creswell & Poth, 2018). Disability Theory suggests the need for change within CB to further increase focus on the inclusion of people with disabilities into community and public institutions such as schools and workplaces (Creswell & Poth, 2018). Focus needs to be placed on improving the quality of services and increasing the quality of life for children with IDD. Advocacy theory would suggest that a strong emphasis should be placed on changing CB's organizational practices to provide better support and advocate for marginalized people (Creswell & Poth, 2018).

Throughout the OIP, the evaluation of factors influencing the POP as well as recommended solutions will be considered through a Social Constructivist point of view. Social Constructionist perspectives believe that social and interpersonal factors influence human life (Oliver, 1998; Galbin, 2014). People should not make assumptions about the nature or cause of things within human life. Focus should be placed on the complexities of people and the environment around them (Galbin, 2014). According to Galbin (2014), social constructionism is exemplified when people challenge their beliefs and create new frameworks for addressing problems within society. Within CB, the utilization of Social Constructionist theory would eliminate viewing a person with a disability as a commodity, aligning the goals of CB to balance the promotion of organizational efficiency with the need to enhance the lives of children with disabilities (Oliver, 1998; Galbin, 2014).

My assigned position within the organization may bias my evaluations of CB. As an internal member of the organization, I hold personal relationships with the senior leaders and have observed the change process regarding other challenges. Prior opinions and views on other policies and changes, organizational culture and job satisfaction influence employees within an

organization (Gover & Duxbury, 2018). The experiences that I have had while employed within CB will likely influence the evaluation of factors contributing to the POP and potential recommendations for change. Throughout the OIP process, I will attempt to mitigate these biases by examining the organization through existing political frames and making recommendations for change based on pre-existing change frameworks.

Within this section, the scope, agency and bias of the author was presented. The author acts as an informal leader, valuing trust, transparency, and open communication. The author's leadership philosophy is presented, identifying leadership as a process where leadership skills, environmental factors, leadership behaviour, and follower behaviour impact one another and contribute to organizational outcomes. The next section describes a POP within CB that will be addressed throughout the remainder of this OIP.

Leadership Problem of Practice

The POP that will be addressed is a lack of sufficient service delivery capacity within a clinical service organization for children with intellectual and developmental disabilities (IDD). This leadership POP is the result of gaps within in the current organizational state and organizational practices. According to Bryan (2011) organizational capacity is defined as the combination of resources within the organization and the ability of the organization to meet internal goals as well as meet the needs of stakeholders, and build relationships with other external agencies. This aligns with the process described earlier. Within CB, there is a discrepancy between organizational capacity to provide service and the number of children and families who are waiting for behavioural services

Clinicians provide outpatient support to children and families through consultation and education. CB referrals also indicate that the needs of the children with IDD have changed over

the past five years. The complexity of factors contributing to challenging behaviour is increasing for these children, resulting in longer term support from clinicians at CB (Champion Branch, 2016). In addition, as children wait for service, the rate and intensity of their challenging behaviour may increase, limiting a child's opportunity for development (Champion Branch, 2016). A lack of behavioural support for children with IDD diminishes their ability to learn the skills needed to fully participate in school and their community (Perry, 2017). According to Dube (2016) if challenging behaviour continues into adulthood for people with IDD, it can result in segregation from the community and overall decreases in the person's quality of life.

Gaps in organizational practices and the factors described above have resulted in a decrease in the number of children and families receiving service and an increase in the length of time children are waiting for service. Between 2013 and 2016, there was a 16% decrease in the number of children and families receiving services (Champion Branch, 2018). During this time, the number of children referred for behavioural services remained constant (Champion Branch, 2018), resulting in increased wait times.

The POP will be addressed within this organizational improvement plan (OIP), by investigating current culture, practices, procedures and structures within CB. Included within this OIP is an analysis of factors contributing to the POP, including impact of stakeholders on the organization. In addition to providing a deep examination of the organization, organizational leadership, and the context of the POP, this OIP will provide a vision for change. The OIP will seek to find solutions to the POP such as structural changes and modifications that could be made to the service delivery model, and leadership structure changes to increase clinician capacity and reduce overall wait times.

This section identified the POP, a lack of sufficient service delivery capacity within a clinical service organization for children with intellectual and developmental disabilities (IDD). This POP will be examined further in the following section, which provides a guide for framing the POP and viewing the problem from multiple perspectives to identify factors that influence it.

Framing the Problem of Practice

The POP has been examined using organizational factors, frames, and models. Framing the POP assists in identifying the factors influencing the problem and the current organizational context. Bolman and Deal (2013) are the primary frames utilized within this OIP. The Congruence model (Nadler & Tushman, 1989) is used as a supplemental guide to frame the POP. Additionally, the POP is framed from a social constructivist lens. This section also includes a PESTE analysis and a review of how the history of services for children with developmental disabilities contributes to the POP and hold influence over the organization.

Champion Branch Data. Internal data from CB can be used to illustrate that the CB does not have the capacity to meet the needs of all waiting for service. As seen in Appendix C, there were 478 children waiting for service from CB in the 2017/218 fiscal year. In the 2017/2018 fiscal year, CB provided clinical services to 615 children and their families. In the same year, services were ended for 138 children (Champion Branch, 2018). The number of children receiving services and the number for children whose services completed and cases were closed over the past two years is illustrated in Appendix D. This data displayed in the charts below was shared with the author by a senior leader within the organization who was supportive of this OIP study. Since the data is shared in aggregate, the confidentiality of clients is provided. In summary, over the last 5 years, the length of the wait list has remained constant, while the numbers of clients receiving service and cases closed has decreased. The development of this

OIP is based on the theory of action that if organizational capacity to provide service increases, then wait times for service will decrease.

Organizational Frames

Bolman and Deal (2013) have developed four frames leaders can utilize in preparation for making changes within an organization. While all four frames suggested by Bolman and Deal (2013) hold value for framing the POP, an emphasis will be placed on the human resources frame as it aligns with the values of the organization and my leadership philosophy. The human resources frame provides leaders with a method for investigating the needs of employees and determining what is required to meet these needs. For example, within CB, clinical supervisors should ensure there is a good alignment between the organization and clinicians, ensuring that the needs of both can be met (Bolman & Deal, 2013). Focus is placed how the organization and the clinicians can work effectively to serve one another. The human resources frame also suggests that the clinician's physical and emotional need for safety must be met within the organization (Bolman & Deal, 2013). If a clinician feels safe and secure within the organization, they will develop more positive relationships in the workplace, have increased confidence in themselves, and feel a sense of belonging within the organization (Benson & Dundis, 2013).

In addition to the human resources frame, the structural frame can also be utilized. It highlights the need to ensure clinicians are in the correct roles, determine standards of practice, and ensure that clients are receiving consistent services. The structural frame examines the roles and hierarchy within the CB to highlight limitations. The frame is also utilized to determine if structural changes can increase the efficiency and effectiveness of service delivery (Bolman & Deal, 2013).

Culture within the organization and the impact it has on clinicians will be analyzed through the symbolic frame. According to Bolman and Deal (2013) the symbolic frame evaluates rituals and ceremonies to determine their impact on the clinicians and determine if these symbols increase connectivity and commitment to the goals of the organization. Leaders would benefit from the use of this frame to evaluate the culture within CB, to identify the shared beliefs within the organization and the impact that those beliefs have on the POP. For example, CB's culture values the dissemination of clinical decision making and building capacity within the community. These values results in clinicians focussing on teaching clinical skills to families and community agencies. Leaders within CB will need to evaluate how these values influence the POP, the organization's capacity to provide service, and therefore the length of time clients are waiting for support.

The utilization of the political frame allows leaders within the organization to evaluate internal and external politics influencing the POP. Through this frame, leaders identify different opinions from clinicians, community agencies, and other stakeholders, and how they impact operating procedures. The political frame also identifies areas in which conflict negotiation needs to occur and facilitates further collaboration (Bolman & Deal, 2013).

Social Constructivist, Disability and Advocacy Lens

In addition to the frames presented by Bolman and Deal (2014), the POP should be framed through a social constructivist, advocacy and disability lens. A strong focus of disability supports is to ensure inclusion children with developmental disabilities into their communities and schools and enhancing the lives of people with disabilities (Creswell & Poth, 2018).

Leaders within CB need to evaluate how these perspectives influence the POP. For example, as children with IDD integrate into classrooms or community events, they may require more

behavioural supports. When evaluating options for solving the POP, advocacy theory should be used to identify methods to increase the quality of services provided to clients and their families. Focus should also be placed on providing improved services that increase the clients and their families' quality of life (Creswell & Path, 2018). In summary, framing the problem from these perspectives will allow leaders to identify what factors contribute to the need for behavioural support in this population and evaluate methods of service delivery that will ensure more children and families get access to high quality service.

The Congruence Model

The Congruence Model (Nadler & Tushman, 1989) assists with the analysis of CB by examining relationships between CB and factors external to the organization (Nadler & Tushman, 1989). The Congruence Model outlines components influencing an organization's ability to meet its goals. Within CB, these components include: required work tasks, work completed by CB, clinicians, senior management, an advisory board, community agencies, families of the children receiving support, policies, procedures and hierarchy of CB and the affiliated pediatric health clinic, and the culture, rituals and ceremonies within CB (Nadler & Tushman, 1989; Cawsey et al., 2016). The Congruence Model incorporates organizational inputs (external factors, resources and history of the organization) which transform during the change process to result in outputs (Nadler & Tushman, 1989; Cawsey et al., 2016). The outputs for CB would include the behavioural services provided by clinicians, goal attainment for children receiving service, satisfaction of the families, clinician satisfaction, and the development of clinician skill sets.

PESTE Analysis

Incorporated within the Nadler and Tushman Congruence Model (1989) is the PESTE analysis which examines the political, economic, social, technological and environmental factors impacting the POP (Cawsey et al., 2016). Table 1.1 summarizes the factors influencing CB, as identified through the PESTE analysis.

Table 1.1

Outline of PESTE analysis relating to POP

<i>Political</i>	<ul style="list-style-type: none"> • Political ideologies of funding sources • Affiliation of health clinic
<i>Economical</i>	<ul style="list-style-type: none"> • Limited fiscal resources (public funding source) • Resources are allocated to salary, employee expenses, education, and skill development opportunities, building costs and materials for service delivery
<i>Social</i>	<ul style="list-style-type: none"> • Varied age and gender of clinicians • Range of education and experience levels of clinician • Only 8% of clinicians are registered with the Certification Board • Recent staff turnover
<i>Technological</i>	<ul style="list-style-type: none"> • Clinicians are required to complete specific assessments however methods for completion vary • Clinicians have autonomy over the type of service children receive, impacting duration, intensity and quality of service
<i>Environmental</i>	<ul style="list-style-type: none"> • Large service area • Clinicians travelling long distances • Cultural factors may impact service delivery • Limited number of certified behavioural providers in Eastern Canada

Each of the PESTE factors, as listed in the table above, may influence the POP. These factors contribute to CB's capacity for service delivery and may be contributing to the problem.

Political. CB branch is greatly impacted by the direction provided by the provincial government. The provincial government prioritizes which families are able to receive service (Struthers, 2013). For example, a child's diagnosis, their ability to live at home and whether or not the government considers the child to be in crisis, can impact the urgency and quality of

service delivery. In addition, CB is required to follow procedures outlined by the associated pediatric health clinic. CB's mission, vision and goals must align with that of the pediatric health clinic.

Economic. There are a number of economic factors influencing the POP. Most significant is the funding provided through a department of the provincial government. This funding is subject to the priorities of current government officials (Struthers, 2013). CB's Executive Director develops an annual budget. CB is expected to reach service targets set out by the provincial department while utilizing resources within the fiscal budget. Fiscal resources are allocated specifically for salaries of employees, expenses of employees, skill development opportunities for clinicians, building costs, and materials needed to run the organization. As a result, opportunities to trade-off between expense categories are limited.

Social. Within CB, clinician demographics are varied, including age, gender and education. Clinicians' educational backgrounds range from college diplomas to Master's degrees. Some clinicians lack any formal education in behaviour analysis, but however have many years of experience providing behavioural services. Others have a higher degree of formal education but less experience. Approximately 5 of the clinicians at CB are certified through the Behaviour Analyst Certification Board. Through this board, these clinicians are required to follow a code of ethics while providing behavioural services (Behaviour Analyst Certification Board, 2017), that the other clinicians are not required to follow. In addition, there has been much recent turnover within CB, where 10 staff members have left the organization in the 2017/2018 fiscal year (Champion Branch, 2018).

Technological. Clinicians currently complete functional behaviour assessments, utilizing a biopsychosocial approach. The goal is to determine the reason why a child would be engaging

in challenging behaviour, while ensuring that all biological, psychological and social factors are evaluated (Cooper, Heron & Heward, 2007; Champion Branch, 2018). However, not all clinicians are using consistent methods of completing this assessment, recording, or analyzing data. Once assessments are completed, clinicians have a great deal of autonomy in the development of behavioural support strategies for children, families, and support staff. This results in children receiving services that differ in quality, duration and intensity.

Environmental. CB provides services to children and families over a large catchment area consisting of several regions, with both rural areas and city centres. Clinicians have to travel long distances in order to provide community-based supports. Clinicians also need to account for different cultural factors that might influence how services are provided, such as preferred language of family, number of people in the home environment or specific cultural practices that the children engage in. Culture can vary based on where the services are provided within the catchment area (Fong, Catagnus, Brodhead, Quigley & Field, 2016).

While the field of behaviour analysis is growing, provincially funded services are still limited within Canada. Currently the priority is to serve children with Autism Spectrum Disorder (ASD). These services also have long wait lists similar to Champion Branch and have strict criteria for service (Shepherd & Waddell, 2015). In 2006, 1.2 % of Canadian children were diagnosed with a chronic developmental disability (Statistics Canada, 2006). In contrast to the growing need for behavioural services, there are a limited number of certified professionals. Currently, there are 1452 clinicians registered with the Behaviour Analyst Certification Board (BACB) in Canada, with only 54 located in Eastern Canada (Behaviour Analyst Certification Board, 2019). Therefore, the limited number of behaviour clinicians certified by the BACB is a factor, but one not unique to CB.

In summary, Bolman and Deal's (2013) organizational frames, social constructivist, disability and advocacy theories and the congruence model can be used to frame the POP. A PESTE analysis is then used to identify a variety of factors contributing to the problem. The following section identifies questions that may emerge when evaluating the POP, developing solutions and implementing a change process.

Questions Emerging from the Problem of Practice

Questions will guide the process of planning change, identify additional challenges to implementation and lead to areas of further evaluation for CB. Throughout the change process, many questions will arise, guiding the change that leaders will need to consider. These questions are organized into three categories: (1) prior to the change process; (2) during the change process; and (3) the evaluation of the change process. Each of these categories has been separated into a series of sub-questions. The questions leaders will need to consider during each stage of the change process are summarized below in Table 1.2.

Table 1.2

Summary of Questions Guiding the Change Process

Prior to the Change	Why does change need to occur? What is the preferred result of organizational change? What are the variables influencing the POP? Who are the stakeholders involved and what influence do they hold? Is the organization ready for change? Does CB have enough resources to operate and to enact change? What mechanisms will be in place to ensure adequate communication?
During the Change	Who is responsible for managing the change process? What aspects of the change process are going to be monitored? Who will monitor the change process as it progresses? What is the mechanism for providing feedback during the change?
Evaluation of the Change	How will CB determine if the goals for change were met? What methods of evaluation will be used? How can large goals be broken into smaller steps?

Prior to the Change Process. When evaluating potential solutions for the POP, leaders must identify the key influencing variables. As identified in the PESTE analysis above, there are a variety of factors impacting CB's ability to provide behavioural service to those on the waiting list (Cawsey et al., 2016). Leaders should be continually asking: what factors are influencing CB's capacity to provide behavioural support? More in-depth analysis should occur regarding stakeholders. Who are the stakeholders influencing CB? In what area do these stakeholders hold influence? In preparing for change, leaders must evaluate organizational readiness. Evaluation of organization climate should be considered. Will the climate within CB influence readiness for change? Prior to the change process, leaders within CB will need to identify if the organizational members have the skill sets necessary to absorb change. Do leaders have the required skills to act as change agents? Are clinicians equipped with the necessary education and skills to enact the change? What can be done to increase organizational readiness?

In order to successfully implement change, leaders should collaborate with clinicians to establish why change is needed and what areas of the organization should be modified. People often have differing opinions on change, and leaders should work with clinicians to answer the following questions. Why does transformation need to occur within CB? What should the change goals be for CB? What would staff, clinicians and leaders like to see as the change outcomes for CB? Collaborating to answer these questions will help to promote the need for change within CB and decrease resistance from clinicians (Ackerman-Anderson & Anderson, 2010).

In addition to determining organizational readiness, leaders within CB should determine the urgency for change (Ackerman-Anderson, 2010). How quickly does the change need to be enacted? Are there variables influencing when the change needs to occur? What are the impacts of continuing the status quo? Once a level of urgency has been established, leaders can create a

realistic timeline for change. Leaders will also need to evaluate if CB has resources available to change in addition to the resources needed for regular operations (Ackerman-Anderson, 2010).

During the Change Process. There are also a variety of questions that leaders will need to consider during the change process. Who will oversee the change process? What parts of the change process are going to be observed, and monitored? What are the mechanisms in place for organizational members to provide feedback during the change process?

Leaders will need to identify whose role it is to monitor change as CB is undergoing change. Additionally, leaders will need to determine what communication mechanisms should be put in place throughout the change process. Leaders should also be engaging in critical inquiry regarding evaluation of the change process. What are the intended goals of organizational change? How will CB evaluate whether or not they have met these goals?

Evaluation of the Change Process. Investigation needs to determine types of measurement and data that should be collected. Is it possible to evaluate interim goals that lead to the overall goals of the change process? Evaluating the change process and determining small gains within the organization will help to maintain buy-in from clinicians (Cawsey et al., 2016). Leaders will also need to identify who is involved with the decision-making process, if evaluation during the change process indicates the need for revisions or modifications to the change plan (Cawsey et al., 2016).

While there are a variety of questions to be answered, it is important to recognize that leaders may not be able to address all of these questions within one OIP cycle. After the change process, leaders will need to evaluate the guiding questions, determine which ones have been answered and use both answered, and the unanswered questions to guide future cycles of change.

Leadership Focused Vision for Change

Gap between Present and Future State. The vision of CB is to increase quality of life for children with IDD and their families through the provision of clinical services. Currently over 400 people are waiting to access behavioural services at CB, and the number of people on the list is not reducing (Champion Branch, 2018). The future state of the organization is one in which clinicians have the capacity to provide a greater volume of service, provide service more efficiently and meet the needs of children and families. While changes may occur within CB, the future state will still promote high quality evidence-based services. CB will continue to utilize a synthesis of liberal and conservative tenets. Additional conservative tenets may need to be embedded to create a standard of practice and set procedures. The future state of the organization will ensure children and families are receiving adequate, and uniform support (Gutek, 1997). Liberal tenets will still be intertwined as the individual needs of children and families are being met by clinicians (Raven, 2005). However, the specific services offered will be based on results of standard measurement tools and evaluation procedures.

It is recommended that leaders use the Organizational Culture and Assessment Instrument (OCAI). This tool will assist leaders to determine the current cultural state within CB and to identify a preferred future cultural state. The OCAI evaluates characteristics of current organizational culture and the values under which CB is operating (Cameron & Quinn, 2006), and identifies areas for growth and change. To meet CB's vision, leaders will need to foster an organizational culture that balances these conservative tenets with interpersonal relationships, employee mentoring, and collaboration (Gutek, 1997; Cameron & Quinn, 2006)

Priorities for Change. When planning for change, leaders within CB will need to identify their change priorities. Within CB there are five main priorities for organizational

change: (1) meeting the needs of clientele; (2) fulfilling needs of funding source; (3) meeting requirements of affiliated pediatric health clinic; (4) fostering a positive organizational climate; and (5) modifying organizational procedures to create a standard of practice.

The first and overarching priority of CB is to meet the clinical needs of children with IDD. For example, the first priority of a clinician within CB is to ensure that a child is receiving high quality evidence-based support. This aligns with the mission of CB and the affiliated pediatric health clinic. Therefore, within the change process, there will be a commitment to continuous quality of care. Currently, families and agencies receiving service from CB are asked to provide feedback on the services they receive. Feedback has indicated that change needs to occur in two areas; the clinician's ability to respond quickly to the needs of current clients, and the overall wait times for service (Champion Branch, 2018). Based on these results, leaders within CB are obtaining feedback from families, community agencies, and organizational members within CB to determine priorities for change. Surveys could be used to request additional feedback to determining whether, for example, stakeholders prefer quicker access to services, or services that are longer in duration (Champion Branch, 2018). In addition to the surveys, feedback will also be solicited from CB's advisory board. Data collected through this process will be utilized by senior leadership when developing CB's strategic plan in 2019 (Champion Branch, 2018).

The second priority for change is to meet the needs of CB's funding source, the provincial government. Currently within eastern Canada, provincial governments are associated with both liberal and conservative ideologies. CB should always be aware that government ideologies shift based on individual leadership within the government. As CB plans for change, they must ensure the priorities and needs of the funding source are being met. For example, if the

government would like all children with Autism Spectrum Disorder (ASD) to receive support in their homes and schools, the change plan for CB will need to incorporate this priority.

The third priority for change is to meet requirements or restrictions set out by the affiliated pediatric health clinic. CB must align their practices with those of the pediatric clinic. For example, if the pediatric health clinic develops procedures to improve employee safety, CB members must also follow these procedures. Therefore, planning for the change process would ensure that requirements from the pediatric health clinic are considered. It is recommended that CB's leaders complete a stakeholder analysis (Cawsey et al., 2013), determining which stakeholders have the ability to demand change. A stakeholder analysis would also identify the power held by each stakeholder, the influence they hold over people involved in the organization, their priorities, and their motivation to participate in the change process (Cawsey et al., 2016)

Additional change priorities within CB should include shifting organizational culture to one that promotes peer support, collaboration, shared leadership, and personal growth amongst clinicians (Avolio et al., 2009; Northouse, 2018). Leadership within CB should focus on shifting operational procedures to provide a more consistent model of service and to incorporate standards of practice (Gutek, 1997).

Change Drivers. According to Whelan-Berry and Somerville (2010), change drivers are variables that influence the planning and implementation of the change process. Change drivers assist with organizational change by acting as catalysts, spearheading the change process (Whelan-Berry & Somerville, 2010). Appendix E summarizes the main change drivers within CB. The primary change driver within an organization is the marketplace (Ackerman-Anderson and Anderson, 2010). The marketplace for CB consists of children with IDD, their families and

other community agencies that provide other services. If the needs of children with IDD shift, the services provided within CB must shift to meet those needs. The marketplace also includes the services provided by similar agencies (Ackerman-Anderson & Anderson, 2018). While CB is a non-profit organization, it is still valuable to understand services provided by other non-profit and for-profit behavioural service providers, to determine the effectiveness of their models of service delivery, and to ensure that the various service providers are complementary.

The second change driver within CB is the perceptions of organizational members and stakeholders on the urgency of change and change vision (Whelan-Berry & Somerville, 2010). The vision for change within CB must be valued by the human resources department, leaders, and other stakeholders at the affiliated hospital, community service agencies, clinicians, the funding source, and embraced by the advisory board. If clinical supervisors and clinicians participate in determining the need for change and planning the changes, they will all act as change drivers. The participation of all organizational members increases commitment to the change (Ackerman-Anderson & Anderson, 2010).

The third change driver is the behaviour of all members within CB. The leadership team within CB must demonstrate the need for change and display themselves as active participants in the change process (Whelan-Berry & Somerville, 2010). Behaviour includes the actions of organizational members, their style of work, and the manner in which they conduct themselves. Leader behaviour must be both conducive to, and supportive of change, in order to assist with shifting organizational culture (Ackman-Anderson & Anderson, 2010).

The fourth driver for change within CB is the mindsets, beliefs and assumptions of organizational members (Ackerman-Anderson, 2010). All members must be aware how they approach problems. Members of CB need to identify their current mindsets, any bias towards

change and be willing to work towards a shift in thinking (Whelan-Berry & Somerville, 2010). Leaders of CB can promote a change in mindset through open communication and education on factors influencing the problem and the changing needs of the children and families receiving services (Ackman-Anderson, 2010). This shift in mindset will be critical when the leaders and clinicians promote the value and future benefits of the change process while collaborating with other community organizations.

A fifth driver for change includes the promotion of transparency through the use of open communication. Strong communication regarding the change process between leaders and clinician will ensure that all members of CB have input and feel valued. Clinicians should be given the opportunity to ask questions, present concerns and receive feedback from leadership throughout the change process (Whelan-Berry & Somerville, 2010).

Comprehensive education acts as the sixth driver for change within CB. CB will need to provide in-depth skill development for clinicians, provide outlines for the change process, and the frameworks and theoretical underpinnings to be utilized. This education will give clinicians the opportunity to learn changes to their role, additional responsibilities they may have, and the potential outcomes of such changes (Whelan-Berry & Somerville, 2010). Many of the variables influencing change within CB are people (Whelan-Berry & Somerville, 2010).

The seventh driver of change is influential people including the senior management team, clinicians, stakeholders from the affiliated hospital, CB's advisory board, community agencies, the funding source, and the clients. According to Ackerman-Anderson & Anderson (2010) stakeholders, community agencies and funding sources are all examples of external factors acting as change drivers for the organization.

Finally, leadership models implemented within CB could act as an eighth change driver within CB (Ackerman-Anderson & Anderson, 2010). If CB's leadership team were to utilize distributed leadership, sharing leadership tasks with clinicians, this would act as a change driver. Distributed leadership would demand all members to be more actively engaged in embracing the process and assist with gaining buy-in to the structural and procedural changes that may occur (Avolio et al., 2009).

While there are eight change drivers within CB, leaders will need to prioritize a subset to use as catalysts for change. Due to the complexities of each change driver, prioritization needs to occur, ensuring that leveraging change is manageable within a 12-month OIP cycle. Prioritized change drivers may include the market place (needs of families and children), organizational members' belief in the vision for change, comprehensive education during the change process, and external influences such as political ideologies of the provincial government. Leaders within CB must recognize that change drivers are interrelated, working to utilize one change driver will impact others (Whelan-Berry & Somerville, 2010).

This section identified a vision for change within CB, while highlighting priorities for change and factors that will drive change forward. Moving forward, the following section will describe CB's readiness for change and suggest methods for improving organizational readiness.

Organizational Change Readiness

According to Weiner (2009) organizational change readiness is a state of mind shared by organizational members. If there is positive organizational readiness, the collective mental state consists of positive perceptions of change. Organizational members are committed to the change process and believe there is the need, and the ability to enact change effectively (Weiner, 2009). Cawsey et al. (2016) views organizational change readiness as a question of whether or not all

parties believe in the need for change and accept that change procedures will be implemented. Additionally, Ackerman-Anderson and Anderson (2010) suggest that organizational readiness involves the emotional and psychological state of organizational members with regard to the change process. Within CB, clinicians will need to agree that they have the capacity to fulfill their responsibilities during the change process and believe that the organization will better meet their goals after the change. (Weiner, 2009).

Assessing Organizational Change Readiness

Cawsey et al., (2016) provides leaders with a questionnaire that can be used to assess organizational change readiness. This questionnaire could be utilized by leaders, during the implementation of this OIP, to identify areas within their organization that need to be developed further prior to organizational change or areas to be focused on during the change process. For example, if clinicians believe they do not have the knowledge or skills to implement change, leaders can facilitate education and skill development for clinicians prior to the change (Cawsey et al., 2016). This tool outlines a variety of areas in which organizational readiness should be assessed. These areas include previous attempts at organizational change; leadership readiness; leadership support for change; skills of change agents; organizational culture; openness to change; current conflicts within CB; conflict resolution style; ability to measure change; reward systems for clinicians; and the development of rewards associated with the change process (Cawsey et al., 2016).

According to Chilenski, Olson, Schulte, Perkins and Spoth (2015), employee perceptions that leadership is transparent, and communicates clearly, increases the likelihood that employees will support change, specifically when involving the implementation of evidence-based practices. If the climate of the organization is positive, with high morale among members,

organizations are more likely to be successful at implementing change procedures (Weiner, 2009; Chilenski, Olson, Schulte, Perkins, & Spoth, 2015). Evaluations of the organizational climate should occur by leaders, as this is a factor that may impact the implementation fidelity of change procedures within CB.

In addition to evaluating organizational readiness in terms of the perceptions of clinicians, it is important that leaders within CB also evaluate the capacity for change, to ensure that all clinicians have enough time to maintain supports for their current caseload as well as implement change procedures. Increasing work demands on clinicians without allocating additional time and resources may have a negative impact on their emotional reaction to the change process. (Ackerman-Anderson & Anderson, 2010). In order to evaluate organizational capacity and climate it is recommended that leaders within CB utilize a capacity assessment. The capacity assessment be distributed to all staff and leaders, allowing input from all organizational members. The assessment should be specifically for non-profit organizations. An example of a such a capacity assessment is the Organizational Capacity Assessment Tool (OCAT), developed by McKinsey and Company (2013), to assess organizational goals and aspirations; climate and perceptions of the people within the organization; funding structure; organizational structure and capacity; culture and values; innovation; and business structure within non-profit organizations (McKinsey & Company, 2013). The use of capacity assessments in CB will be further discussed in Chapter 3.

Improving Organizational Change Readiness

Once leaders within CB have assessed organizational change readiness, leaders will need to determine methods for increasing organizational readiness for change. The first step would be to collaborate with clinicians, together creating a vision for change (Kotter, 1996; Schalock &

Verdugo, 2012). CB will also need to identify strong leaders who will act as change agents, advocating for change and teaching others about the benefits of change (Cawsey et al., 2016). Education and skill development for clinicians within CB will also assist with increasing organizational readiness (Cawsey et al., 2016). This will give clinicians the opportunity to learn about the value of models of service within other behavioural service providers. According to Cawsey et al. (2016), leaders should develop a vision for change, provide education and promote the need for change, to ensure clinicians are no longer be satisfied with status quo and will be motivated to participate in the change process.

Strategies for overcoming resistance to change include identifying states of mind that limit change and attempting to shift thinking in organizational members to future focused mental states (Schalock and Verdugo, 2012). Shifting mindsets can be done through the use of open communication and educating members on the value of change for both themselves and for the children receiving service (Ackman-Anderson, 2010; Cawsey et al., 2016). Leaders need to instill a sense of security into clinicians by reassuring that all futures are secure and reminding them of the value that they hold for the organization (Schalock and Verdugo, 2012; Cawsey et al., 2016). Leaders need to highlight areas of self-interest for clinicians (Schalock and Verdugo, 2012). For example, if assessments were to become streamlined, a clinician's role may become less stressful and cumbersome. Additional strategies include ensuring change occurs at a pace that allows for thorough understanding and the opportunity for critical inquiry, education on the values leading the change process, and providing clinicians with examples of historically effective change within the organization. (Thomas & Hardy, 2011; Schalock and Verdugo, 2012; Cawsey et al., 2016). Providing clinicians with the opportunity to be a part of the change process,

developing new practices, and determining new relationships within the organization will also further increase participation. (Thomas & Hardy, 2011).

Leaders should recognize that resistance can add value to the change process. Resistance from clinicians will ensure that leaders are critically evaluating their recommendations for change within CB. As leaders are challenged, the methods for producing change often shift and become more effective in order to address the resistance (Thomas & Hardy, 2011).

Internal and External Forces Shaping Change

There are many internal and external factors shaping change within CB. Factors internal to CB provide influence over the organization's readiness for change. Some of these internal factors include the psychological state of mind of clinicians, including: a fear for job security; organizational climate; education of clinicians; desires of clinicians to be able to deliver more value to clients, communication within the organization; utilization of specific leadership models; and skill sets of employees (Weiner, 2009; Ackman-Anderson & Anderson, 2010; Chilenski et al., 2015; Cawsey et al., 2016).

On a micro level, there are also many factors shaping the change. These tend to be internal factors that influence the specific services that are being provided to each client. Micro factors include organizational culture and current models of leadership within CB; the diversity of clinicians providing service and the existing autonomy of clinicians in treatment decisions. Clinicians with formal education may be more rigid about incorporating the principles of behaviour analysis into their practice, while clinicians with education in other areas may be more inclined to promote counselling or thought-based practices. Clinicians have a high degree of autonomy currently over their clinical decisions, and the use of evidence-based practices may vary. Clinician autonomy has a great impact on service delivery and therefore is a factor

influencing change. Some clinicians are members of regulatory colleges or boards such as the College of Psychotherapists or Behaviour Analyst Certification Board. Differences between the regulations from colleges or boards may also impact clinical decision making.

While external factors also shape change within CB, these factors influence the need for change on a meso level. This is demonstrated through systemic challenges faced by non-profit organizations providing services to children with IDD (Schalock and Verdugo, 2012). A large meso factor shaping change is limited fiscal resources available to CB. This impacts the capacity to provide service including the amount of time clinicians spend with children and their caregivers. Fiscal resources also impact the education and development of clinicians. Additionally, limited resources of families and other community agencies to whom CB consults act as a barrier to providing effective service. Families and community agencies are often unable to implement clinical recommendations due to factors external to CB.

A macro factor influencing change is the shift in services for children with IDD, moving from a medical model to a more therapeutic model, focusing on teaching children the skills they need to fully participate in their communities and schools (Anastasiou & Kauffman, 2011). Focus is also placed on ensuring that children are able to engage in functional activities that are meaningful within their lives (Anastasiou & Kauffman, 2011). As the focus shifted from a medical to therapeutic model, the need for behavioural support increased, as engaging in challenging behaviour impacts a child's ability to fully participate in these activities. This has resulted in a higher demand for CB services, and changes in the nature of those services.

Chapter 1 Conclusion

This chapter has provided background and content for the POP within CB. Currently, there are over 400 people waiting for behavioural service with Champion Branch. While there

are many factors influencing the POP internal and external to CB, priorities and drivers of change have been identified which create urgency and the opportunity to initiate change at CB to deal with the POP. This chapter also highlights the need for leaders within CB to prioritize the goals for change, gain support from internal and external stakeholders, and answer questions emerging from the change priorities and the drivers of change. Moving forward, Chapter 2 of this OIP will evaluate change frameworks for implementation during the OIP cycle. In addition, potential solutions identified, and specific solutions are recommended to address the leadership POP.

Chapter 2: Planning and Development

Chapter 2 Introduction

Chapter 1 provided an overview of the context and history of CB, the clinical service agency around which this OIP is centred. A POP was presented. There is a lack of sufficient service delivery capacity within a clinical service organization for children with IDD. Chapter 1 includes a vision for change and an assessment of organizational readiness. Chapter 2 now identifies and proposes solutions for to address the POP. These changes include adapting organizational procedures and operating models in order to increase service delivery capacity and decrease wait times for behavioural services. In order to effectively make these changes, leaders within CB will need to effectively utilize established leadership approaches and change path models. These models will include some shifts from the current leadership approaches and frameworks that are currently implemented within CB. Chapter 2 discusses the alignment between leadership approaches, change frameworks and potential solutions for change. Ethical considerations for the implementation of leadership approaches and change frameworks are also examined.

Leadership Approaches to Change

As discussed in Chapter 1, the leadership within CB currently utilizes aspects of different leadership approaches, including transactional, situational, collaborative, and transformational approaches. Clinical managers attempt to solicit feedback from organizational members in order to implement a collaborative approach and build trust with clinicians. While the promotion of these leadership approaches may be helpful, leaders within CB need to ensure that they are actively modelling the leadership behaviours they promote. Rather than focusing on the use of positional power to maintain control of information, leaders will need to expand their leadership

behaviours and incorporate behaviour reflective of a variety of appropriate leadership approaches. Leaders incorporating new behaviours will allow them to share focus between the priorities of providing an effective and efficient service, and meeting the needs of clinicians. Focusing on the needs of the clinicians will increase commitment to the organization and increase clinician motivation (Taucean, Tamasila, & Negru-Strauti, 2016).

While currently some leaders in CB are attempting to implement collaborative leadership, they regularly display leadership behaviours related to transactional leadership. Members of CB would benefit from engaging in a variety of behaviours related to transformational leadership and distributed leadership as these are better aligned with implementing this OIP and would assist to create successful change within the organization (Yang, 2016; Northouse, 2018). Utilizing transformational and distributed leadership may help to build trust and will encourage collaboration within CB. Building a strong coalition between all of the organizational members may assist with promoting the need for change and maintaining momentum during the change process (Kotter, 1996; Cawsey et al., 2016). Transformational and distributed leadership approaches will be discussed in the following section.

Transformational Leadership. By implementing transformational leadership strategies, leaders would place an emphasis on motivating organizational members within the CB and increase the commitment of all organizational members to facilitate better goal achievement (Yang, 2016). Transformational leadership consists of four components: idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration (Valero, Jung & Andrew, 2015; Northouse, 2018). Leaders focus on building respect; motivating clinicians to meet the organization's vision; collaboration during problem solving; and focusing on the individual abilities, strengths, and goals of each organizational member (Valero et al., 2015).

Through implementation of transformational leadership, clinicians within CB may become motivated to meet their own professional and personal needs and are likely to also be motivated to work to meet the needs of CB as an organization (Yang, 2016; Northouse, 2018). According to Yang (2016), it is through the process of meeting personal and professional goals that clinicians will increase their self-confidence. Transformational leadership encourages communication between all organizational members, potentially increasing trust and connectivity within the organization, allowing members within CB to work together through the change process (Braun, Peus, Weisweiler and Frey, 2013).

An additional benefit for using transformational leadership within CB is the demonstrated effectiveness of this model when used with non-profit organizations. A study completed by Valero et al., (2015) found that the use of transformational leadership increased resiliency in public and non-profit organizations. The use of transformational leadership within non-profit organizations increases the level of trust within an organization and increases the capacity of the overall organization to implement change procedures (Yasir, Imran, Irshad, Mohammed & Khan, 2016). According to Dirks and Ferrin (2002), this trust can be created by leaders building strong relationships with clinicians based on mutual respect and fostered through open communication.

Geer, Maher & Cole (2008) found a positive connection between the use of transformational leadership and commitment to implementing procedures within a non-profit organization. Organizations where transformational leadership is implemented are likely to fulfill their obligations to stakeholders (Geer, Maher & Cole, 2008). Jaskyte (2004) studied a sample of disability service organizations, finding a positive relationship between the use of transformational leadership and alignment between the values of the organization and its internal members and the support of innovation within the organization.

Distributed Leadership. Within the context of this OIP, distributed leadership is defined as the process of leadership behaviors being shared among members of CB, including non-managers, who are working together within the organization to provide leadership within the organization. According to Spillane (2006), distributed leadership not only accounts for the sharing of responsibilities but also describes the interactions between multiple leaders, followers and the environment. Within CB, both the assigned leaders and clinicians will act as leaders through two processes that Spillane (2006) describes as collaborated distribution, clinicians working together to enact a leadership practice; and collective distribution, clinicians working independently to fulfill leadership responsibilities. The change implementation plan in Chapter 3 will outline specific instances where clinicians will either be working together as part of a team or working independently during the change process.

Implementing distributed leadership within the CB will ensure that all leadership roles are fulfilled, making leadership more manageable during the change process (Spillane, 2006). It also supports clinicians in the development their own leadership skills (Avolio et al., 2009). Additional benefits of distributed leadership include increases in cohesion and trust during the change process, potentially increasing organizational readiness for change and acceptance of procedural changes. (Wang et al., 2014). Utilizing distributed leadership will prompt clinicians at CB to be motivated and actively engaged throughout CB's change process (Wang et al., 2014). The use of distributed leadership advocates for a distribution of power amongst organizational members (Burnes, 2009). This may help to improve the social climate within the organization and decrease resistance to change.

Aligning distributed leadership with transformational leadership will give leaders within CB tools to use when implementing the change frameworks described in the next section of this

OIP. Transformational leadership acts as an approach for leaders to implement in an attempt to increase leadership effectiveness, while distributed leadership is a method for designing and allocating leadership responsibilities within the organization (Spillane, 2006).

This section introduced transformational and distributed leadership as beneficial approaches to be used within CB to guide successful change. The following section will identify change frameworks that could be used within CB to help facilitate change.

Leadership Approaches and Change Frameworks

This OIP recommends the use of two change frameworks to assist leaders of CB move through the change process. These frameworks include the concurrent use of Lewin's (1947) three step change model and Kotter's (1996) eight step framework. These two frameworks align, as they include areas of focus in three main areas; preparing for change, undergoing change, continuous evaluation and future change. It is in the first area of focus, preparing for the change, where leadership approaches within CB need to be evaluated and potentially shifted to meet the changing needs of the organization, the clinicians, and the stakeholders, including the children and families receiving service. For example, leadership approaches may shift to incorporate the use of distributed leadership, as described in the section above.

Throughout the change process, it may be of benefit for both assigned and emergent leaders within CB to promote transformational leadership, ensuring that clinicians are receiving the individualized support needed throughout the change process. Support will be individualized based on the needs of the clinicians, the situation in which feedback is required, and the phase of the change path that is being implemented (Valero, Jung & Andrew, 2015; Yang, 2016; Northouse, 2018). Within my scope and agency within CB, I am also able to model

transformational leadership through peer consultation and motivating colleagues to meet both their personal goals and the goals of the agency.

Incorporating approaches from both transformational leadership and distributed leadership will align with the change frameworks. Utilization of these approaches will ensure that all organizational members receive the individualized feedback in order to increase motivation and empower members to meet organizational goals, contribute innovative ideas, collaborate on leadership processes and promote the change initiative (Spillane, 2006; Wang et al., 2014; Yang, 2016; Northouse, 2018).

Initial stages of change within CB requires leaders to build a coalition of people within the organization, including clinicians, who can work alongside assigned leadership and act as drivers for change (Kotter, 1996). By sharing leadership tasks, this coalition of people will promote change. The implementation of transformational and distributed leadership, as described above may assist with creating this coalition and a more positive impact on the organizational climate (Weiner et al., 2009). In summary, a shift in leadership approach focusing on the needs of all organizational members through individual empowerment and situation specific support will assist with implementation of change. Transformational and distributed leadership align well with the combination of Lewin's (1947) three phase model for change and Kotter's (1996) eight step framework. These leadership approaches will position leaders within CB to improve organizational readiness and to secure a coalition of change drivers from within.

Framework for Leading the Change Process

The section below provides insight into the value that Lewin's (1947) Three Stage Theory of Change and Kotter's (1996) Eight Stage Process change path models hold, their

alignment with one another, and how both frameworks can together be used to implement change within CB.

The first change path model that would be beneficial is Lewin's The Three Stage Theory of Change (1947). Lewin created this model to help organizations change and develop while remaining focused on the members of the organization. Lewin held strong values regarding social conflict. He placed a large focus on ensuring that people learn about their environments (Burnes, 2009). This model is based on the belief that clinicians should evaluate their own behaviour within CB and identify how these behaviours are maintained. Through this investigation, clinicians will identify the purpose of their behaviour and understand the value of changing it (Burnes, 2009; Burnes & Bargal, 2017).

The three stages include Unfreezing, Changing, and Refreezing. Stage one, Unfreezing, will occur when leaders, clinicians, and stakeholders of CB collaborate and come to a consensus about the need for change and the development of new operating procedures (Burnes, 2004; Cummings, Bridgman & Brown, 2016; Burnes & Bargal, 2017). Stage two, Changing, will occur when the organization is undergoing the change process. Clinicians will participate in the development and implementation of change processes, and there will be a shift in behaviour from levels of the organization (Burnes, 2004; Cummings et al., 2016; Burnes & Bargal, 2017). Stage three, Refreezing, will only occur through the ongoing and consistent use of new behaviours, structures, and procedures (Burnes, 2004; Cummings et al., 2016; Burnes & Bargal, 2017).

The use of Lewin's Three Stage Theory of Change (1947) is beneficial CB for three reasons: simplicity, proven success in a not-profit environment, and the impact of employee behavior on other people and the environment. The model provides a simple to understand tool,

which is valuable as CB has not had significant changes to its operating procedures within the last 20 years. While the clinicians hold a high degree of technical knowledge in the areas of behaviour analysis and developmental disabilities, they may lack any background in organizational behavior or change. Due to these factors, utilizing a simple framework will assist with establishing support from the clinicians, managing resistance to change, and encourage clinicians to be active participants in the change process. As CB progresses through the OIP cycle, leaders may gain the skills needed to enact a change framework and organizational members may become more accustomed to the idea of change. Therefore, in future OIP cycles, a more sophisticated model for change could potentially be implemented.

Lewin's Three Stage model has a history of successful implementation within non-profit organizations and health care settings (Medley & Akan, 2008; Manchester et al., 2014). Lewin's three stage model was derived from the desire to increase access to community services by capitalizing on the existing strengths of leaders within non-profit organizations (Martin, 2016). Lewin's model helps non-profit leaders educate the organizational members on how changes to their own behaviour can increase the success of organizational change and positively impact the outcomes for clients (Medley & Akan, 2008). Medley & Akan (2008) demonstrated the effective use of Lewin's (1947) three stage model in a job service organization, creating change to ensure that their services were relevant to the changing needs of the people served and community businesses. Manchester et al., (2014) implemented Lewin's three step model to illustrate the value of the model in the promotion, education and adoption of evidence-based practices of health professionals in two hospitals. Archer, Fuller, Cox and Swearingen (2019) illustrated the use of Lewin's (1947) three step model in a case study where the model was effectively used to adopt the use of a standardized tool to provide feedback to emergency services on treatment of

stroke patients. Archer et al., (2019) were able to prepare the environment for change utilizing the three-step model and found that people implementing the tool were satisfied with the change at a 10-week follow up.

Lewin's focus on employee behaviour and the impacts of the environment align well with one of CB's core services, behaviour analysis. Lewin promotes the evaluation of the consequences to one's actions and the investigation as to whether or not such consequences maintain a person's behaviour (Burnes, 2009). This is an example of operant conditioning, a foundational concept within behaviour analysis, where future occurrences of a person's behaviour are impacted by the consequences or stimuli that occur within the environment afterwards (Skinner, 1938; Cooper, Heron & Heward, 2007). Clinicians within CB would relate to Lewin's beliefs, increasing buy-in during the change process.

While Lewin's model provides an easily understood three step process, it may be more effectively operationalized if combined with a more granular, operational change model. Kotter's (1996) eight stage model provides a clear step-by-step guide for leaders to use while planning the change process. According to Pollack and Pollack (2015), Kotter's model also places an emphasis on planning for change to ensure organizational readiness. Preparing for the change process and ensuring clinicians believe in the necessity for change is crucial for the change process to be successful within CB. Without an understanding of the need for change, clinicians may be resistant.

Kotter's eight stage model creates a guide for organizations to follow in order to meet the demands of a changing marketplace (Kotter, 1996), allowing CB to address the change needs of all clients, their families, stakeholders, and the provincial government. The eight stages of Kotter's model integrated into Lewin's three stage model are illustrated in Appendix F. Utilizing

these models concurrently provides a guided structure to the change process, allowing members of CB a simplified view of the change process, relating to the behavioural services they provide and providing leadership the specific granular steps to implement successful change. Lewin's stage of unfreezing will be used concurrently with Kotter's (1996) steps of establishing a sense of urgency, forming a guiding coalition, and developing vision for change initiatives (Kotter, 1996; Cummings et al., 2016). Lewin's stage of changing will be used concurrently with Kotter's (1996) steps of communicating and implementation of the vision for change; empowering employees to enable broad-based change; and planning for short term successes within CB. Lewin's stage of refreezing will be used concurrently with the Kotter (1996) steps of producing more change and incorporating new approaches within the CB's culture (Kotter, 1996; Cummings et al., 2016).

Kotter's (1996) eight step model is linear, providing a specific guide that leaders can follow when incorporating change. The structure of this model will assist with mobilizing leadership and motivating all clinicians to participate in the change process (Kotter, 1996). However, leaders must recognize that the change process is cyclical and not always linear. During the OIP process, leaders may need to revisit earlier stages Kotter's (1996) model, out of sequence. For example, while implementing the change, leaders may need to continue communicating the sense of urgency and continuously building a guiding coalition to keep the change process in motion.

According to Brisson-Banks (2010) leaders should utilize Kotter's eight step model to ensure that transformation within the organization occurs; utilizing urgency among leaders and a coalition of organizational members. A clear vision needs to be communicated to all clinicians and members of CB to ensure that the change rationale, and how it addresses all stakeholders'

needs, is understood, and a focus should be placed on transparency throughout the entire change process (Brisson-Banks, 2010). Leaders must use compelling messages and communication to describe the vision and articulate the value of the vision for change in order to gain buy in and motivate clinicians for change (Peleg, 2014).

According to Kotter (1996), one of the largest mistakes made by leaders is not creating a sense of urgency amongst teams. If clinicians do not feel a sense of urgency, change may begin but become stalled. A lack of urgency can result in complacency within clinicians, inhibiting change (Kotter, 1996; Peleg, 2014) According to Harraf, Soltwisch and Talbott (2016), leaders need to foster an environment that is accepting of change in order to avoid complacency amongst organizational members.

The second critical step within Kotter's model is creating a guiding coalition (Kotter, 1996). A coalition within CB consists of clinicians, leaders, other organizational members and external stakeholders. The goal of this coalition is to ensure that everyone is an active participant in the change process and allows all organizational members to contribute in a meaningful way, giving a sense of importance and purpose (Kotter, 1996). The third step of Kotter's eight step model is to create a clear vision for change. Through collaboration, this vision will be created within CB and communicated throughout the organization. Communication, the fourth step, ensures that leaders within CB are constantly communicating the vision and the need for change with all members of the guiding coalition (Kotter, 1996).

The fifth step of Kotter's (1996) model involves motivating organizational members and preparing them for the change process. This includes ensuring that any organizational members or stakeholders who are necessary to implement change, or are resistant to change, are educated, involved, and on board prior to the change occurring. Kotter's (1996) sixth step suggests that

leaders within CB should incorporate smaller incremental milestones into the change process. This will allow organizational members to celebrate small victories, visualize progress, and recognize contribution. Celebrating these wins will reinforce the value of clinician's efforts and promote continued change (Kotter, 1996). This promotion of continued change leads to Kotter's (1996) seventh step, consolidating gains and producing more change. The value of change needs to be instilled into CB's culture. Rather than being satisfied with initial change, leaders should continuously evaluate why the change was effective and determine new goals for the services provided by CB. Kotter (1996) suggests an eighth step, the promotion of a culture where clinicians are able to continuously evaluate change and provide feedback to leaders on areas for future growth. Changes that have occurred within the organization need to be maintained over time and become a part of the organizational culture.

Lewin (1947) and Kotter (1996) frameworks align well with transformational and distributed leadership. In addition, these change frameworks align with Bolman and Deal's (2013) human resources frame theory, which was used in Chapter 1 to frame the problem of practice. This frame focuses on investigating the needs of employees and determining what changes need to be made to meet these needs. Using the frame, leaders within CB must ensure there is an alignment between the organization and clinicians, ensuring that the needs of both can be met (Bolman & Deal, 2013). Focus will be placed on ensuring that the organization and the clinicians can effectively respond to the needs of one another. In summary, both Kotter's (1996) and Lewin's (1947) frameworks will be applied to propel CB's vision for change. These frameworks will assist all leaders in creating alignment between leadership approaches and needed change. They will act as a structured guide in which to lead organizational members through the change process.

In summary, the concurrent use of Kotter's (1996) and Lewin's (1947) change frameworks provides leaders within CB with a proven step by step guide to change implementation. The following section will describe the results of a gap analysis, identifying specific areas that would benefit from change within CB.

Critical Organizational Analysis

In order to effectively determine specific need for change, leaders within CB will need to conduct a gap analysis. According to Cawsey et al. (2016), a gap analysis answers questions regarding the need for change and assists with the communication of the vision for change within the organization. This analysis will focus on the differences in features between CB's present state and the preferred future state (Cawsey et al., 2016). Results of the gap analysis will assist leaders within CB to gain support and build the guiding coalition needed to propel change and increase capacity (Kotter, 1996; Cawsey et al., 2016).

Beckhard & Harris (1987) have developed a change management process that is comprised of five steps for organizations to follow. This change management process allows leaders to become aware of factors influencing change within their organization; identify when change is needed; develop a comprehensive vision for change through comparing the current and desired state; and plan for change within the organization (Beckhard & Harris, 1987; Cawsey et al., 2016). The five steps of the Beckhard & Harris Model include: (1) Internal Organizational Analysis; (2) Why Change; (3) Gap Analysis; (4) Action Planning; and (5) Managing the Transition.

Using a part of the Beckhard and Harris' (1987) model within CB provides a tool for leaders to use when completing a gap analysis. Additionally, it aligns well with Lewin's (1947) change model and Kotter's (1996) model for change, promotes the completion of an internal

organizational analysis and determines the need for change. Leaders will need to collaborate with clinicians to move through the “unfreezing” phase, identifying the need for change and building a guiding coalition to develop the vision for change and acting as change drivers, propelling change forward (Lewin, 1947; Kotter, 2009; Whelan-Berry & Somerville, 2010).

Beckhard & Harris (1987) suggest that it is critical for organizations to complete an accurate gap analysis in order to bring about change. This analysis identifies discrepancies between current performance and performance in CB’s preferred state. Sharing the results of an accurate gap analysis can assist with building motivation for change within CB and articulating the sense of urgency surrounding the need for change (Beckhard & Harris, 1987; Kotter, 1996; Cawsey et al., 2016).

Champion Branch (CB) Gap Analysis

The gap analysis examines four areas: (1) systems and processes; (2) power and cultural dynamics; (3) stakeholders, (4) recipients of change. Examining these areas will help to determine changes that need to be made to structures and procedures, changes that are influenced by the organizational culture, and changes that can assist in meeting the needs of stakeholders, including the families and children receiving support. CB’s gap analysis is summarized in Appendix G.

Systems and Processes. An analysis of formal systems and processes needs to occur within CB in the areas of intake processes, waitlist management, case assignment, assessment methods, types of treatment offered, and length of services. Referrals to CB are sent to administrative services where a priority rating scale is completed. This scale identifies the level of risk involved for the child and their support system. Children who are scored at a higher risk of self-harm, injury to others or at risk of losing housing receive priority service. Children who

receive with low scores are placed on a waiting list for service. Evaluation of the priority rating system should be conducted to determine if it is reliably objective for scoring level of need for behavioural support.

Once children are placed on the waiting list, there are currently no standardized measures for contacting their families or updating rating scales. CB is currently undergoing a pilot project, where some clinicians within CB contact a specific number of families per month to determine if services are still needed. This illustrates a potential process gap within CB, a lack of consistent procedures for waitlist contact and management. Currently, clinicians are assigned cases on the judgement of their clinical managers, based on the number of cases already assigned to clinicians, the intensity of service being provided by the clinician, and the needs of the case waiting for assignment. Therefore, a procedural gap exists, as there is no formal mechanism for the assignment of cases.

Once cases are assigned, clinicians are expected to complete a functional behaviour assessment (FBA), identifying the factors contributing to challenging behaviour (Cooper et al., 2007). However, CB procedures do not indicate which resources or tools should be used by clinicians to complete a FBA. This leaves clinicians with the autonomy to determine whether to complete direct or indirect assessment and to determine the time required to complete the assessment. Clinicians also have the autonomy to determine specific services received by children and families. While CB needs to ensure that children and families are receiving individualized services, based on the factors contributing to specific behaviours, CB must also ensure that clinicians are providing evidence-based behavioural treatment (Champion Branch, 2016; BACB, 2017). CB lacks a prescribed list of services offered by clinicians within the organization. For example, CB will provide a FBA, adaptive skills assessments, preference and

reinforcement assessments, development, and evaluation of behaviour support plans. While these services are prescriptive, clinicians can then tailor specific services and goals for each individual child.

Power and Cultural Dynamics. As described in Chapter 1, CB holds a hierarchical culture, with conservative tenets, as demonstrated through the organization's structure and the focus on efficiency and procedural fidelity (Guteck, 1997; Cameron & Quinn, 2006). A hierarchical culture can lead to the use of transactional approaches, which while useful in achieving short term goals and gaining compliance around policies and procedures, limits innovation and motivation of clinicians (Northouse, 2018). There is cultural gap within CB. The current culture focuses on ensuring clinicians follow procedures and engage in expected work exchanges with leaders. A shift in culture is needed to promote innovation, collaboration, and to motivate clinicians to provide high quality services (Cameron & Quinn, 2006). It is critical for all members of CB to recognize that organizational culture can impact, and is impacted by the social climate of an organization, and therefore impacts the work performance of clinicians and ultimately impacts services offered to children and families.

Stakeholders. Included in the gap analysis are the needs of various stakeholders. Chapter 1 discussed the use of a stakeholder analysis, determining stakeholders' power and ability to act as change drivers and enact changes (Cawsey et al., 2016). The gap analysis also identifies the stakeholders' needs, ensuring that gaps between the needs of children, families, agencies, and government funders, and the services offered by CB are understood. Additional data collection should be conducted through surveys and focus groups to identify gaps between CB service and the needs of stakeholders and to ensure that the vision for organizational change promotes closing these gaps.

Recipients of Change. Additionally, a gap analysis includes the needs of the recipients of change. In the case of CB, this includes both the children and families receiving service and the organizational members who will be enacting the change. As mentioned above, the needs of children and families need to be considered identifying the change that will occur within the organization (Cawsey et al., 2016). Leaders within CB need to evaluate the organizational readiness for change including the readiness of clinicians and members of CB who will be implementing change. Leaders need to evaluate the current mindset of clinicians and determine if changes need to occur to improve organizational readiness. As described by Weiner (2009), a collective state of mind consisting of positive perceptions of change is required to effectively implement change.

Changes Embedded in Organizational Framework

The timing of required changes can be identified within the Lewin (1947) and Kotter (1996) change path frameworks. A visual representation of this can be found in Appendix H. The gap analysis occurs within Lewin's (1947) unfreezing stage, with all members of CB and stakeholders collaborate in determining the vision for change. This aligns well with the timing of Kotter's (1996) steps of establishing a sense of urgency, building a coalition, and creating a vision for change. Within these initial stages of the change framework, changes that will need to occur within CB include a shift to more collaboration and distributed leadership (Avolio et al., 2009).

The second phase of Lewin's (1947) model, changing, occurs when the organization is undergoing the change process. During this time, leaders within CB will implement Kotter's (1996) steps of communicating the vision; empowering clinicians to engage and voluntarily participate in organizational change, and to plan short term goals in order for the organization to

achieve success (Kotter, 1996). Changes that may occur during these stages including changes to the cultural dynamics within CB. Measures of organizational readiness will occur, and leaders will need to modify their behaviour to create a trusting, caring and transparent social climate, where the clinicians feel comfortable implementing changes (Weiner, 2009). Procedural changes are likely to occur during these stages of change. This includes changes to clinical procedures, treatment options and intake and management of waitlists and caseloads.

During Lewin's (1947) third phase, refreezing, CB needs to consistently implement organizational changes, including clinicians continuously implementing procedural changes and leaders continuing to use modified leadership approaches. During this time, CB will implement Kotter's (1996) final two stages, sustaining acceleration and institutionalizing change. By this phase of change process, CB should have initiated all of the originally planned changes and have celebrated short term successes. Changes that occur during this phase are as a result of evaluation of the change process or are building on the previous change in order to continue with the successful transition (Kotter, 1996; Cummings et al., 2016).

In summary, change path models from Lewin (1947) and Kotter (1996) will be used concurrently and act as a resource for all organizational members. Incorporated in the change path is preparing for change on an individual and organizational level, implementing change strategies and evaluation and continuous promotion of change for CB (Kotter, 1996). This aligns with transformational and distributed leadership models, and gives leaders an approach to form a guiding coalition and overcome the potential barrier of resistance from clinicians. In addition, alignment occurs with the human resources frame which outlines the need for moving towards a culture that nurtures relationships rather than focusing on hierarchy (Bolman & Deal, 2013).

Utilizing these change frameworks, leadership models and frames will help to create a structure in which CB can implement changes identified in the gap analysis.

In summary, this section summarizes the results of a gap analysis for CB. It evaluated areas including systems and processes; power and cultural dynamics; stakeholders, and recipients of change to determine beneficial changes within the organization. The following section will investigate solutions to the POP and makes recommendations for leaders for CB to implement during the OIP cycle.

Possible Solutions to Address the Problem of Practice

This OIP aims to address the following problem of practice: a need to improve CB's organizational capacity in order to reduce wait times for behavioral services for children with intellectual and developmental disabilities (IDD). This section describes four possible solutions for CB, investigating the risks and benefits for each. The four possible solutions include: (1) maintaining the status quo; (2) developing a more positive organizational culture; (3) modifying the types of service provided; and (4) creating integrated service delivery teams. The possible solutions to this POP are summarized in Appendix I.

Solution 1: Maintaining the Status Quo. In this solution, CB would continue to provide services using the current operational procedures. Internal structure and policies would not change leaving clinicians the autonomy to determine the methods of providing service. The goals and priorities within CB would remain the same. Practices would remain unchanged. My role within the organization would remain the same and I would continue providing behaviour support within my scope. The organization's capacity to provide service would not increase, and children would continue to wait long times for service. Perhaps incremental improvements could

continue to be made, but the fundamental leadership and organizational model would not change, nor would the results.

Solution 2: Developing a Positive Organizational Culture. In this solution, organizational members within CB would work together to develop a more positive organizational culture, focused around service delivery. A positive organizational culture can increase employee engagement within the organization and increase the quality of work that it can produce. Positive organizational culture increases employee satisfaction and reduces turnover (Luthans, Youssef and Avolio, 2007; Edelman, 2011; Yanti & Dahlan, 2017). Positive organizational cultures have been shown to improve how organizational members react to change within the organization. This solution would be beneficial as a step in addressing the POP if additional organizational changes are planned to be made in the future.

A variety of steps can be taken by both CB leadership and organizational members. According to Luthans, Youssef and Avolio (2007), CB needs to focus on developing the strengths of the clinicians (. For example, leaders could determine how clinicians can expand their skills and grow as clinicians within the workplace. Leadership should place an emphasis on providing reinforcement to employees and motivating them to continually provide effective service (Edelman, 2011; Parent & Lovelace, 2018). In addition to the leaders' efforts to develop clinicians' strengths, clinicians can promote the growth of their colleagues through peer mentorship and feedback. Increasing transparency and promoting open communication throughout the organization will further assist with creating a positive culture (Edelman, 2011). Leaders and clinicians should both be aware of any changes within the organization. Recognizing the value of the contributions made by all organizational members will assist with creating a positive culture. Clinicians who feel valued within their roles will likely be more

motivated, have increased work performance, and maintain a commitment to the organization (Edelman, 2011).

As a behavioural clinician, I can help develop the skills of my fellow clinicians and provide and positive feedback. Creating mechanisms for peer mentorship and recognition will allow clinicians to receive positive feedback frequently. I can also foster more open communication between myself and the leadership team, as well as other clinicians. These strategies may help to improve the immediate climate rather than overall organizational culture. As a clinician and emergent leader within the organization, I should leverage my social power to assist in creating a positive climate including the promotion of change and the value of the change process for all organizational members, as well as for the families and children receiving support.

While it is in within my scope to promote an improved climate within CB, leader engagement in the process would create a much broader impact on changing the culture of the organization. Reconstructing existing committees as peer teams to work toward the structured service solutions demonstrates distributed leadership and reinforces the culture change. Edelman (2011) makes some suggestions for leaders to foster a positive culture. These include ensuring that clinicians are well compensated, promoting ethical decision making, and leading toward organizational goals rather than personal goals. Leaders should focus on collaborating clinicians, effective communication aligned with the organizational goals, and working alongside them, minimizing effects of hierarchy within CB (Edelman, 2011).

Resources will need to be allocated to this solution if the organization is going to effectively create a positive culture. Leaders will need to allocate time to collaborate with other organizational members, eliciting their feedback and providing them with positive feedback on

their work. Leaders will need education on effective methods of creating a positive workplace, and on effective leadership techniques that contribute to a positive climate. Fiscal resources will need to be allocated to this solution to ensure that clinicians feel sufficiently compensated for their work. Fiscal resources will also provide clinicians with recognition for providing quality and effective services in a timely fashion, which they are more likely to continue providing (Daniels, 2016).

Solution 3: Modifying Structure of Services. Currently, clinicians have the autonomy to determine how to provide behavioural support and what types of support a person will receive. This solution would involve changes to procedures regarding the provision of behavioural service. An evaluation of service should be completed, tracking how long cases are currently open and the type of services provided. The organization would need to develop new service delivery targets and develop mechanisms for reaching them. These new mechanisms could include providing a core prescribed list of services, which provide maximum impact versus time and effort.

It is within my scope to apply this solution with my personal caseload. I can modify the structure of services I provide. I could define and choose services needed for clients from a prescribed list, including a functional behaviour assessment, a preference assessment and the development of strategies to teach functionally equivalent behaviour. Using this solution would allow me to provide service to a more clients. I can also track my results in terms of client outcomes and effectiveness, providing evidence internally of the value of these changes

In addition to implementing this strategy within my own caseload, I can use my influence as a member of internal committees focussing on increasing best clinical practices within the organization, to develop recommendations regarding methods of service delivery and

implementation to present to the senior leadership team for consideration. Additionally, with prior approval from the executive director, it is within my scope to develop an organization wide implementation plan to present to the senior leadership team as a proposed solution to the POP.

This solution would have a greater impact on decreasing wait times if it were rolled out on an organizational level, including an exception procedure to allow flexibility. Leaders within CB can promote the use of prescriptive core services by all clinicians and define the times that clinicians are able to provide service.

Implementing this solution will require resources in the form of time and information. Clinicians will need to collaborate to determine the list of services in which CB should offer. All clinicians should have the opportunity to provide feedback on what these services should be. However, in accordance with the organization's values, and the ethics code provided by the BACB, services offered must be considered evidence-based (Champion Branch, 2016; BACB, 2018). Internal committees that focus on service delivery will need to review available research to ensure that the prescribed list of services are considered evidence-based practice. In addition to developing prescribed services, communication will be needed to inform stakeholders, families and other community agencies of changes and improvements that will be occurring to the services provided by CB.

Solution 4: Creating Integrated Service Delivery Teams. An additional solution would be for CB to develop integrated service teams within the organization. These teams would consist of behaviour clinicians with assistance from consulting psychologists, nurses, speech language pathologists and occupational therapists. An integrated service delivery model (ISDM) is often used between partnering professionals to provide social services and healthcare. The goal of ISDM is to ensure supports are client focused (NWT Social Services, 2004). While

traditionally this method is used in social services to increase collaboration between different agencies, ISDM is a solution that could be implemented internally at CB. Integrated service delivery teams could also reach out to partnering agencies that support children on CB's waitlist. Teams could collaborate on a weekly basis, receiving an update on cases, and provide recommendations for initial supports or assessments that could be completed by the agency.

There are many benefits to developing integrated service teams including providing a continuum of care and services for children that ensures that professionals are using a holistic, comprehensive approach to providing service. Services would be coordinated together, allowing for capacity building across groups of professionals and caregivers who are currently providing support for the children (Government of New Brunswick, 2015). Utilizing an ISDM allows for services to be tailored to their specific environments, focusing on strengthening the children's existing supports. Additionally, an ISDM provides professionals with improved opportunity to collaborate within one another, sharing resources regarding behaviour analysis and developmental services (Government of New Brunswick, 2015).

Clinicians would need to spend time learning about frameworks for providing an ISDM and connecting weekly with families and service partners during implementation of the project. While initially leaders would need to be involved with the roll out of an ISDM, leader involvement would likely decrease after implementation, as integrated service delivery teams would provide peer feedback and clinical support to one another. An ISDM also allows for teams to collaborate on developing new mechanisms for service delivery. Therefore, over time CB might be able to shift fiscal resources from leadership into creation of more clinical positions, further increasing capacity.

It is within my scope to collaborate with internal committees to investigate integrated service delivery teams and utilize an ISDM to collaborate with other professions providing services to my clients. Collaborating with clinicians within CB would provide the opportunity for peer feedback and mentorship. Additionally, it is within my scope to contact families and children waiting for service to potentially provide recommendations for interim support until services are available.

If the leadership team accepted a recommendation for the use of an ISDM throughout CB and were to formally promote the use of an ISDM, the scope of this solution would broaden. Contact and interim support for all families waiting for service could occur. An ISDM would allow for more peer feedback and mentorship, allowing leaders to focus on other needs of the organization.

Recommended Solution

After evaluation of the possible solutions for change, it is recommended that CB implements a combination of two solutions: creating a positive organizational culture through and modifying the structure of services. These solutions were chosen as they complement one another well and offer the greatest leverage to reduce wait times quickly. As described in chapter 1, organizational culture is defined as a combination of ideas, practices, attitudes, and beliefs within a workplace (Edelman, 2011; Bolman & Deal, 2017). Therefore, it is important to recognize that shifts in organizational culture occur over long periods of time, and that multiple OIP cycles may be needed in order for the necessary cultural shift to be completed. This cycle will focus on creating a positive shift in workplace climate in order to achieve buy in for any other subsequent changes to be successful. Therefore, it is recommended that when planning for change, CB fosters a positive climate change prior to modifying the structure of services. This

solution is based on the theory of action that developing a more positive climate, modifying the structure of services, promoting ongoing change, and implementing transformational and distributed leadership will result in a more positive organizational culture over time, and deliver real operational benefits.

The second solution, implementing changes to structure of services, I will refer to as an Evidence Based Structured Services (EBSS) solution. Both assigned and emergent leaders within CB will need to motivate clinicians to embrace EBSS, by providing reinforcement and feedback about their strengths and abilities to succeed in their roles. Individual confidence will increase if clinicians feel they are trusted to actively engage in the change process (Rafferty & Griffin, 2004; Rajput & Novitskaya, 2014). Efforts must be made to increase trust between the leaders and the clinicians. According to Zhu et al. (2011) if the clinicians feel that the leaders within CB care about them, their well-being, and value their work, they will be more likely to participate in change procedures. If leaders within the organization demonstrate open communication and trust, clinicians are more likely to engage in similar behaviour with their colleagues. Building trust and ensuring that all organizational members feel cared for and valued not only contributes to a positive organizational climate but decreases resistance to structural changes to the organization (Elsmore, 2018; Rajput & Novitskaya, 2014).

In order to effectively combine both of these solutions, CB should develop a pre- and post- measure of organizational climate. Leaders will measure the climate change with a variety of measurement tools including questionnaires, interviews and observations. Utilizing these tools would allow CB to create a climate baseline against which to measure change.

At the same time, teams should be created to determine the EBSS services that CB will offer to children and families. The process would consist of examining literature and research to

determine best practices in behaviour analysis, solicit feedback on services currently offered and develop a list of services that are to be offered. Mintzberg and Waters (1985) would describe this solution as a prescriptive organizational strategy. This type of strategy provides clinicians with a step by step process to follow during the change. This solution will provide more predictability for all members of the organization and for families. Implementing EBSS, will provide a structured model of service delivery which may ease any trepidation from both families and clinicians during the change process. Prescriptive strategy and organizational changes are often linear which will increase the ease of implementation (Syed, Shah & Kazmi, 2015). A linear plan for these changes within CB also aligns with the use of Lewin's (1947) three step model for change and Kotter's (2009) eight step model for change. As discussed, the use of a linear model assists with ease of implementation in the first OIP cycle. However, for subsequent cycles of change, steps should be taken in a more cyclical manner, ensuring that steps are always being evaluated and revisited as needed throughout the change process.

Creating an ISDM has significant potential for CB, particularly in terms of increasing service outcomes. To yield results, however, it demands a high level of effective peer level teamwork; which means that to be successful, it requires both the recommended culture change and more structured services solutions. An ISDM should be considered as a future change, but only once the two recommended solutions are successfully implemented.

Plan Do Study Act Model

The recommended solutions described above should be implemented using a Plan Do Study Act (PDSA) Model. This model has four main stages through which CB can move. The first stage is Plan, where assigned and emergent leaders work together to plan the change process. This will include leaders planning the strategies for the shift in climate and internal

committees planning the procedural changes for service. The second stage is Do, where members of CB will begin to implement the plan. In Study, the third stage, CB will evaluate the implementation of the change plan on a limited basis to determine if it is effective at reducing wait time for service. The final stage of the model is Act. In this stage members of CB will determine if change should be implemented long term or if the change solution should be terminated. Chapter 3 will include further discussion of the PDSA model and its alignment with the recommended change frameworks, and leadership models within CB.

In this section, four possible solutions were described to address the problem of practice within CB. The recommended solution is together creating a more positive climate and implementing EBSS offered to families and children, resulting in a change in culture over time. By utilizing these recommendations together, clinicians within CB will be more motivated to participate in the change process. CB will utilize a PDSA model to implement solutions to the problem of practice.

This section of the OIP identified four potential solutions to address the POP. A combination of two of the solutions, (1) shifting the organizational culture and (2) modifying the structure of services was recommended. The ethical implications of the implementation of a solution and the use of specific leadership approaches and change frameworks will be discussed in the section below, followed by Chapter 3, which lays out the structure of the proposed change plan in detail.

Leadership Ethics and Organizational Change Issues

This section identifies the ethical issues that may arise when implementing the change process within CB. Ethical implications of transformational leadership, distributed leadership will be discussed. In addition, Lewin's three step model for change and Kotter's eight stage

process for organizational change will be examined to determine ethical issues that need to be considered.

Ethical Concerns within Champion Branch

CB provides services to a vulnerable population, children with IDD and their families. All organizational members at CB have an ethical responsibility to ensure that the families and children serviced are getting the support that they require to succeed within their current environments. One of the CB's values is for clinicians to deliver service in an ethical and accountable manner (Champion Branch, 2016).

As the main service provided at CB is behaviour support, clinicians are required to use evidenced based services. This is promoted in the values of the organization and the ethics code by the BACB. Even though the majority of the clinicians within CB are not certified by the BACB, it is in the best interests of children and families for the organization to follow the ethical code organization wide. The comprehensive code states that behaviour analysts must use information based on scientific literature when providing human services (BACB, 2017). Therefore, any services offered by CB must be backed by scientific research and be proven an effective service for children. Behaviour clinicians within CB often collaborate with other professionals who recommend strategies or programs for children that are not backed by science. Children with IDD have the right to effective services, and so clinicians within CB are responsible for ensuring that families and agencies are aware of the risks and benefits to strategy implementation (BACB, 2017).

In addition to ethical considerations of the types of services recommended by CB, ethical considerations would need to be evaluated when determining whether or not to only provide

services for a specific duration of time. Specifically, CB would need to determine whether or not a specified duration of would allow children to meet their goals and receive effective treatment.

The need for effective and evidence based service delivery for children with IDD impacts my decision making and leadership approaches. As a BCBA, ensuring the implementation of evidence based practices within the organization is critical. Additionally, a lens of equity should be used when determining potential strategies for change. Children with IDD have varying needs based on their diagnosis and cognitive skill level. Effective service demands that services must be tailored to the needs of the child. With a structured list of services, each service would be adapted to fit the needs of the child and the context in which they live. For example, if a functional skills assessment were completed, it would recommend individual target skills to teach a specific child, and some children may require more service than others to meet the same goals.

Ethical Implications of Leadership Approaches

There are ethical implications associated with the implementation of specific leadership approaches. Leaders must consider the impact these implications will have on the organization. There are positive and negative implications of both distributed leadership and transformational leadership approaches and they are illustrated in Table 2.1, followed by a discussion of benefits and risks.

Table 2.1

Ethical Implications of Leadership Approaches

	Distributed Leadership	Transformational Leadership
Ethical Benefit	<ul style="list-style-type: none"> Power is shared among various members of organization 	<ul style="list-style-type: none"> Leaders model ethical behaviour and develop future leaders with strong moral values
Ethical Risk	<ul style="list-style-type: none"> Power is allocated to organizational members at the discretion of leaders 	<ul style="list-style-type: none"> Pseudo-transformational behaviour may be displayed from leaders if they do not truly desire to help empower others

Distributed Leadership. The goals of distributed leadership are to share work tasks and responsibilities, utilizing the leadership skills of all organizational members and increasing motivation to reach a common goal. According to Dion (2012), the goal of leaders who engage in distributed leadership is to work towards creating a common good for as many clinicians within the organization as possible. Leaders believe that benefits for the overall group of clinicians and overall population receiving services outweigh benefits to one individual (Dion, 2012), ensuring the needs of the organization are met. While distributed leadership has many benefits, there are ethical issues that may arise during its application. For example, there may not be a proper distribution of power and/or the lack of experience and expertise of people executing leadership tasks (Lumby, 2013; Tahir et al., 2016). It may be of benefit for leaders of CB to address ethical concerns around the distribution of power during the OIP cycle. While distributed leadership involves sharing of task, a hierarchy of power still exists (Lumby, 2013). Within CB, clinical managers will assign leadership tasks to clinicians. If tasks are distributed unevenly, this could negatively impact the culture within CB (Lumby, 2013).

Transformational Leadership. Transformational leadership involves the use of idealized influence, idealized inspiration, intellectual stimulation, and individualized consideration. A transformational leader must provide these supports to clinicians within CB. For example, Dion (2012) suggests that when clinical managers provide individualized influence and consideration, they hold a lot of power. Leaders have the ability to influence the beliefs of followers and shape them as future leaders. As a result, transformational leaders carry responsibility for modeling ethical leadership and fostering strong morals within clinicians. If implemented effectively, transformational leadership will teach clinicians to focus on the needs of others and help to create a sense of community within CB (Dion, 2012). Similar to distributed leadership, transformational leaders also focus on the best interest of the group (Kanungo, 2001).

Equity is an important consideration when utilizing specific leadership approaches. Leaders need to ensure that they are providing adequate support and consideration to each clinician's unique needs. For example, while some clinicians may be able to implement change and distributed leadership tasks autonomously, others may require more support to reach the same outcomes.

Ethical Implications of Change Path Models

In addition to the ethical implications of leadership models, leaders must consider the ethical implications associated with the chosen change path frameworks, to determine the impact these will have on the organization. Table 2.2 summarizes the ethical implications of utilizing both Lewin's three step model and Kotter's eight step model as a change framework.

Table 2.2

Ethical Implications of Change Models

	Lewin's Three Step Model	Kotter's Eight Step Model
Ethical Benefit	<ul style="list-style-type: none"> • Values free will, a distribution of power and participation without coercion 	<ul style="list-style-type: none"> • Values trust and transparency within the organization
Ethical Risk	<ul style="list-style-type: none"> • Values do not align with organizations participating in the free market needing to evaluate change in terms of profit 	<ul style="list-style-type: none"> • Kotter's model does not directly consider the ethics of organizational change

Lewin's (1947) Three Step Change Model. Lewin's three step change model was developed based on his interest in behavioural change within organizations, on the premise that all organizational members had free will and participated in the change process without pressure from leaders (Burnes, 2009). Organizational members were taught about their own behaviour, the factors that influence behaviour and the consequences that maintain it. Lewin believed that after the examination of one's own behaviour, organizational members would be willing to participate in the change model (Burnes, 2004; Burnes, 2009; Cummings et al., 2016; Burnes & Bargal, 2017).

Lewin's change model is based on a set of ethical beliefs and values (Burnes, 2009). Organizations were developed based on the goals and values of its members, and prioritizes the need of the organization. There is a focus on increasing organizational effectiveness, and distributing power in order to promote a democratic environment (Lewin, 1947; Burnes, 2009). Lewin's change model focuses on creating a democratic, participatory environment rather than forcing change through coercion. While Lewin's values may be considered beneficial to CB during the change process, these values can differ from those used in organizations within

the free market that focus on organizational change to increase service levels and profit margins (Harvey, 2005; Burnes, 2009).

Kotter's Eight Stage Model. While Kotter's (1996) eight stage model does not include a description of ethical values, it promotes honesty amongst the members. Kotter (1996) proposes that leaders should engage in discussions with organizational members about the overarching problems within the organization that are leading to the change. When participating in the first stage of Kotter's (1996) model, establishing urgency, leaders within CB should meet with internal committees comprised of clinicians to discuss the problem of practice and contributing factors. Throughout the eight-step process, leaders and clinicians within CB will develop shared ethical and moral values which will become ingrained in the organizational culture by the final step, anchoring new approaches in organizational culture (Kotter, 1996).

Summary of Ethical Concerns. There are many ethical implications of change within CB that leaders need to consider, but on balance, the ethical benefits of proposed changes far outweigh the risks. Leaders should be considering the impact the change will have on the equity and quality of services children and families receive. Leaders will need to balance the needs of the families and children, and the needs of clinicians. There are ethical benefits and risks to utilizing distributed and transformational leadership. Leaders within CB will need to identify concerns that they can address during each OIP cycle. During the first OIP cycle, focus may be placed on the equity of services and ensuring children and families have access to evidenced based support.

Chapter 2 Conclusion

Chapter 2 has identified the leadership style changes that can enable change. A set of change frameworks, and tools has been proposed along with gap analysis. An in-depth

evaluation of four potential solutions for the problem of practice within CB is presented. These solutions include maintaining the status quo, developing a positive organizational culture, structural changes to service procedures and the development of integrated service teams. The solution recommended within this chapter is a combination of developing a positive climate and implementing structural changes to service delivery. Lewin's three stage model and Kotter's eight stage process can be utilized together to provide a clear model for change within CB. Lewin (1947) provides a model that aligns well with non-profit organizations and aligns well with concepts within behaviour analysis. Kotter (1996) provides additional details leaders need to ensure that change within the organization is implemented effectively, evaluated, and cemented within CB's culture. Finally, Chapter 2 evaluates ethical issues faced by CB and issues that arise with the use of specific leadership approaches and change path models. The most appropriate problem analysis, and solution recommendations will only be effective if they are successfully implemented. Therefore, Chapter 3 will discuss the specific plans for communicating the need for change, implementing the change plan and evaluating the results of the change process.

Chapter 3: Implementation, Evaluation, and Communication

Chapter 3 Introduction

Chapter 1 of this OIP outlined a problem of practice (POP) within the organizational context and history of Champion Branch (CB). The author's scope, agency and biases are also discussed. Chapter 2 identified leadership approaches to facilitate change to address the POP, and process and change frameworks to guide the change within CB. Transformational and distributed leadership were presented as a method for facilitating the concurrent use of Kotter's (1996) eight step change model and Lewin's (1947) 3 step model. A combined solution, fostering a shift in organizational culture and modifying the structure of services, is recommended. Chapter 3 proposes a detailed plan to implement these changes, outlining the roles and responsibilities of organizational members, a monitoring and evaluation framework, and plan for communicating change. This chapter also includes next steps for Champion Branch and provides a discussion around future considerations for the organization, including a next cycle for change.

OIP Implementation

This OIP recommends the change plan and processes needed within Champion Branch (CB) to address the POP, specifically, the lack of service delivery capacity by a clinical service agency to provide sufficient service and to decrease wait times for children with intellectual and developmental disabilities (IDD). In order to implement the recommendations suggested within this OIP, CB will need to follow a change implementation plan that aligns with the values of the organization. As described in Chapter 1, CB holds a set of values that must be upheld during service delivery, and maintained through any change. One such value is that the clinicians must provide ethical, high-quality services while acting in a respectful, caring and compassionate

manner towards the children and families receiving clinical support (Champion Branch, 2016). CB also values responsiveness to the needs of the children and families as well as to other community agencies that are involved in the provision of support and evidence-based services (Champion Branch, 2016). At the same time, the evolving priorities of the provincial government, which CB serves, have the potential to create additional constraints, or demands for change that CB will need to adapt to, in order to maintain its adherence to its values.

Chapter 2 recommended the utilization of a combination of two strategies for initial change: (1) fostering a culture shift in the organization through a positive climate fostering an environment that the clinicians view as both positive and empowering; and (2) the successful implementation of structural changes to services delivered to children and families. The change implementation plan will draw guidance from the change frameworks outlined in Kotter's (1996) 8-step change model and Lewin's 3-step model (1947). These change frameworks are both well established, and suit CB's existing organizational capability to execute.

Scope and Influence

As set forth in Chapter 1, my role within CB is to provide behavioural support to children, families and other community organizations. It is within my scope to provide education and feedback to other clinicians, families and service providers. As well, as a member of various internal committees, part of my role is to collaborate on the development of new and more effective methods for service delivery. Through this committee work, I have been able to focus on overcoming existing barriers to providing services, decreasing wait times for services, and evaluating the methods in which CB is currently providing services. I am also able to exercise leadership through influence, modelling leadership approaches and influencing others to do the same. The director of CB has approved the development of this OIP and has given approval for

the development of a change implementation plan that can be utilized by the entire organization. Therefore, it is within my scope and agency to develop an OIP including a detailed change implementation plan for the purposes of moving change forward across CB.

Change Implementation Plan

The first phase of the change implementation plan follows first phase, Unfreezing, of Lewin's (1996) three step model and the first three steps of Kotter's (1996) change path model: establishing urgency; developing a guiding coalition; and creating a vision and strategy for change. Lewin (1947) suggests that this is the time to determine what needs to be changed and to gather information from all organizational members to determine priorities. During this time, a Change Management Leadership Team (CMLT) will be created to elicit feedback from all CB staff on the current structure of services and on potential solutions for change within the organization (Lewin, 1947). An organizational change readiness analysis can be conducted through tools outlined by Cawsey et al. (2016). These tools may help to determine the education and types of support from assigned leadership that is required for clinicians to implement changes. Using the feedback that the CMLT receives, and the research on effective evidence-based services, the CMLT will create a plan for change, outlining the specific services to be offered by CB and how they will be implemented.

The second phase of the change implementation plan allows for CB to proceed through Lewin's (1947) second phase, Change, and three steps of Kotter's (1996) change model: communicating vision; empowering broad based change; and planning for short term wins. The CMLT will be actively involved in sharing the vision and plan for change with all organizational members, and gaining approval from external stakeholders (Kotter, 1996). The value of the proposed changes should be communicated clearly to all internal and external stakeholders in

order to ensure that they are aware that implementing the change will improve CB's ability to reach its goal of providing effective and accessible clinical services, in order to enhance the quality of life for children with IDD and their families (Champion Branch 2016).

Education and skill development sessions will be provided for the clinicians, assigned leadership, and other organizational members by the CMLT. These sessions will cover, for instance, new waitlist contact procedures, criteria for case assignment and the clinical service tools that will be used following the change. Additionally, all members of the organization will be able to benefit from education on the value of transformational leadership and distributed leadership specifically for CB. This education would provide examples of how all members of CB can lead regardless of their role within the organization. The CMLT can utilize external trainers with experience implementing these leadership models as necessary, to provide further education.

As discussed in Chapter 2, transformational leadership approaches will help to foster an environment where all members are motivated to focus on the best interests of the organization and provide support to one another (Kanungo, 2001; Dion, 2012). Distributed leadership approaches will encourage all members of the organization to participate in change. A Clinical Service Leader (CSL) will be assigned from the clinician team to 'own' each of the new 'Service Tools', to reinforce distributed clinical leadership. Other clinicians who are not members of the CMLT will be able to participate in the change process as part of related working groups or accepting assignments in the implementation plan (Avolio et al., 2009). Broadening the number of participants in the change process will help to increase their commitment to the change process and provide additional opportunities for the clinicians to learn about the overall change process and to develop skills that will be useful in future cycles of change (Cawsey et al., 2016).

Furthermore, the plan for change should include short-term goals, allowing for CB to assess the progress it is making throughout the change process (Kotter, 1996). Reaching short-term goals also allows assigned leaders the opportunity to ensure they are providing positive reinforcement and recognition to the clinicians who are embracing and helping to implement the changes. (Daniels, 2016).

The third phase of the change implementation plan incorporates the use of Lewin's (1947) phase of refreezing and Kotter's (1996) steps of consolidating gains to produce more change and anchoring new approaches in the culture. Within CB, this consists of implementing a new structure of services with all clients, and continuous assessment of performance with comparison to service delivery targets. The capacity to provide services will be evaluated by comparing the duration of service and the numbers of children and families serviced before and after the changes, and the amount of clinician time devoted to actual service delivery (Kotter, 1996). Utilizing pre and post change data will allow leaders to compare service delivery targets, duration of service, and the amount of resources used, to determine if the change makes a difference in these areas. Reinforcement systems will be put in place by the assigned leaders to help ensure that the clinicians continue to be motivated to provide services on an ongoing basis (Daniels, 2016). A 12-month change implementation plan for CB to utilize when addressing the POP is outlined in Appendix J.

During all phases of the implementation plan leaders need to focus on changing the organizational climate on the path to an organizational culture shift. Leaders should focus on utilizing and developing the strengths of clinicians (Luthans, Youssef and Avolio, 2007), and building positive relationships between clinical managers and clinicians. Incorporating transformational and distributed leadership approaches will help to increase personal support and

opportunities for clinicians, increasing their buy in and providing an environment where individual clinicians feel that their needs are being met. All of the organizational members in leadership roles should ensure that they are using positive reinforcement and demonstrating that they place value on the work of the other organizational members (Edelman, 2011; Daniels, 2016; Parent & Lovelace, 2018). Implementing multidirectional open communication will also help to build trust between members of the organization and to contribute to a positive shift in the immediate climate (Edelman, 2011). In addition to the immediate impacts of a positive organizational climate, the implementation of the Kotter's (1996) change path model throughout the OIP cycle will allow for leaders to instill the value of change within CB and ensure that the promotion of ongoing change becomes a part of CB's long term culture shift.

Stakeholder Reactions

CB has a variety of associated stakeholders that will likely all be affected by the change process. These stakeholders include: the associated pediatric clinic, community service agencies, families of the children receiving support, clinicians, the funding source, and CB's advisory board. Each of these stakeholders is likely to benefit from the implementation of the change plan, however they may also have reservations or be hesitant throughout the process. For example, the families of the children receiving support may be concerned about how proposed changes will impact their individual child and the quality of services that they receive. As described in Cawsey et al. (2016), the change leaders will need to understand the views of both the internal and external stakeholders in order to mitigate any concerns, and to effectively gain acceptance and buy-in during the change process.

The associated pediatric clinic, the advisory board and funding source should view the changes in a positive light as they hope to allow more children to gain access to behavioural

service without requiring additional funding. Families of the children receiving services are likely to benefit from the organizational change as their children will have access to more structured, evidence-based services. If the change process is successful at adapting the service delivery model and decreasing wait times for service, children will be able to access the benefits of behavioural service at a faster rate.

Internal stakeholders at CB such as the clinicians and other organizational members may initially be concerned about change, in particular the amount of resources required to effectively plan for change, and possible personal impacts (Cawsey et al., 2016). Therefore, both the CMLT and the assigned leadership within CB should assist in providing education and support regarding the benefits that are hoped to be obtained via the change process. The CMLT and assigned leaders should place focus on creating a positive organizational climate in an attempt to help facilitate future change (Ehrhart, Schneider & Macey, 2014). The creation of a more positive climate within the organization and the implementation of a structured model of service delivery will give the clinicians an exciting opportunity to collaborate as a team, allowing for easier and more delegated decision making during clinical service delivery, while providing the guidance and structure to ensure that evidence-based services are being provided consistently (Luthans, Youssef & Avolio, 2007; Edelman, 2011).

People Driving Change

In order to enact the change process within CB, a change champion will be appointed. As discussed in Chapter 2, the implementation process will be assisted through the use of transformational and distributed leadership principles. The change champion will create and lead a team that focuses on the planning of the change process, the CMLT. It is within my scope and agency at CB to help facilitate the development of this team, and to participate as a member. As

a member of committees focusing on overcoming barriers to service delivery and decreasing waitlists, I can assist in repurposing these committees to focus on the change plan activities.

During the change process, committees will be restructured as teams. According to Grigsby (2008), the role of committees is to focus on specific topics and to collaborate on decision making. The role of a team is to work together towards goals and outcomes in order to fulfill a common purpose (Katzenbach & Smith, 1993). Utilizing team structures will instill commitment to achieving results, and continually improve performance during the change process (Grigsby, 2008; Katzenbach & Smith, 2015). The CMLT will provide a source of constant focus and leadership for the change process. The CMLT will assist by increasing effective collaboration, and will help with the distribution of change related tasks (Wang et al., 2014). The CMLT will be responsible for: planning the change process; coordinating the sub-teams to complete their tasks efficiently; incorporating the feedback from all of the various organizational members into the plan for change; educating all organizational members; and providing ongoing communications to all internal and external stakeholders. According to Katzenbach & Smith (1993) sub-teams are a collective of people or working group that hold a specific skill set, working together to achieve specific tasks. Within CB, sub-teams will focus on the structure of service delivery, disseminating information of evidence-based practice, internal communications, stakeholder relations, and the monitoring and evaluation of the project and its goals. A vitality team will be created to help with the shift in organizational climate, to create a more positive work environment, and increase employee retention (Luthans, Youssef and Avolio, 2007; Edelman, 2011).

As mentioned above, selected clinicians will be given the opportunity to be assigned as a clinical service leader (CSL). This role will give clinicians the opportunity to oversee clinical

skill development and implementation of a specific evidence-based service. For example, one CSL will be responsible for education and skill development, and overseeing the implementation of functional behaviour assessments. The role of CSL adds additional scope to the current role of the clinicians, distributes leadership tasks related to change implementation, and helps to promote long term development of EBSS in CB's operations going forward. An additional benefit of the new service delivery structure is the ability for less skilled or experienced clinicians to work more efficiently and effectively as they will now have more structured solutions and additional service delivery guidance from a CSL.

This change initiative is occurring at a micro level. Therefore, while the responsibilities of the clinicians and assigned leaders will expand, the structure of the organization will not change. As explained above, a current member of the organization will be assigned as a change champion by the director. Clinical managers, clinicians, and others will be members of the CMLT. The new roles are outlined below in Appendix K.

Resources

In order to implement this OIP, CB will need to allocate the resources required for change. These resources primarily include the use of human capital such as time to plan, implement, and evaluate the change process. These resources will have to be redeployed from other projects. The director and assigned leadership will need to evaluate areas from which resources can be shifted, in particular those with value that will decline as change is implemented. In addition to the dedicated change champion, dedicated time from clinicians participating on teams will be required, as well as organizational members that are assigned change management implementation tasks. For example, clinicians will spend time researching the use of evidence-based practice while setting the new parameters for service delivery and

clinical managers will guide the clinicians through new processes.

Short, Medium, and Long-Term Goals

The change plan will be broken down into short, medium, and long-term goals. Breaking down goals into smaller steps that organizational members can implement will assist with motivation, and maintain momentum. The short-term and medium-term goals for CB are outlined in Appendix L.

The change implementation plan includes 90 day (short term) goals and 12 month (medium term) goals. Long term goals extend past the implementation of this change plan at 36 months. Within the first 90 days, short term goals include identifying the CMLT, assignment of leadership tasks, developing a prescribed list of services, appointment of CSLs, and formalized procedures for case intake and assignment. Medium term goals include an implemented change to the structure of services to new case assignments. The implementation progress will be evaluated every 90 days. Once this 12 month change cycle is complete, long term goals may include implementation of new service structures across all behavioural cases, the adaptation of the organization to reflect the new culture and service delivery model, and the creation of Integrated Service Delivery Teams (ISDT) across multiple linked agencies. Additionally, as CB moves through the change process, revisions may be required based on actual results and progress.

Challenges to Implementation

CB will likely encounter barriers and challenges when moving forward with this change plan. Overcoming these may require support from both internal and external stakeholders. The affiliated pediatric health clinic, CB's advisory board, and the provincial funding source will all need to support this organizational change for it to succeed. CB's director will need to articulate

the need and urgency during the first phase (Kotter, 1996). CB will need to identify goals and feedback from families waiting for support. Without such feedback, the stakeholders are less likely to support the change plan, and could even sabotage or protest the implementation of the plan. An example of resistance from stakeholders can be seen in the recent changes that have been announced to autism services within Ontario, where changes were made without incorporating feedback from all stakeholders. According to the Ontario Association for Behaviour Analysis (2019) the government did not collaborate with families or autism professionals when developing the plan for implementation. This program focuses on removing all the children from the waitlist and providing a maximum (upper limit) amount of annual funding per child based on age (Ministry of Children, Community Social Services, 2019). Groups of both families and professionals have been protesting the implementation of the new program structure, as they feel it does not promote the use of evidence-based services or meet the individualized needs of each child (Ontario Association for Behaviour Analysis, 2019).

Additional challenges to implementation will be resistance from clinicians, including concerns about increasing workloads, inflexibility when proposing changes to the services offered, and the impacts that changes may have on their current caseload. In order to address these concerns, leaders will need to facilitate a shift in resources during the change process. For example, in order to ensure that clinicians have enough time to participate in the change process, other initiatives or projects may have to be put on hold. Administrative staff could also be utilized to cover some administrative tasks for the clinicians, allowing them more time to participate in the change initiative. Education and skill development sessions will be required for services that will be provided as part of the EBSS. Not only will the clinicians require skill development on new tools and services, but education should also focus on the value of these

services and benefits for CB and the children receiving support. Understanding the value of the change in services will help to decrease any resistance (Cawsey et al., 2016).

Embracing distributed leadership may be a challenge for the current assigned leaders. Responsibilities may need to be shifted from current assigned leaders to clinicians or members of the CLMT. Therefore, managers may see the change as an infringement or threat to their current roles and authority. CB must ensure that currently assigned leaders understand and accept the shifts in their roles, focusing on the promotion of a culture of change and reinforcing the clinicians as they take on their new roles and implement changes (Daniels, 2016). Assigned leadership will play an important role in ensuring that continuous change and evaluation become part of CB's culture (Kotter, 1996). This leadership will also help to ensure that clinicians continue to implement the changes over the long term.

In summary, this section outlines the change implementation plan, which is broken down into three phases. Within each phase, steps from Lewin (1947) and Kotter's (1996) change path models will be implemented. Goals for the change process are broken down into 90day assessments and 12-month evaluations. Long term goals such as a shift in organizational culture will be evaluated after multiple OIP cycles. Strategies to mitigate challenges to implementation were also discussed in this section. The next section describes the significant benefits of incorporating the PDSA model into the change process.

Plan Do Study Act Cycles

As discussed in Chapter 2, the Plan Do Study Act (PDSA) model should be incorporated throughout the change process. The PDSA model promotes a scientific methodology to organizational change and was developed by Langley, Nolan & Nolan (1994), based on previous work of Deming (1986; 1993). A scientific methodology is a process in which a test or

experiment is designed to test a hypothesis, analyze the results and determine whether or not the hypothesis was valid (Speroff & O'Connor, 2004). Using a scientific methodology within the process of organizational improvement will provide CB with the opportunity to trial strategies for structured services, and to determine if there is evidence demonstrating that the changes are effective, before their full implementation (Shojania & Grimshaw, 2005).

Langley, Nolan, Nolan, Norman & Provost (1996) modified the PDSA cycle to best fit health care settings from its origins in a manufacturing setting (Taylor et al., 2014). The model provides a simple framework for leaders to follow when implementing organizational changes, allowing for testing of changes prior to full implementation. Strategies for change can be tested on a small scale prior to being implemented on a large scale (NHS Improvement, 2018). Within CB, for example, a subset of clinicians could begin offering a new service or prescribed list of services before implementation by the entire organization. The PDSA cycle ensures that leaders evaluate change prior to full implementation (NHS Improvement, 2018).

Plan Stage

The planning stage of the PDSA cycle helps to ensure that leaders and clinicians will take the time to validate prospective changes prior to implementation. Planning the change process will allow for CB to evaluate what change is needed within the organization and to create hypotheses on methods to help reach those goals. During this phase, several questions must be answered to determine the goals of change, the actions that are taken to produce change, and the method for determining if the change has been effective (Taylor et al., 2014; NHS Improvement, 2018). The CMLT will need to define the objectives for change and anticipate possible outcomes when the change occurs. During the Plan stage, roles and responsibilities are going to be

assigned, timelines for change are planned, and tools for monitoring and evaluating change are created (Taylor et al, 2014; NHS Improvement, 2018).

The Plan stage of the PDSA cycle incorporates well into the first stage of Lewin's (1947) change model, Unfreezing, and the first three stages of Kotter's (1996) change model, establishing urgency, building a coalition, and developing a strategy and vision for change. These stages of Kotter (1996) and Lewin (1948) focus on developing a plan for change, determining priorities and goals for change, and outlining the steps to change. Using the PDSA model, these planning stages will be taken one step further with the addition of monitoring and evaluation procedures (Taylor et al, 2014).

Do Stage

The Do stage of the PDSA cycle occurs when members of the organization implement the strategies for change developed in the Plan stage. Within CB, the Do stage would consist of clinicians implementing the steps to have a prescribed list of services or having leaders implement reinforcement systems for the clinicians. The Do stage becomes an element of Lewin's (1947) Change phase and Kotter's (1996) fourth and fifth step, communicating the vision for change and empowering broad-based change. It is during these stages that the CMLT will communicate the overall need for change, the sense of urgency, and the plan for change to all members of CB and initiate the change process. According to Bollegala et al. (2016), this stage includes data collection to monitor implementation and ensure that the plan for change is being implemented as designed. During the do stage, it would be the responsibility of the change leader and the CMLT to ensure that data collection is being conducted and ensure that both clinicians and clinical managers are supporting and adhering to the change plan (Taylor et al., 2014; Bollegala et al, 2016). Examples of data collected during the Do stage could include

implementation fidelity data, frequency of implementation of new structured services, duration of services, and outcome measures such as number of clients served.

Study Stage

During the Study stage of the PDSA cycle, the data that was collected in the Do stage is analyzed by the CMLT and CSL's as appropriate to determine if the strategies developed in the Plan stage and implemented in the Do stage were effective at meeting CB's goals. This phase is to review what was completed in the Do stage in order to determine if the change was successful (Taylor et al., 2014; Bollegala et al, 2016; NHS Improvement, 2018). This stage becomes a technique of the change phase of Lewin (1947) and Kotter's (1996) sixth stage of planning short-term wins. The change leader and CLMT within CB will evaluate the limited changes completed in the do stage to determine if the goals were met and verify if the forecasts made in the planning stage were correct (Taylor et al., 2014). For example, identifying the effects of a subset of clinicians implementing an EBSS within their current caseload.

Act Stage

During the Act Stage, decisions will be made based on the results of the Study phase. Leaders within CB will need to decide whether the changes are to be implemented on an ongoing basis, if they will be adopted organization wide, and/or if the plans for change will be modified and there will be another PDSA cycle (Taylor et al., 2014). This aligns with Lewin's (1947) freezing phase and Kotter's (1996) seventh and eighth stages of consolidating gains and producing more change and anchoring new approaches to change. The Act stage will help to ensure that continuous change becomes a part of CB's culture moving forward.

Benefits to Utilizing the PDSA Cycle with CB

The PDSA model allows for CB to develop strategies for change and the methods that can be used to test and evaluate the change concurrently with the other change frameworks. The concurrent use of models in CB's plan for future service delivery is illustrated in Appendix M.

PDSA cycles are often used within health care settings when planning & implementing changes in order to improve the quality of services that patients receive. They provide a method for testing the success of changes without the risks of disrupting services for all patients (NHS Improvement, 2018). A further benefit to using the PDSA cycle is the ability to show the potential for the success of organizational change on a smaller level. This can contribute to increased buy-in from stakeholders. It may also decrease potential resistance towards further implementation.

CB could utilize multiple PDSA cycles concurrently. This can occur when change plans involve multiple strategies for change. (Taylor et al., 2014; NHS Improvement, 2018). Multiple PDSA cycles could be implemented: changes to structured services, new leadership approaches, and a more positive organizational culture. The CMLT will need to address any factors that may interact between various cycles. The CMLT will ensure that the goals of the cycles are aligned, and the methods being tested in one cycle will not impact another (NHS Improvement, 2018).

Additionally, PDSA cycles can be used continuously, with the results of one cycle informing the next. For example, if CB implemented the use of a specific tool when providing EBSS, the PDSA cycle will evaluate the use of the tool, determine if using that tool helped them reach their intended outcomes. The CMLT would then have the opportunity to determine if this tool should be adopted by all clinicians moving forward, or if a different structured tool should be considered for broader implementation. If a different tool was required, it would be introduced in the next PDSA cycle (Taylor et al., 2014; NHS Improvement, 2018). Currently,

when new procedures are implemented, formal evaluation procedures are not in place. Utilizing PDSA cycles would ensure that change processes are formally documented and provide a mechanism for ensuring that the results of evaluations are used to inform future decisions with the organization (Taylor et al., 2014; NHS Improvement, 2018). Appendix N provides an example of how CB could utilize multiple PDSA cycles to help foster a more positive climate. The figure illustrates simultaneous PDSA cycles due to the complexities involved with changing organizational climate, including the introduction of different approaches to leadership, communication, and reinforcement (NHS Improvement, 2018).

Monitoring and Evaluation Framework

CB will need to also implement a framework for monitoring and evaluating change. The director, clinical managers, CMLT, sub-teams, and CSLs should all utilize a consistent set of measurement and evaluation tools. Continuous measurement can impact the direction of the change process and the outcomes of the change product (Cawsey et al., 2016). The measurements analyzed in the study phase of a PDSA cycle can impact decisions moving forward (Taylor et al., 2014). Examples include measuring the extent to which managers are implementing traits from transformational leadership through self-measurement and questionnaires, or measuring the rate at which clinician's implement EBSS with recently assigned children and families.

Measurement tools will be broken up into two categories: monitoring tools and evaluation tools. Monitoring will be defined as the process of measuring the implementation of steps within the change plan. Monitoring tools will assess changes to procedures as they are being implemented. These will identify treatment integrity, adherence to new policies, and help to ensure that change management strategies have been implemented (Markiewicz & Patrick,

2016). According to Markiewicz and Patrick (2016), the goal of monitoring tools is to provide leadership with more information regarding program implementation, helping to ensure that program changes are implemented as they originally planned to, in order to meet outcome goals.

Evaluation will be defined as the overall assessment of the change outcomes, a comparison of the pre and post change state. Tools will be used to assess whether CB was successful at meeting its overall goals for the change process. Most importantly, whether CB was able to increase the capacity of the clinicians to provide services, and therefore decrease the length of time that children and families are waiting for service. Markiewicz and Patrick (2016) suggest that evaluation tools assess the quality and value of a program and the ability for a program to produce outcomes that align with program goals. **Both monitoring and evaluation tools will be used throughout the OIP process. The value of monitoring and evaluation tools is summarized in Appendix O.**

Measurement Tools will be used to monitor implementation of change procedures and to evaluate the effectiveness of the overall change process. The tools that will be used in each phase of the change implementation plan are summarized in Appendix P. Additionally, the CLMT will use baseline data on the duration of service provided over the last five years to compare with the duration of services provided after the change process was implemented. This is necessary, as many children receive services for longer than 12 months. **The tools used for a short-term and medium-term timeline of evaluation and monitoring tools is illustrated in Appendix Q.**

Monitoring Tools

Monitoring tools should be used throughout the change process to assess implementation of new procedures within CB. The CMLT, CSL and clinical managers will be responsible for monitoring the implementation of changes. There are three different levels of measurement

within CB: (1) systems level evaluation; (2) solution level monitoring and; (3) strategy level monitoring. The solutions and strategies levels outline the need for continuous monitoring throughout the change process, assessing changes as they are implemented. Measurement of the overall effectiveness of the changes within CB will occur through a systems level evaluation, including the assessment of overall organizational performance. The three levels of measurement within CB are illustrated within Appendix R.

During the change process, the CMLT will monitor the sub-teams to ensure task completion. For example, a sub-team can focus on evaluating the evidence-based procedures prior to the CMLT establishing the new roster of EBSS. The CMLT will need to ensure that this task will be completed by the target date and that the outcomes produced are given to the sub-team responsible for creating the roster. As the CMLT monitors task completion, clinical managers will continue to monitor progress in order to provide ongoing support and reinforcement to sub-team members.

Once procedures for the provision of services have changed within CB, CMLT and the clinical managers will both need to continue to monitor the implementation of the change. This will allow the clinical managers the opportunity to practice transformational leadership and reinforcement. Clinical managers can monitor their own use of transformational leadership through a checklist created by a sub-team and through self-assessment tools (Northouse, 2018). Additionally, the number of opportunities for the clinicians to become involved the change project through the CMLT, sub-teams, or as a CSL will be monitored. This will allow for CMLT to measure how effectively distributed leadership is being utilized.

As described earlier in the change implementation plan, the CSL is responsible for the implementation of a specific EBSS. For example, one CSL will be responsible for ensuring

successful development and implementation of functional behaviour assessments by all clinicians. In order to effectively monitor the implementation of each service, the CSL will be responsible for developing Service Fidelity Checklists (SFCs) and clinicians will be responsible for developing Treatment Integrity Checklists (TICs). SFCs are for clinicians to use to as a guide, outlining all the steps required to provide an EBSS. The goal of the TICs is to ensure that behavioural recommendations and treatment are being followed as recommended by clinicians, families, and other service providers. TICs are often used to ensure behavioural treatments are implemented as recommended (Moore & Symons, 2011). For example, a TIC would be created to monitor the effective implementation of a behaviour support plan in a child's home.

Evaluation Tools

Leaders and the CMLT will need to complete specific assessments to determine organizational readiness, identify the priorities for change, and seek feedback from organizational members on CB's current capacity and perceptions of organizational climate. Implementing the Organizational Capacity Assessment Tool (OCAT) may help to measure these factors prior to change (McKinsey & Company, 2013). The OCAT, an online tool, has been chosen as a measurement tool for CB based on its use frequently within other non-profit organizations (Brown, 2014). Informing Change (2017) completed a comparison of capacity assessment tools, and determined that the OCAT is easy to conduct, available for multiple users, evaluates a broad range of areas, and is well suited for small organizations. Utilizing the OCAT, CB will evaluate the goals and strategies of the organization as well as leadership, funding structures, internal processes, communication, culture, values, and innovation (McKinsey & Company, 2013). Users could include stakeholders, assigned leadership, members of the CMLT and clinicians. OCAT has some limitations including the length of the assessment and the

investment of time to complete the assessment. However, overall the OCAT is recommended for CB as it will not only act as a capacity assessment tool but promote collaboration and distributed leadership throughout the assessment process.

Baseline measurements will need to be collected. Using internal statistics, the CMLT will determine the number of cases closed and opened throughout the previous year. The CMLT will also need to collect baseline data on the duration of services over the last 5 years. Currently, services provided to children within CB are conducted over multiple years. Data will be reviewed in the aggregate in order to preserve the confidentiality of clients.

With CB switching to a prescribed roster of evidence-based services, the quality of services must also be evaluated to ensure that children and families continue to receive high quality services that meet their individual needs (Champion Branch, 2016). One of the primary services that will continue to be provided is the development of behaviour support plans. Baseline measurement for the quality of behaviour support plans can be collected through the use of the Behavior Intervention Plan Quality Evaluation II (BIP-QE II). This tool provides a scoring guide to use when reviewing behaviour support plans to ensure that the strategies within them are evidence-based and are derived from the science of behaviour analysis (Browning-Wright, Mayer & Saren, 2013). The BIP-QE II has been found to a valid and reliable tool for evaluating the equality of behaviour support plans written for both children and adults with IDD (Webber, McVilly, Fester & Zazells, 2011; McVilly, Webber, Paris & Sharp, 2013; Wardale, Davis, Vassos & Nankervis, 2018). The BIP-QE II is an example of one method CB can use to assess the quality of services provided to families and children throughout the OIP cycle.

After the change plan has been implemented, baseline data will be compared to new data collected. Comparison of baseline and new data will allow the CMLT to see changes in the data

over time (Cooper, Heron & Heward, 2007). For example, the number of cases opened and closed after change versus the baseline, or the BIP-QE II scores of behaviour support plans after the introduction of EBSS compared to the scores collected at baseline.

This section has discussed the measurement tools that will be used during the OIP cycle. Monitoring tools will be used to measure short term goals and ensure change related tasks are being implemented. Evaluation tools will be used at the end of the OIP cycle and after additional OIP cycles to determine if the change plan contributed to an increase in organizational capacity. It is recommended that the PDSA cycle be used as a scientific method for evaluating change procedures. Data collection through the use of these tools is an essential part of tracking the change and its outcomes for CB. The next section of the OIP illustrates a communication plan that leaders will use to facilitate the change process.

Communication Plan

A communication plan is a strategy for methods of communication that will be used to support the change process. An effective communication plan can have an impact on the success of the change (Bel, Smirnov & Wait, 2018). Communication can impact the commitment of organizational members and the fidelity of change implementation, the degree to which people implement the changes as planned (Cawsey et al., 2016). An effective communication plan will help to ensure that all members are informed of the change process, the value of change, and will encourage members to participate fully (Bel, Smirnov and Wait, 2018). The developed communication plan must align with the leadership style within CB to maximize its effectiveness (Jones, 2008; Bel, Smirnov & Wait, 2018).

Salem (2008) suggests that common errors in communication such as insufficient communication, lack of trust within the organization, and lack of interpersonal skills within

leadership can contribute to a lack of success in organizational change efforts. As outlined in Chapter 2, transparency in communication will be valued throughout the change process at CB. The director should communicate his personal commitment to the need, urgency, and importance of the change program (Brisson-Banks, 2010). The CMLT will strive to provide continuous, transparent, and honest information about the need for change, the roles within the change process, and the planned outcomes of change. Both the assigned leadership as well as the change leaders will focus on the use of transformational leadership, utilizing their interpersonal skills, informal and formal recognition, and rewards to motivate and inspire organizational members throughout the process (Dion, 2012; Northouse, 2018).

The communication plan presented in this chapter aims to provide CB's change leaders with a guide; ensuring that essential communication occurs throughout the change process, as CB moves through different phases of Lewin's (1947) three step model and Kotter's (1996) eight step model. The communication tasks required throughout the change process are outlined in Appendix S.

Communication during Phase 1

During the first phase of the change process, the leaders of CB will need to create a sense of urgency by sharing information about the need for change and identifying the current service shortfalls, such as the current number of families waiting for service. This will need to be presented internally and also externally to the stakeholders, such as families, other community agencies, the affiliated pediatric health clinic, and the funding providers. Sharing the information will help to create and convey a sense of urgency, ensuring all stakeholders understand the need for change, and the value that change can create for all stakeholders (Kotter, 1996). In order to promote participation in the change event organization wide, the director will need to articulate

methods for which people can communicate their personal perspectives on problems and on the priorities of change, and to establish a feedback mechanism throughout the change process. Leadership's expectations for the participation of all members needs to be communicated in Phase 1. Clinicians will have the opportunity to provide feedback to the CMLT multiple ways throughout the change process. This information will be reviewed by the CMLT and shared with members of the organization on a timely basis.

Once the CMLT has been established, communication around the roles of the change leaders will need to occur to ensure that all clinicians have thorough understanding of the roles of the director, clinical managers, change champion, CLMT, CSL and sub-teams. During the change, continuous communication needs to occur regarding the responsibilities of each organizational member to ensure that all members understand and see value in how other members are participating.

Communication during Phase 2

During the second phase of the change process, the CMLT will inform internal and external stakeholders the methods of communication that they can anticipate the during the change process. Internally, communication on the list of EBSS that will be implemented will occur. Clinical Service Leaders (CSL) will provide clinicians an understanding on the new value that these services provide and the research that informed the decision to provide these services. This will highlight for clinicians the external research that validates the use of each service. Once implementation has commenced, short term results will be communicated every 90 days to internal and external stakeholders, through email alerts that contain both qualitative and quantitative results. Incorporating qualitative results will allow all stakeholders the opportunity to see other stakeholder perspectives and hear how the change processes has impacted them.

Quantitative data will be able to provide stakeholders with objective measures showing the changes that have occurred and the impact it has on service delivery. Regular, ongoing communications with stakeholders should include brief updates to reinforce the change progress. If revisions are made to strategies or steps in the change processes based on assessment results, communication will occur between CLMT and both internal and external stakeholders updating the plan.

Communication during Phase 3

The third phase of the change process includes sharing overall results of the change process with stakeholders. Communications must shift focus from what has changed, to the impact of the changes on CB's ability to serve their clients, and the benefits to internal and external stakeholders. Examples of results that might be shared include improvements in the total number of people served, quality of services offered and the number families each clinician is able to serve. CMLT should prepare a report on the results of the change process in order to disseminate information. The CMLT will also solicit feedback through online surveys, from both internal and external stakeholders, on their perspectives on the change process. This information will be used to inform future change. Based on learnings during the process, the CMLT will communicate next steps and identify follow-up plans for additional change. All stages of the communication plan must include consistent transparent communication from the director and CMLT to all stakeholders involved with the change. During Phase 3, the leadership should formally recognize individual and team contributions to the service results that have been obtained.

The timeline and audience for which communication tasks will be completed throughout the change process is outlined in Appendix T. In addition to the tasks outlined in the

communication plan, assigned leadership and CLMT will provide updates on the change process at monthly organization wide meetings.

Forms of Communication

Multiple forms of communication will be used within CB as it will provide opportunities for all stakeholders to access information about the change process. These forms of communication can be classified as formal and informal communication (Daneci-Patrau, 2011). Within the context of this OIP, formal communication is defined as a mechanism for sharing information with the purpose of disseminating information about the change process. Examples of formal communication within CB may include presentations, organization or department wide memos, department meetings, teleconferences, and internal reports. Typically within CB, major announcements have been provided internally through formal communication. This includes announcements at organization wide meetings, emails from the director, and the distribution of formalized policies.

A benefit to using formal communication is that it helps leaders to disseminate information in a uniform way. For example, the clinicians will all receive the same information regarding the change process (Daneci-Patrau, 2011). However, formal communication is often one directional. It does not always allow for discourse between the parties. Using only formal communication limits the clinicians' opportunities to provide feedback and ask questions about the changes in service structure. The reduced amount of discourse may increase anxiety for the clinicians and increase their resistance to change (Daneci-Patrau, 2011; Cawsey et al., 2016). Throughout the change process, the CMLT will elicit feedback from internal and external

stakeholders to facilitate two-way discussion and mitigate risk involved in one directional communication.

Within CB, informal communication can be defined as information exchanges between members of the organization that do not occur through an approved mechanism or planned process. Informal communication occurs frequently within CB. Examples of informal communication include any feedback, conversations or suggestions passed on from one person to another. Informal communication often occurs between clinicians, and between clinicians and clinical managers. Informal communication can also include nonverbal communications such as facial expressions and gestures (Graham, Unruh & Jennings, 1991). During the change process, informal communication should be encouraged between clinical managers, CSL, CMLT and clinicians. Assigned leaders and change drivers should provide an opportunity for and promote an environment conducive to two-way communication where clinicians feel comfortable asking questions, giving feedback or expressing concerns during the change process (Graham et al., 1991; Spaho, 2012). The use of informal communication can also pose a risk during the change process. If organizational members are hesitant about the change process, too much informal communication may lead to conflict within the organization (Spaho, 2012).

Two-way Communication

CB needs to ensure that leaders that communication is flowing in many different directions to increase participation in change process. Multi-directional communication may also decrease resistance to organizational change (Daneci-Patrau, 2011; Cawsey et al., 2016). Downward communication describes assigned leaders communicating with people that they manage or supervise. Within CB, downward communication currently occurs with leaders communicating procedures and giving directives to clinicians and other organizational members

(Katz & Khan, 1978; Spaho, 2012; Cawsey et al., 2016). Throughout the change process, downward communication will be needed when creating a sense of urgency, sharing the procedures for change, communicating the results of the change process, and when recognizing contribution. It is important that leaders also incorporate opportunities for two-way communication and maintain awareness that reliance on downward communication may contribute to a power imbalance within CB and may contribute to the use of transactional leadership (Northouse, 2018).

Spaho (2012) describes other directions in which communication can flow including upwards and horizontally. Upwards communication occurs when information is shared from employees to the senior leadership team. Ensuring effective mechanisms for upward communication will allow for clinicians to give feedback about the changes to culture and service structures while they are occurring. Upwards communication may assist the CMLT to gain a full understanding of how the roll out of new procedures is impacting employees and the children and families receiving service (Spaho, 2012; Cawsey et al., 2016). Horizontal communication is described as communication that occurs between clinicians, members of CMLT, SCLs, and other colleagues that are collaborating during change implementation. Sub-teams working together to complete change related tasks will engage extensively in horizontal communication in order to solve problems and create innovative solutions (Spaho, 2012). A visual depiction of the communication model for CB can be found in Appendix U. It promotes the combination of both downward, upward and horizontal communication. As within internal communication, CB will need to ensure there is two-way communication with external stakeholders. CB should continue to elicit feedback when updating external stakeholders. This feedback will help to ensure that the goals of the change process aligns with the needs of external

stakeholders. Methods of communication that will be used with each stakeholder are summarized in Appendix V.

Surveys. Formal surveys will be sent to organizational members on four occasions during the change process: (1) initial planning stages to determine priorities for change; (2) elicit feedback during initial implementation; (3) gain qualitative information during the initial 90-day checkpoints; and (4) to gain follow-up insights at the end of the change process. The use of surveys is a cost effective way of gathering information from a large group of participants. Surveys should to be used as part of a comprehensive measurement package with other data collection tools, ensuring that both subjective and objective measurement are used (Levenson, 2014). The CMLT will need to spend time reviewing survey responses, ensuring feedback is utilized during decision making time and creating a mechanism to share results (Levenson, 2014). According to Levenson (2014), during a change initiative surveys can be used to measure change readiness and the organization's ability to adapt. The use of online survey tools can be an effective way to assess the comfort level of the clinicians and other employees, and to gauge their willingness to implement future changes (Graham et al, 1991). External surveys can be utilized at the beginning and end of the change process to gain stakeholder feedback on priorities for change and thoughts on the next cycle of change for CB.

Additional Communication Methods. In addition to monthly organization-wide meetings, the CMLT will organize meetings with each location office to discuss the changes. These meetings will encourage open discourse about the value of the changes and any setbacks that occur during the implementation of changes (Daneci-Patrau, 2011). Each CSL will hold a monthly teleconference for clinicians to discuss clinical tools. This will give clinicians the opportunity to learn and seek clarification on implementing new tools, review results of recent

implementations and address any clinician concerns. Using email, internally a biweekly update sent by the CMLT would share information on progress towards goals and providing recognition for organizational members who have shown commitment to the change. Progress reports will be written in collaboration by the CMLT and shared at every 90-day checkpoint. These reports will be electronically distributed internally and to some external stakeholders to outline the progress being made and to allow for celebrations of short-term goal completion. Clinical managers will meet with clinicians approximately every six weeks to provide individualized support needed for implementing change and to provide clinicians with reinforcement and positive feedback. These meetings give assigned leaders the opportunity to utilize transformational leadership approaches, motivating the clinicians to meet the goals of the organization while also ensuring that the personal goals of the clinician are met (Dion, 2012; Northouse, 2018).

Communication Summary

Communication plays an important role within any organization. Methods of communication can impact employee satisfaction, job performance, and relationships between organizational members (Cawsey et al., 2016). Sapho (2012) suggests that organizations should focus their use of communication on fostering interpersonal relationships. The use of multidirectional communication tends to increase the morale within an organization and creates a more positive climate (Sapho, 2012; Cawsey et al., 2019). In addition to traditional written and oral communication, leader behaviour can have a significant impact on organizational change (Detert & Burris, 2007). Most of the behaviours that people engage in are forms of communication (Cooper, Heron & Heward, 2007). As described in Chapter 1, the behaviour of assigned leaders, the change champion, the CMLT, and the CSLs will impact the behaviour of the clinicians. Leaders need to behave and communicate in a consistent manner that promotes the

implementation of the change plan. Collaborating with the clinicians and providing them with constructive feedback will likely result in clinicians who are more engaged with the change process (Detert & Burris, 2007).

Chapter 3 Conclusion

OIP Conclusion

This OIP addresses the problem of practice, a lack of organizational service capacity in a clinical services agency for children with intellectual and developmental disabilities (IDD). The organizational context discussed is Champion Branch (CB), a non-profit organization that provides children with IDD behavioural support. Currently, CB has over 400 families and children waiting to receive service (Champion Branch, 2018). This OIP builds a case for creating a streamlined approach to providing evidence-based services to increase the capacity and effectiveness of service and to increase efficiency within the organization.

Chapter 1 outlines the leadership problem of practice, the organizational context, leadership approaches used within the organization, organizational structure, and the vision for change. My personal scope and agency are explained, as well as my bias, utilizing a social constructivist lens to approach the problem. Chapter 2 introduces leadership approaches and change frameworks. Lewin's (1947) three step change model and Kotter's (1996) eight step change path model are presented concurrently, along with the PDSA model, as a guide for change leaders within CB. Transformational and distributed leadership are used to complement the implementation of these frameworks. An organizational analysis assesses gaps in the organization between the current state and a preferred future state that addresses the POP. This OIP offers four potential solutions to the POP and recommends a combination of two, fostering a positive organizational climate and implementing a change in the structure of services provided.

Chapter 3 outlines the change implementation plan for the recommended solution. It outlines the steps to implementing change over a one-year period. A plan for monitoring and evaluating the change is proposed. Specific measurement tools are outlined to provide change leaders with methods to monitor the implementation of changes and for evaluating the effectiveness of the change plan. A communication plan is proposed to ensure transparency, keeping both internal and external stakeholders aware of information related to the change, and celebrating successes.

Next Steps for Champion Branch

In the final stage of the change framework, Kotter (1996) suggests that organizations should incorporate ongoing change into their culture. Therefore, part of CB's change implementation plan is to plan for the next cycle of change. This OIP has been created based first on an assessment of CB's clients' needs, along with the current organization and its capabilities. Commitment from all organizational members is required to execute the leadership and responsibilities within this plan and to achieve the objective of increasing service capacity, reducing wait times, and building the organizations capacity for continuous change. Next steps after this initial change cycle within CB should be developed based on the results from the current change implementation plan. If the change produces an increase in CB's capacity to provide service, leaders within CB should collaborate with the pediatric health clinic and the funding source to determine new service directions and objectives. In addition to service targets focusing on the number of people receiving service, targets can focus on the effectiveness of services provided.

Leaders within CB should ensure the continuation of the CSL role. The role of CSL formalizes the use of distributed leadership by assigning responsibility to clinicians, granting control to educate and support others (Avolio et al., 2009). The CSL role also provides a career

development option for some clinicians. Ensuring that distributed leadership is continued after the OIP cycle is an essential element for changing the organizational culture and providing on-going opportunities for informal leaders to enact change.

While behavioural supports are the main service offered by CB, there are additional specialized services provided such as speech and language pathology, occupational therapy, and dual diagnosis nursing. A new PDSA cycle could be initiated to implement EBSS within these disciplines as well. Leaders within CB should continue to utilize the PDSA model when initiating change, incorporating the scientific method to trial changes (Taylor et al., 2014). This will allow the organization to ensure that the changes reinforce the implementation of structured services and help to solidify a culture change of continuous change and growth.

Future Considerations

The following OIP section outlines four areas for future consideration for leaders and stakeholders within CB: (1) changing the structure of CB; (2) implementing the ISDM; (3) sharing the change strategies with other organizations; and (4) preparing for change driven by the provincial government.

Changing the Structure. Through the continued use of CSLs, instituting structured services and distributed leadership, the role of managers will likely shift. This may lead to an increase in the capacity of managers to provide support to additional clinicians, which could result in more organizational resources available to provide direct clinical services.

ISDM. CB could implement a PDSA cycle designed to evaluate the use of an ISDM. This model would allow for CB to partner with other community agencies, collaborating on client focused supports, and make sure that services align with one another, avoiding duplication of services. (NWT Social Services, 2004).

Dissemination. CB could share the results of the change process with other agencies providing clinical services to children or adults with IDD, who could benefit from learning about the successful outcomes and leadership learnings. If the results of the change process show that EBSS are effective, other agencies could initiate a PDSA cycle implementing similar procedures.

Political Priorities. Government priorities may shift in the area of social services. CB should always be ready to adapt to change. Continuously utilizing distributed leadership to promote procedures that increase the capacity of clinicians while providing evidence-based services and becoming more proficient at adapting to a changing political and social services landscape will help prepare CB for future changes.

Summary

The behavioural services that CB provides are extremely valuable to the families that they serve. Successfully implementing this OIP can improve the effectiveness of CB's service offerings, its capacity to serve, and its employee morale and retention. It also provides CB with an improved ability to integrate additional new innovations in service delivery and to respond to changes in its external environment, while maintaining and improving current services. These capabilities will allow CB to continue to deliver and increase value to its clients. These outcomes are significant and to succeed with this change plan requires use of the solutions, and the tools and techniques identified. Most significantly, though, it represents an opportunity for leadership at CB, both formal and assigned, to collectively embrace the new leadership philosophies and to inspire the entire team to deliver these results together. When successfully implemented, these changes can differentiate CB in its field, and establish CB in a leadership position that can also enable partners and other agencies, for the good of the people and the stakeholders they serve.

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Appendix A

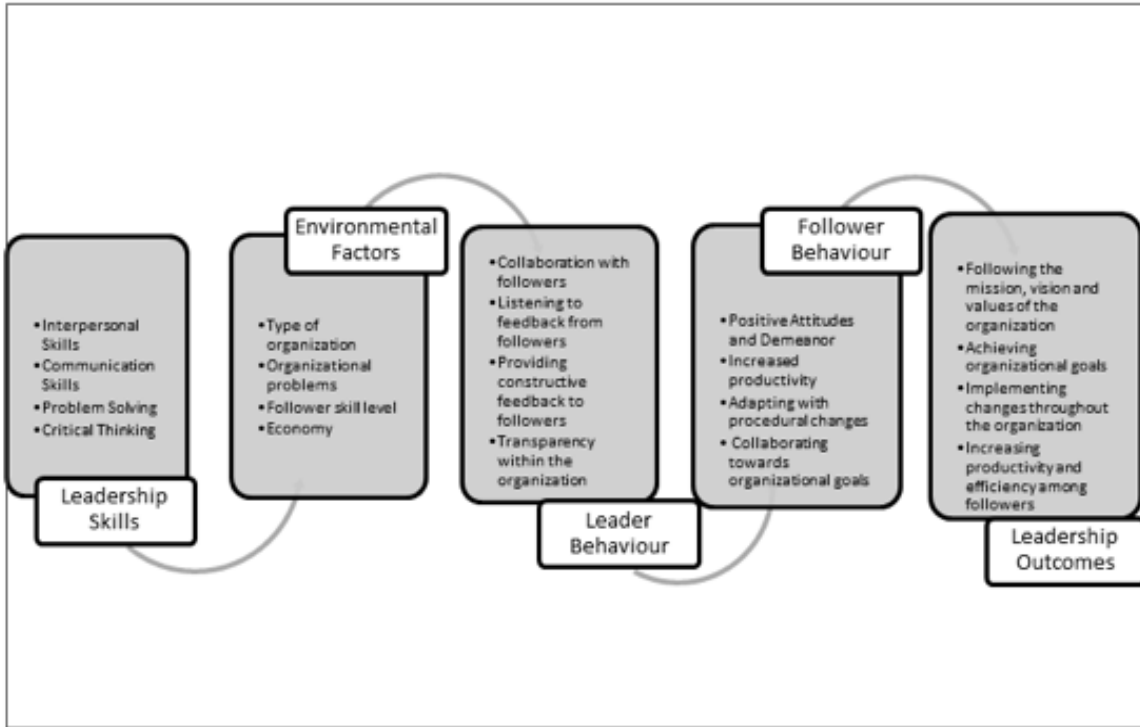
Social Context of Champion Branch



Adapted from Glisson. (2002). The organizational context of children's mental health services. *Clinical Child and Family Psychology Review*, 5 (4), p. 235.

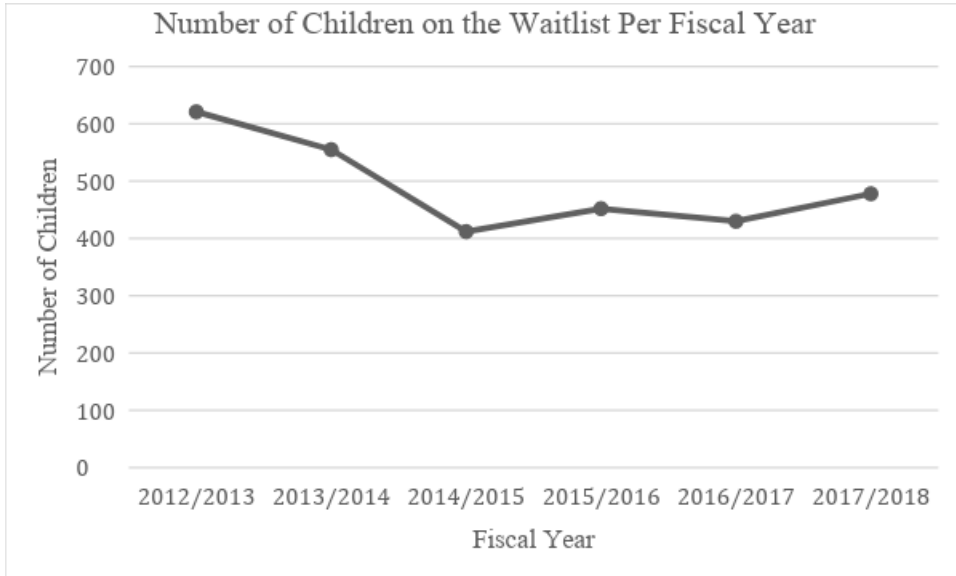
Appendix B

The Leadership Process



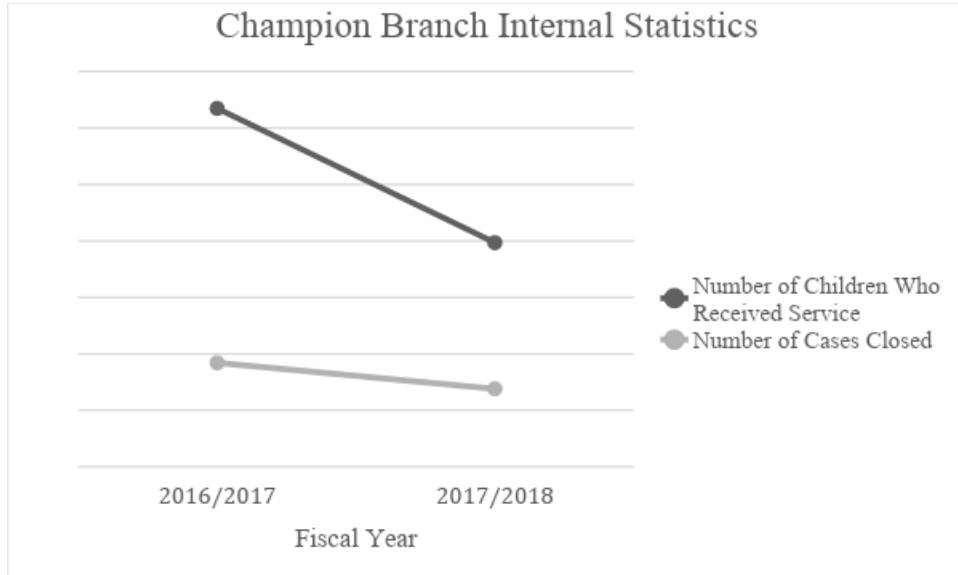
Appendix C

Number of Children on the CB Waitlist per Fiscal Year



Appendix D

Number of Children Receiving Service and the Number of Closed Cases Annually at CB



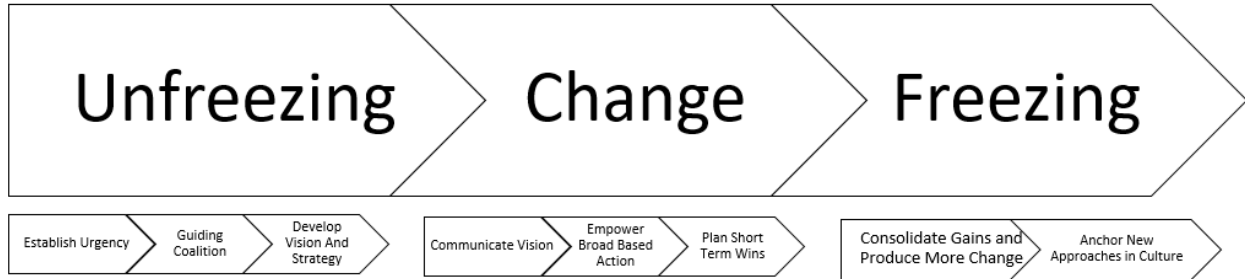
Appendix E

Main Change Drivers within CB

Market Place	The needs of the children with IDD, families and other service agencies impact the services provided by CB.
Organizational Members and Stakeholders	If organizational members and stakeholders must believe in the vision for change, they act as a strong advocate and catalyst for change.
Organizational Member Behaviour	Members of CB need to act in a manner that promotes and is conducive to change.
Organizational Member Mindset	A shift in mindsets may need to occur in order to change culture and have members effectively engage in the change process.
Comprehensive Education	Education should occur prior to implementation of change, ensuring that all members are aware of the change process and how that impacts their role within CB.
External Influences	External influences such as provincial government, political ideologies, stakeholders, community agencies all act as catalysts for change within CB.
Distributed Leadership	Utilizing shared leadership tasks may act as a change driver, assisting with the engagement of all organizational members.

Appendix F

The Concurrent Utilization of Lewin’s Three Stage Model for Change and Kotter’s Eight Step Model



Adapted from Lewin, K. (1947). Frontiers in group dynamics: Concept, method and reality in social science; social equilibria and social change. *Human Relations*, 1(1), 5-41. and Kotter, J.P. (1996). *Leading change*. Boston: Harvard Business School Press.

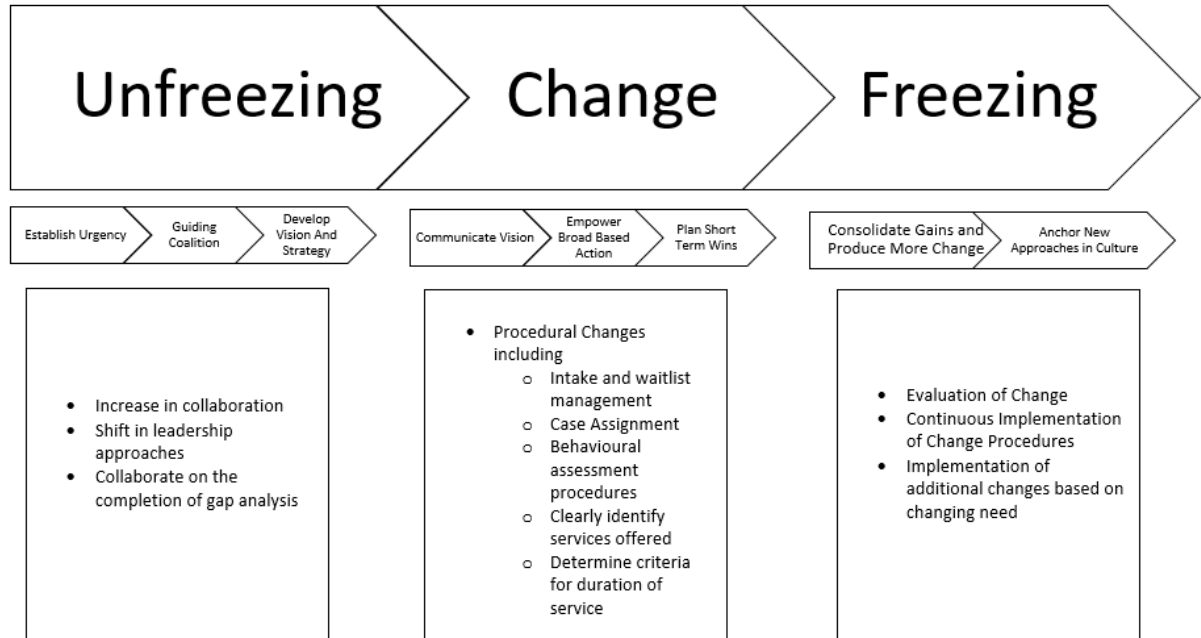
Appendix G

Summary of Factors within Gap Analysis

	Current State	Future State
Systems and Processes	<ul style="list-style-type: none"> - Lack of procedure for contacting families on waits and assigning cases to clinicians - Clinicians have the autonomy to determine the types of offered and types of clinical tools that are used 	<ul style="list-style-type: none"> - Prescribed list of services offered - Procedure for waitlist contact - Formal mechanism for assigning cases
Power and Cultural Dynamics	<ul style="list-style-type: none"> - Hierarchical Culture - Transactional leadership behaviours - Focus on implementation of policies and procedures 	<ul style="list-style-type: none"> - Culture shift focusing on - Collaboration - Innovation - Provision of High Quality Services
Stakeholders	<ul style="list-style-type: none"> - No formal mechanism for receiving feedback on the needs of families 	<ul style="list-style-type: none"> - Formal mechanism for feedback should be created to ensure services fulfill the needs of families
Recipients of Change	<ul style="list-style-type: none"> - Limited discussion of change readiness within the organization 	<ul style="list-style-type: none"> - Evaluation of change readiness - Support to clinicians for fear or uneasiness throughout change and periods of transition

Appendix H

Results of a Gap Analysis Embedded within Lewin’s Three Stage Model and Kotter’s Eight Step Model



Adapted from Lewin, K. (1947). Frontiers in group dynamics: Concept, method and reality in social science; social equilibria and social change. *Human Relations*, 1(1), 5-41. and Kotter, J.P. (1996). *Leading change*. Boston: Harvard Business School Press.

Appendix I

Summary of Proposed Solutions

Proposed Solution	Necessary changes	Resource Needs	Advantages of Proposed Solution	Disadvantages of Proposed Solution
Status Quo	<ul style="list-style-type: none"> - No changes necessary 	<ul style="list-style-type: none"> - No additional resources are needed 	<ul style="list-style-type: none"> - Leaders do not require additional education or a shift in leadership approaches to implement this solution 	<ul style="list-style-type: none"> - Wait list times do not decrease - Risk of not meeting mandated service targets - Children and families continue to go without services
Establishing a Positive Organizational Culture	<ul style="list-style-type: none"> - Shift in leadership to motivate and nurture organizational members - Increase in reinforcement and focusing on the strengths of others 	<ul style="list-style-type: none"> - Time for providing feedback and mentoring - Information and education for leaders on how to effectively change culture - Fiscal resources for fair compensation and reinforcement of all members 	<ul style="list-style-type: none"> - Increase in commitment, satisfaction and engagement of clinicians - Positive impact on clinician's readiness to implement other organizational changes 	<ul style="list-style-type: none"> - May take a long period of time - High response effort from leaders - Children will continue to wait for service
Modifying Structure of Services	<ul style="list-style-type: none"> - Creating a prescriptive list of services offered by CB 	<ul style="list-style-type: none"> - Time and Information: reviewing literature and collaboration to determine services offered 	<ul style="list-style-type: none"> - Duration of service for each child will decrease - Wait times for service will decrease - Increase in children receiving evidence-based services 	<ul style="list-style-type: none"> - Reduction of autonomy for clinicians - Resistance to change service procedures
Integrated Service Delivery Teams	<ul style="list-style-type: none"> - Developing a team of clinicians and professions in order to facilitate collaboration, resource sharing and service coordination 	<ul style="list-style-type: none"> - Time for clinicians to participate in meetings and to engage in peer feedback - Information and education on how to develop teams 	<ul style="list-style-type: none"> - Increase quality of services from a variety of professionals internal and external to CB 	<ul style="list-style-type: none"> - While it may increase quality of services, this may increase the duration of service - May not have an impact on wait times

Appendix J

OIP Cycle Change Implementation Plan

Lewin (1947) and Kotter (1996) Change Frameworks		Implementation Tasks	Responsible Party	Resources	By When (weeks)
Unfreezing	Establishing Urgency	<ul style="list-style-type: none"> - Present status of current waitlist versus service targets to the CB internal and external stakeholders - Lay out environmental challenges, cost of not acting now on problem at individual and team level, and case for change - Elicit feedback from internal and external stakeholder to help determine priorities and support for change 	<ul style="list-style-type: none"> - Director - Assigned Leadership - Current internal Committees 	<ul style="list-style-type: none"> - Time - Existing waitlist data - Electronic Survey System 	2
	Guiding Coalition	<ul style="list-style-type: none"> - Creation of CLMT, peer volunteers, manager rep - Request for written feedback from organizational members on future goals, potential methods for change, and organizational dependencies - Evaluation of organizational change readiness (Cawsey et al., 2016), and action plan CMLT 	<ul style="list-style-type: none"> - Assigned leadership - Management - Clinicians 	<ul style="list-style-type: none"> - Time - Electronic Survey System 	5
	Develop Vision and Strategy	<ul style="list-style-type: none"> - Develop plan for change utilizing feedback from stakeholders - CMLT to complete gap analysis using Beckhard and Harris (1987), and create new structure of services template - Evaluation of the services offered to ensure evidence based. - Create a prescribed list of EVIDENCE BASED STRUCTURED SERVICES (EBSS) for families - Appoint CSL's 	<ul style="list-style-type: none"> - CMLT team - Clinical sub-teams 	<ul style="list-style-type: none"> - Time 	13
Change	Communicate Vision	<ul style="list-style-type: none"> - Present the change plan to the agency - Provide education for organizational members on value of change - Communicate value to stakeholders 	<ul style="list-style-type: none"> - CMLT 	<ul style="list-style-type: none"> - Time 	18
	Empower Broad Based Change	<ul style="list-style-type: none"> - Provide training and education for any required clinicians or partners, ensuring they are able to adapt to EBSS - Provide training and education for all organizational members on transformational and distributed leadership 	<ul style="list-style-type: none"> - CMLT - Clinicians 	<ul style="list-style-type: none"> - Fiscal resource - External trainers - Time 	22
	Plan short term wins	<ul style="list-style-type: none"> - Plan short term goals for each 90 days - Implement service changes for new clients - Provide reinforcement for all organizational members as they implement new structure of services and incorporate evidence-based practices - Monitor implementation of services 	<ul style="list-style-type: none"> - Clinicians - CSL - CMLT 	<ul style="list-style-type: none"> - Time 	30
Freezing	Consolidate Gains and Produce More Change	<ul style="list-style-type: none"> - Assess service delivery against targets - Implement structure of services for all clients - Assigned leaders continuously promote the value of change - Evaluation of service targets - Evaluation of change in capacity 	<ul style="list-style-type: none"> - CMLT - Senior leadership - Clinicians 	<ul style="list-style-type: none"> - Time 	52
	Anchor new approaches in culture	<ul style="list-style-type: none"> - Continuous support for clinicians in implementation - Reinforcement systems continuously implemented by assigned leaders - Continuous evaluation of the success of the change - Evaluation of further organizational change opportunities 	<ul style="list-style-type: none"> - CMLT - Senior leadership - Clinicians 	<ul style="list-style-type: none"> - Time 	Every 90 days

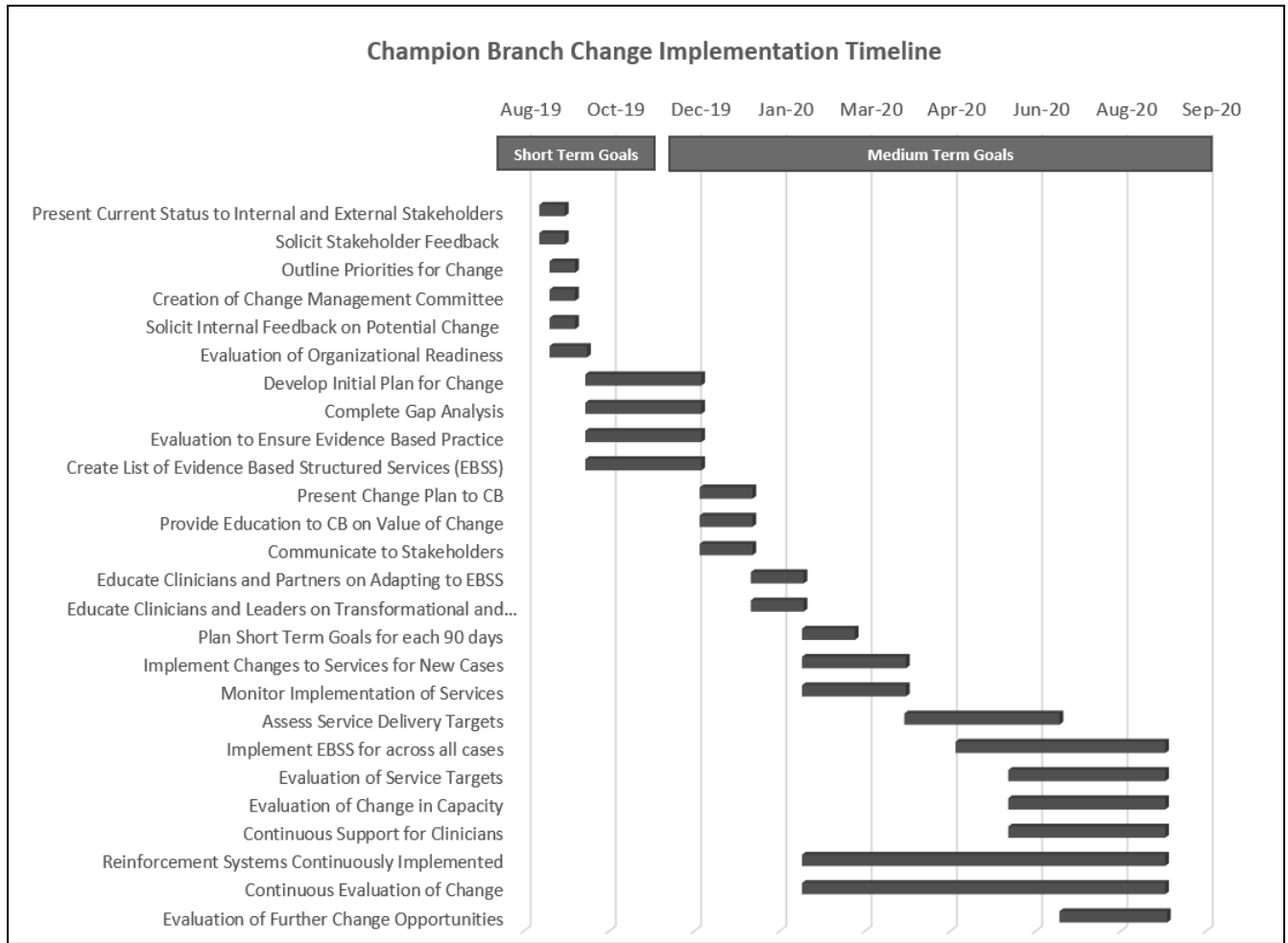
Appendix K

CB Roles during Implementation of Change

Role	Responsibilities
Change Champion	<ul style="list-style-type: none"> - Assigned by the director - Facilitate the development of the CMLT - Assist with communication between CMLT and assigned leadership
Change Management Leadership Team (CMLT)	<ul style="list-style-type: none"> - Plan initial change process - Provide leadership to organization during change process - Facilitate collaboration and distribution of leadership and change tasks - Elicit feedback from other organizational members - Monitor and evaluate the change process
Clinical Service Leaders (CSLs)	<ul style="list-style-type: none"> - Provide education on specific evidence-based services - Oversee the implementation of assigned EEBS procedures - Promote the use of this tool or service within the organization and with external stakeholders
Clinicians	<ul style="list-style-type: none"> - Provide feedback to CMLT - Implement change procedures - Provide evidenced- based services to families - Support children and families as services change
Director	<ul style="list-style-type: none"> - Be personally committed to this change - Present change management plan to stakeholders - Assign a change champion - Promote the development of the CMLT - Provide continuous support to clinical managers to ensure long term commitment to the change process
Clinical Managers	<ul style="list-style-type: none"> - Provide recommendations on membership of the CMLT and to act as CSL - Implement reinforcement systems and provide continuous support to clinicians for implementing changes to the service delivery

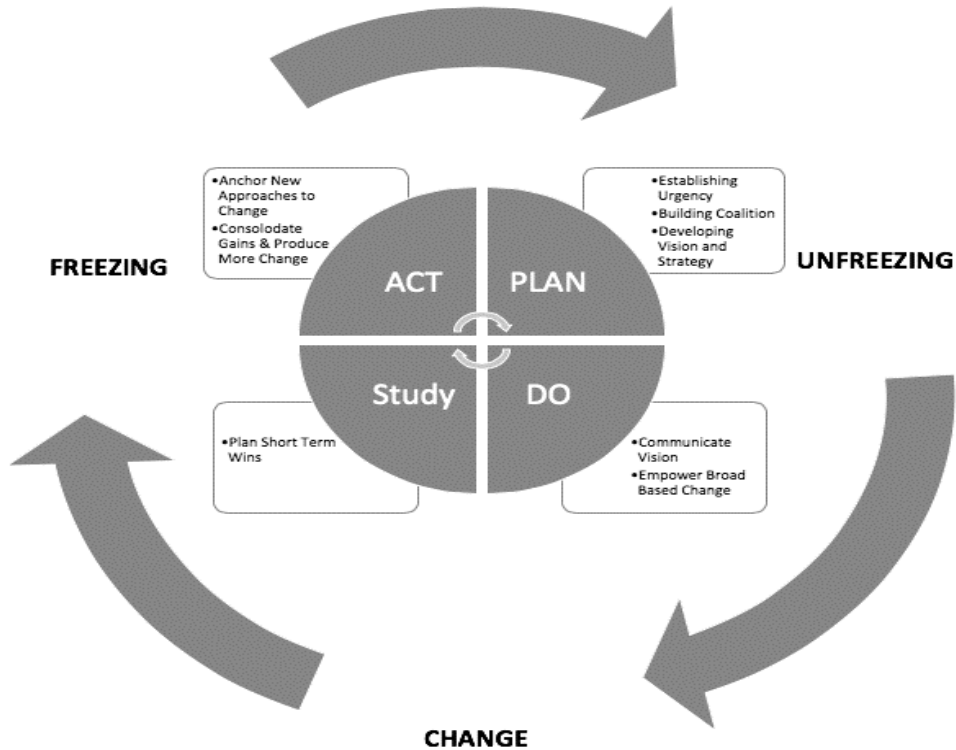
Appendix L

Champion Branch Change Implementation Timeline



Appendix M

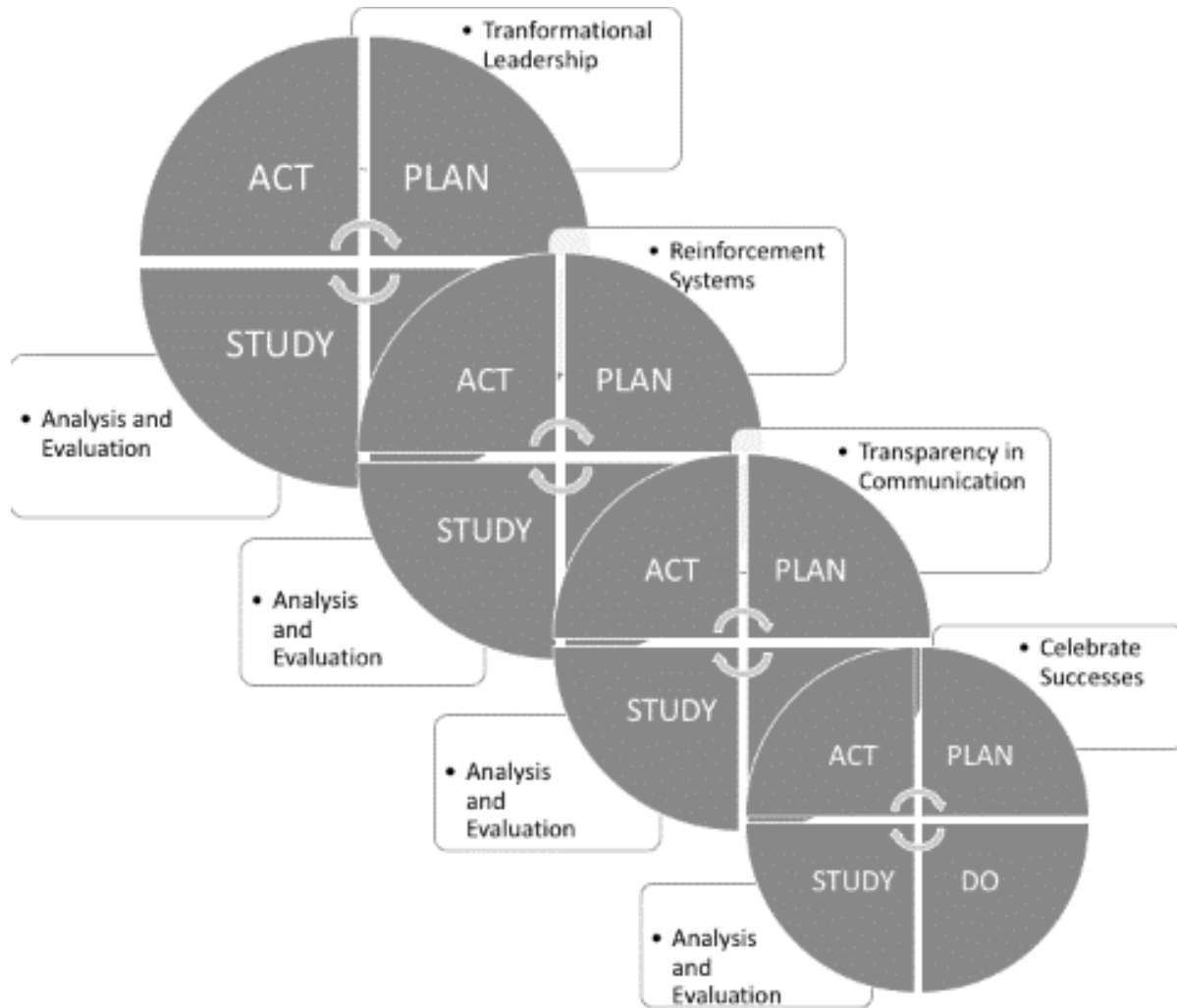
OIP Change Frameworks



Adapted from Lewin, K. (1947). Frontiers in group dynamics: Concept, method and reality in social science; social equilibria and social change. *Human Relations*, 1(1), 5-41; Kotter, J. P. (1996). *Leading change*. Boston, MA: Harvard Business School; and Langley, G., Nolan, K, and Nolan, T. (1994). The foundation of improvement. *Quality Progress*, 27(6), 81-86.

Appendix N

Example of PDSA Cycle within Champion Branch



Adapted from Langley, G., Nolan, K, and Nolan, T. (1994). The foundation of improvement. *Quality Progress*, 27(6), 81-86.

Appendix O

Benefits of Monitoring and Evaluation Tools

Monitoring	Evaluation
<ul style="list-style-type: none"> - Assess treatment integrity - Ensure changes are being implemented as designed - Measure progress towards short-term goals - Assess completion of tasks in accordance with the change timeline - Allows for measurement drive revisions to change plan as needed throughout the change process 	<ul style="list-style-type: none"> - Assess the effectiveness of change implementation plan - Evaluate the effects of change on program goal achievement - Identify if changes within the organization align with organizational priorities and goals - Long term evaluation will determine if the changes impact organizational capacity and decrease length of time children are waiting for services

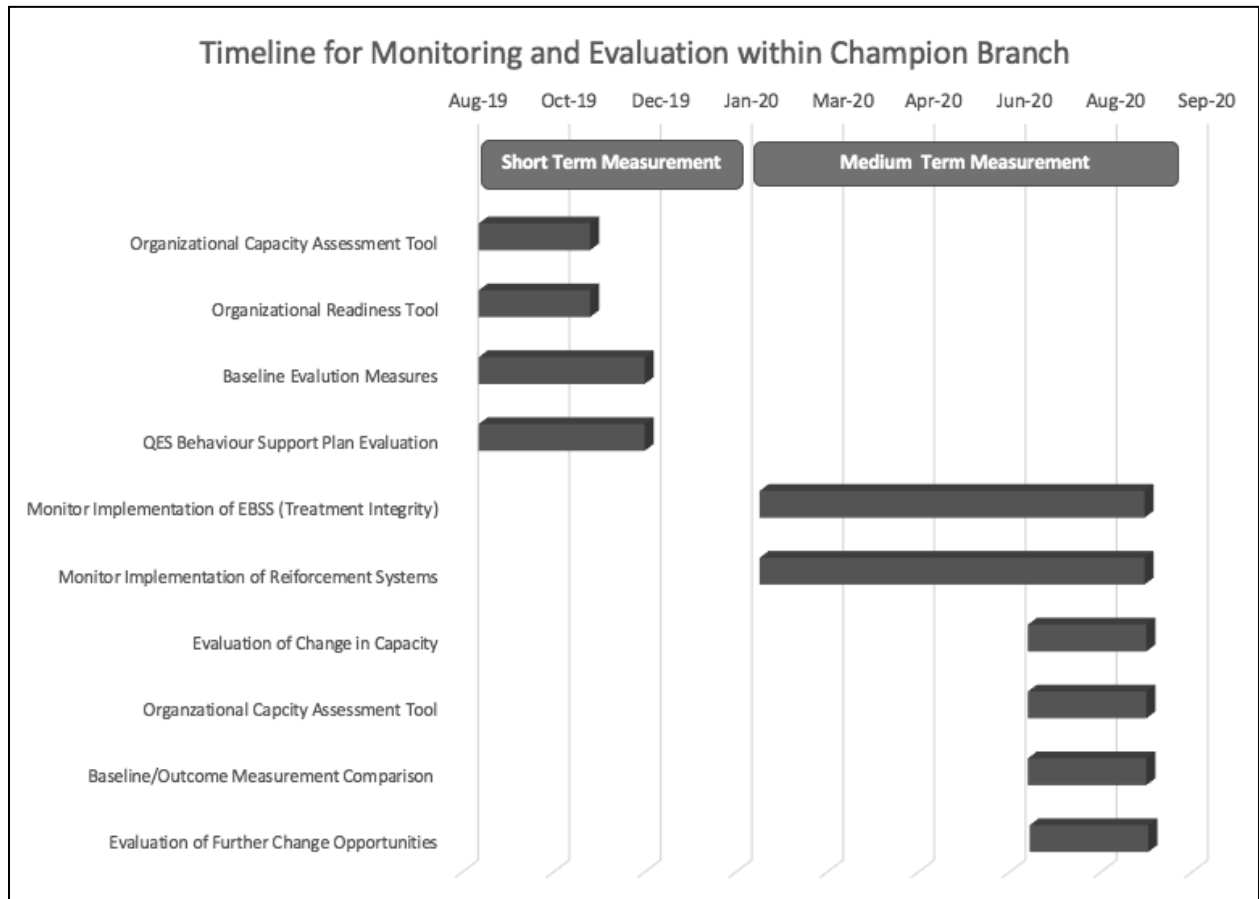
Appendix P

Measurement Methods within CB Implementation Plan

Phase	Lewin and Kotter's Change Frameworks		PDSA Cycle	Measurement Method	Function of Tool (Monitoring or Evaluation)
1	Unfreezing	Establishing Urgency	Plan	<ul style="list-style-type: none"> - Measure baseline data: number of people on waitlist, average duration of services; number of cases opened; number of cases closed - Organizational Capacity Assessment Tool (OCAT) - BIP-QE Baseline--quality of behaviour support plans - Survey feedback on leadership approaches, culture, perceptions of workplace climate - Questionnaire on organizational readiness for change 	- Evaluation
		Guiding Coalition			
		Develop Vision and Strategy			
2	Change	Communicate Vision	Do	<ul style="list-style-type: none"> - Treatment Integrity Checklists (TIC) - Assess short term goals - Measure goal completion compared to implementation timeline 	- Monitoring
		Empower Broad Based Change			
		Plan short term wins	Study		
3	Freezing	Consolidate Gains and Produce More Change	Act	<ul style="list-style-type: none"> - Measure baseline data: number of people on waitlist, average duration of services; number of cases opened in the last year, number of - Organizational Capacity Assessment Tool (OCAT) - BIP-QE Baseline--quality of behaviour support plans - Survey feedback on leadership approaches, culture, perceptions of workplace climate 	- Evaluation

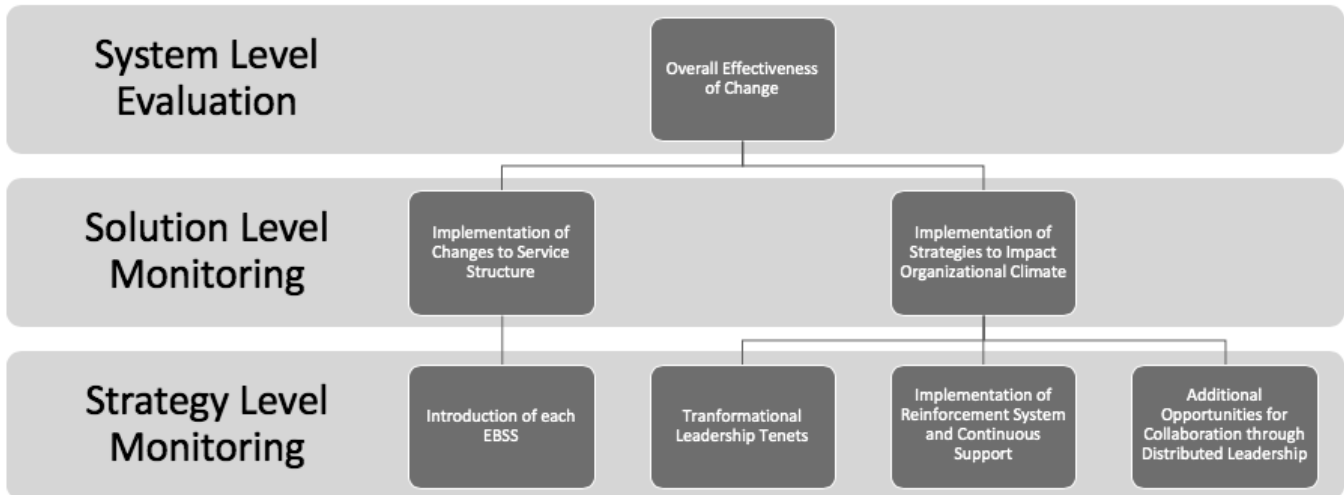
Appendix Q

Champion Branch Measurement Timeline



Appendix R

Different Levels of Measurement within Change Implementation Plan



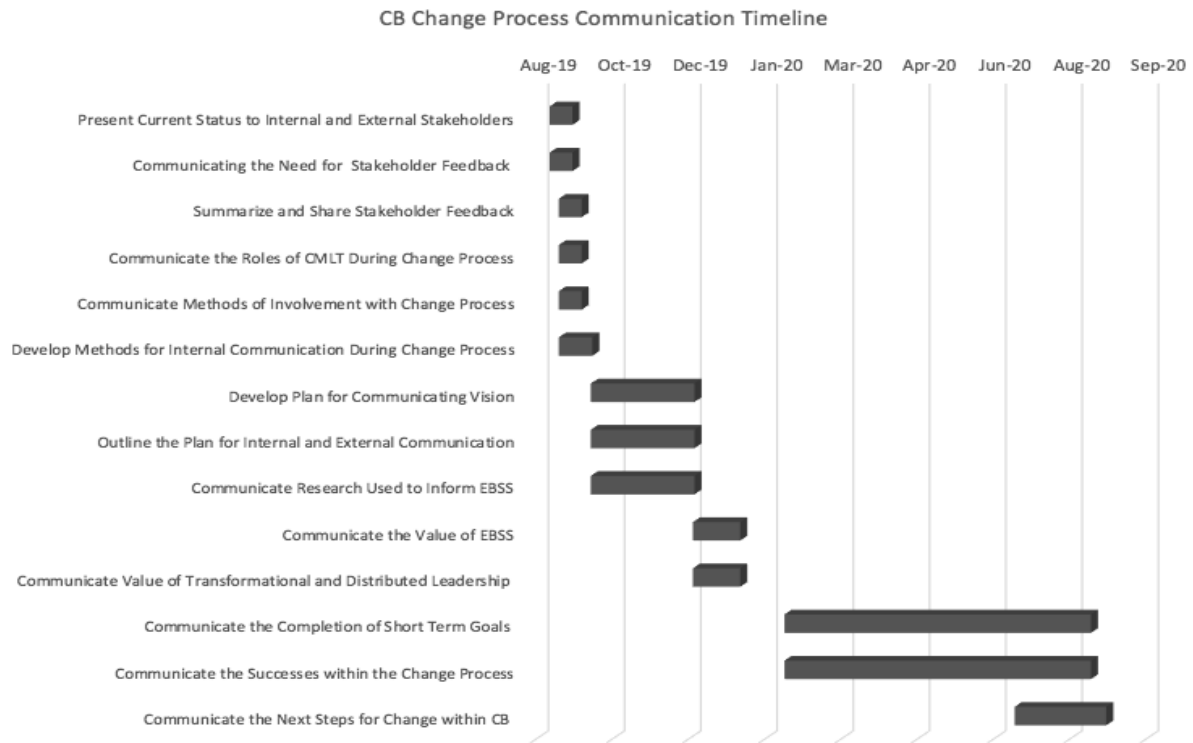
Appendix S

CB Communication Plan

Lewin (1947) and Kotter (1996) Frameworks		Communication Tasks	Responsible Party
Unfreeze	Establishing Urgency	<ul style="list-style-type: none"> - Presenting current status and implications of waitlist to both internal and external stakeholders - Communicating the need for input and feedback - Summarize and share feedback on the vision of CB and priorities for change 	<ul style="list-style-type: none"> - Director - CLMT
	Guiding Coalition	<ul style="list-style-type: none"> - Communicate with the internal and external team the role of CLMT and other positions - Communicate internally how organizational members can become involved in the change process 	<ul style="list-style-type: none"> - CLMT - Clinical - Managers
	Develop Vision and Strategy	<ul style="list-style-type: none"> - Develop methods for internal communication between team members and members of CLMT during change process - CMLT will collaborate with Director to determine plan for communication the vision for change with internal and external stakeholders 	<ul style="list-style-type: none"> - CLMT - Director
Change	Communicate Vision	<ul style="list-style-type: none"> - Outline for the organization how internal and external communication regarding change will occur throughout the change process - Communicate the research and evidence utilized to develop the list of Evidence Based Structured Services (EBSS) - Communicate value of the change process to stakeholders 	<ul style="list-style-type: none"> - CMLT
	Empower Broad Based Change	<ul style="list-style-type: none"> - Through training and education, communicate the value of EBSS and transformational and distributed leadership 	<ul style="list-style-type: none"> - CMLT - Trainers
	Plan Short Term Wins	<ul style="list-style-type: none"> - Internal communication focusing on the completion of short-term goals - Internal and external communication identifying the outcomes of goals including change process update at every 90-day checkpoint - Ensure individual and team recognition takes place, including at CB events 	<ul style="list-style-type: none"> - CMLT - CSL
Freezing	Consolidate Gains and Produce More Change	<ul style="list-style-type: none"> - Internal and external communication regarding the outcomes of service targets and changes in capacity - Communication regarding initiation of EBSS across all children receiving service 	<ul style="list-style-type: none"> - CMLT - Director
	Anchor new approaches in culture	<ul style="list-style-type: none"> - Internal communication regarding success throughout the change plan - Internal and external communication regarding next steps 	<ul style="list-style-type: none"> - CMLT - Director

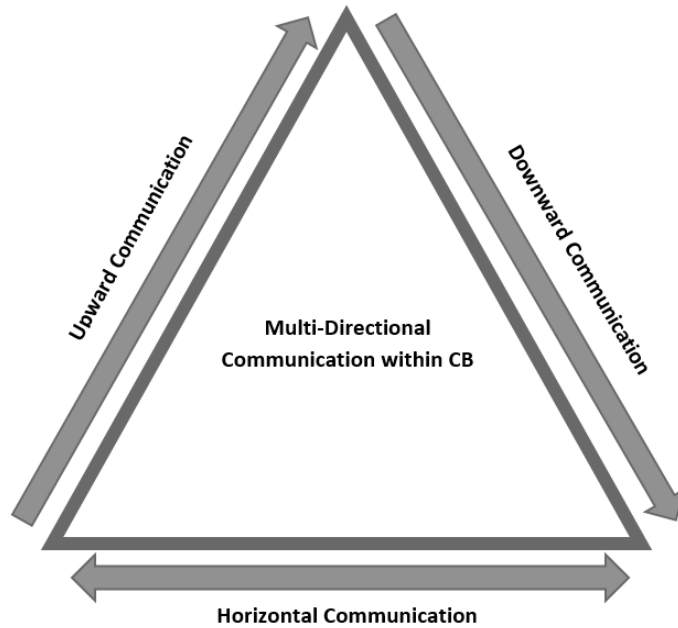
Appendix T

CB Change Process Communication Timeline



Appendix U

Multi-Directional Communication within Champion Branch



Adapted from Spaho, K. (2012). Organizational communication process. *Ekonomski vjesnik: Review of Contemporary Entrepreneurship, Business, and Economic Issues*, 25(2), 318-318.

Appendix V

Communication with External Stakeholders

Stakeholders	Methods of Communication
Families of Children Receiving Service and Families of Children Waiting for Service	<ul style="list-style-type: none"> - Email alerts providing update regarding need and benefit for change - Survey eliciting feedback on priorities - Formal Report outlining changes to service structure and detailing the value of evidence-based services - Meetings with clinicians to discuss the impact of service changes on current supports (families currently receiving services) - Report providing the results of the change effort - Survey eliciting feedback regarding next steps
Community Agencies	<ul style="list-style-type: none"> - Email alerts providing update regarding need and benefit for change - Survey eliciting feedback on priorities - Formal Report outlining changes to service structure and detailing the value of evidence-based services - Meetings with agency representatives to collaborate on the use of new strategies to align with their agency services - Report providing the results of the change effort - Survey eliciting feedback regarding next steps
Advisory Board	<ul style="list-style-type: none"> - Presentation from director on the urgency, need and benefit for change - Feedback elicited during regular advisory board meetings - Email alerts including progress towards organizational goals - Presentation by CMLT to advisory board on results of the change effort - CMLT to elicit feedback regarding next steps during advisory board meeting
Associated Pediatric Health Clinic	<ul style="list-style-type: none"> - Presentation from director on the urgency, benefit and need for change - Provide report outlining the responsibilities of each organizational member in the change process and the resources that will be used - Email alerts including progress towards organizational goals - Presentation by CMLT to advisory board on results of the change effort - CMLT to elicit feedback regarding next steps during advisory board meeting
Funding Source	<ul style="list-style-type: none"> - Direct correspondence from director to government representative on the urgency, benefit and need for change - Provide report the resources that will be used during the change process - Formal Report outlining changes to service structure and detailing the value of evidence-based services - Director to report service targets and the number of people serviced and duration of services at the end of fiscal year