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Organizational Change in Healthcare with Special Reference to Alberta

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Key Implications for Decision Makers

Policy Makers

To encourage the successful implementation of health system change, policy makers should explicitly recognize the tension between the need for both provincial standards and local variation, and the time and intensive human effort required to accomplish change.

Senior Leadership of Regional Health Authorities

Middle-level managers play an important role in implementing system change, encouraging front-line workers to adopt change and facilitating change at upper organizational levels. Yet these managers are assuming so much of the responsibility for implementing change that they are burning out in the process. To ensure the health system retains and develops strong middle management capacity, these individuals need to be given immediate support, including sufficient time and resources.

We observed pockets in the health system that implemented desired change through leaders' cultivation of capacity for building positive work relationships, articulating the principles or significance of people's efforts in changing, and providing cross-level system support needed for change implementation. These pockets showed us that it is important for more areas of the health system to cultivate this kind of capacity for changing.

Change Leaders of All Levels in the Organization

To accomplish desired change, it is critical to pay attention to the less remarkable, less visible, but nevertheless quite significant and essential, everyday "change work." This involves capitalizing on opportunities, proving the value of changing, and altering or creating symbolic forms, such as classifications and principles that support change. It is also important to celebrate small wins that consolidate gains in change while energizing continuing efforts.

To encourage professionals to change behaviour, it is useful to draw on multi-faceted approaches such as explanation, encouragement, or creating circumstances and systems that make it easier for professionals to implement change, or more difficult not to change.

Researchers and Decision Makers

In embarking on a program of research, researchers and decision makers can meet their individual and joint needs by discussing not only the content of the investigation but also the relational foundation of the proposed collaboration. What are the mutual benefits to each of being involved in the research? How and when will research findings be shared? What relational practices can be implemented to enhance the quality of the collaboration and research outcomes? As a result, they can plan to work collaboratively on actions that contribute to the research process.

Executive Summary

The need to effectively implement organizational change is of strategic importance for healthcare leaders as they face continuing pressures to reform healthcare. Yet this task is far from straightforward. The most carefully developed plans for change can disintegrate during implementation, disrupting the lives of people who work in health organizations as well as the service delivery they manage and provide. In addition, organizational research points to the difficulties associated with implementing system change into well-established organizations such as those in the healthcare sector. Research has determined, for example, that as patterns of work become established and taken for granted, they become highly resistant to change. Research has also shown that significant change often originates in events external to the organization, such as mandated regionalization in the case of healthcare.

Although prior research has advanced knowledge about why organizations do not change and the importance of external origins of change, it provides only limited understanding of the internal and contextually situated processes that people undertake to produce organizational change. In this five-year (July 2000 – December 2005) research program, through our decision-maker partners, we were able to gain a close look at *how* people accomplish change in health organizations through their persistent and everyday efforts. As a result, we have been able to generate knowledge on implementing change that contributes to extant organizational theory and provides insight for decision makers undertaking health reform at the organizational and system levels.

Our program of research consisted of two phases.

In phase 1 (July 2000 – June 2003), as a team of researchers and decision makers, we identified four key areas of change to investigate; these initiatives were being implemented in different parts of the Alberta healthcare system at either provincial or regional levels and were relevant for our decision-maker partners. We closely followed the changes of *healthcare regionalization, transforming the delivery of continuing care, primary healthcare reform, and introducing the nurse practitioner role*. We focused on understanding the “everyday” work of implementing change as undertaken not only by top management, but also by middle managers and front-line staff. By examining the real-time work involved in producing these changes, our research disclosed and explained how individuals accomplished organizational change, articulating the micro-processes, practices, and symbols created and used in implementing desired change.

In phase 2 (July 2003 – December 2005), we investigated two cross-cutting themes: *restructuring organizational units and altering provider relationships*. Earlier analyses had suggested that change initiatives in these areas were more difficult to implement because they required individuals to alter established practices and re-interpret their professional and/or organizational identities.

We briefly sketch the four change initiatives and two cross-cutting themes below.

Project #1: Healthcare Regionalization. In 1994, the Alberta government regionalized the delivery system by creating 17 new geographic entities called regional health authorities. In 2003, a second phase of regionalization reduced this number to nine. We investigated the relationship between regionalization and changes in healthcare delivery, attempting to

understand how structural changes affected service delivery. Our analyses show the importance of cognitive change in accomplishing regionalization. Briefly, through regionalization, the government mandated a significant structural change to the system and used a coercive approach to push through the first stage of implementation. From this point forward, it was critical that key actors in the system changed their way of thinking about how the system should function and how they would relate to each other. One way key actors resolved differences was to develop co-operative working strategies at the front line, even though they maintained fundamental disagreements at the system level. These disagreements continued to be represented in different stakeholder perspectives about regionalization.

Project #2: Transforming the Delivery of Continuing Care. Continuing care is a major component of the health system, providing ongoing health services for the elderly and clients with special needs. Our analyses of regional planning documents showed that regions differed in their response to this provincial reform, based in large part on the proportion of elderly in the population served. Investigations of implementing this policy over a four-year period in the East Central Health region and another region's long-term care facility showed that transforming the delivery of continuing care requires attention to both the structural redesign of care and the cultural principles that provide the significance for proposed changes. Middle managers consistently articulated principles honouring choice and control and worked persistently with front-line supervisors to translate the new cultural principles into practice. Front-line supervisors worked every day with staff to change routines and cultivate new care practices that realized the desired culture. Senior managers co-ordinated principle-based relationships among community and staff.

Project #3: Primary Healthcare Reform. Primary healthcare has been a priority across Canada. While many studies point to physicians as cost-drivers and resisters of change, our investigations of an innovative primary healthcare partnership strategy in the Calgary Health Region found that their input and support facilitated reform efforts in primary healthcare. Although top management provided guidance and support, decisions about how to implement new strategies for primary healthcare were left to middle managers in collaboration with service providers. We also found that learning to provide services in new ways was facilitated by drawing on dynamic capabilities already existing within the organization. In particular, learning occurred through experimentation, and the use of pilot projects provided a mechanism for encouraging creative approaches. This organization-wide approach to learning through experimentation required significant managerial involvement, especially in managing the tension between the unrestricted development of local initiatives and organizational needs for guidance and control.

Project #4: Introducing the Nurse Practitioner Role. The number of Alberta nurse practitioners has grown from approximately 15 in 2000 to 130 in 2005. A large percentage of nurse practitioners work in Capital Health, and for this project we partnered with this health authority. Based on our interviews, meeting observations, and archival data of the introduction of this new role, we developed a model of change that explains how embedded actors, in this case nurse practitioners, legitimize the new role through their use of three micro-processes of change: (1) use every available opportunity to advance the change initiative; (2) carefully fit the desired new way of working into established organizational structures and systems; and (3) consistently prove the value of the innovation to others. We also found that nurse practitioners and their managers engaged in a change strategy of "small wins" that celebrated accomplishments while providing a platform that energized continuing efforts. In related research, we found that middle managers

made important contributions to the change process by assisting with the reallocation of tasks that occurred with the addition of the nurse practitioner role. These managers provided guidance that helped team members develop new working relationships with the nurse practitioner, and they kept a focus on the advantages of introducing nurse practitioners that was critical in moving through the disruption of integrating a new team member.

Cross-Cutting Theme #1: Restructuring Organizational Units. This theme examines cultural dynamics in restructuring. The first project identified how a reciprocal dynamic between culture and positive work relationships creates a type of resilience or capacity for a system and its members to endure conditions of extreme change. Cultural symbols not only shape individuals' capacity to develop positive organizational relationships, but positive relationships keep symbolic forms alive and re-infuse them with meaning and significance. These relationships become a life-enriching and energy-producing resource that broaden individuals' repertoires for dealing with change and help them reframe difficult experiences from helplessness and lack of control to hope and purposeful action. The second project examined the merger to form the new David Thompson Health Region. A first set of analyses disclosed innovative cultural practices in merging that call upon prior region and local unit strengths to develop policies and business processes. These practices include flexible application of policies within general standards and consistency expectations; intensive relational work early on for colleagues from various locations to get to know one another; and cross-cutting task committees that bring together members from different prior regions, locations, and sectors of the new region. The third project involves comparative analyses of identity dynamics in merging, with collaborators from the University of Montreal and its HEC business school. Drawing on data from healthcare mergers in Alberta and Quebec, we are examining "identity work," the strategies in dealing with merging that individuals use to alter their own and others' identities, and that managers use to construct a new organizational identity.

Cross-Cutting Theme #2: Altering Provider Relationships. Joining with collaborators at the University of Lethbridge, we conducted comparative analyses of change initiatives (introducing nurse practitioners, reforming long-term care, reforming primary healthcare, and restructuring the rural physician clinic) oriented to institutionalizing new ways of working in health organizations. Our analyses found that in each initiative, key actors at the organizational, group, and individual levels identified new valuable practices and took purposeful actions in an attempt to spread these practices throughout their organization. We identified the role of *institutional change champions* and found that they invested heavily in the process. They used three complementary approaches as they attempted to influence the institutionalization process: they managed the meaning of the desired changes; they focused attention on desired changes; and they created physical situations that encouraged people to try the new ways. We suggest that the role of institutional change champion is critical to the long-term success of organizational change initiatives. Currently, there is more attention given to entrepreneurial activities (developing new ideas and experimenting) but to implement changes and gain widespread acceptance, a longer-term, more nuanced and patient agent of change is required. Through our focus on actions designed to spread change rather than initiate it, we draw attention to a critical component of the overall change process.

CONTEXT

The need to effectively implement organizational change is of strategic importance to healthcare leaders as they face continuing pressures to reform healthcare. Consistently reported as a high priority concern for CEOs,¹ the task of implementing organizational change is far from a linear and straightforward endeavour. The most carefully developed plans for change can disintegrate during implementation, disrupting the lives of people who work in health organizations as well as the service delivery they manage and provide.

As well, organizational research points to the difficulties associated with implementing system change into well-established organizations such as those in the healthcare sector. Prior research has determined, for example, that as patterns of work become established and taken for granted, they become highly resistant to change² Research has also pointed to external events as catalysts for organizational change,³ such as mandated regionalization in the case of healthcare. Although this research advances knowledge about why organizations do not change and the importance of external origins of change, it provides only limited understanding of the micro-level action people take to implement change.

Through access provided by our decision-maker partners on this five-year research program (July 2000 – December 2005), we were able to gain a close look at *how* people accomplish change in health organizations through their persistent and everyday efforts. Two purposes guided our research.

1. To generate knowledge on implementing change that advanced extant theory as well as provided insight for decision makers undertaking health reform at the organizational and system levels.

We identified four key areas of change to investigate which were being implemented in different parts of the Alberta healthcare system at either provincial or regional levels and which were relevant for our decision-maker partners. We followed these changes over time to determine how people worked together to implement desired change. We focused on understanding the “everyday” work of change as undertaken not only by top management, but also by middle managers and front-line staff. In particular, we tried to discern the normally invisible yet critical real-time work involved in producing desired organizational and system change. Our research adds to extant knowledge on change by theorizing how change is produced through contextually situated actions of individuals; it discloses important micro-processes, practices, and symbols that key individuals throughout health organizations create and use in producing change.

2. To cultivate a distinctive relational model that represented how researchers and decision makers collaborated.

In addition to the purpose of generating knowledge, early on we began to see the significance of how we as researchers related with the many people who collaborated in the conduct of this research, including our decision-maker partners and the individuals who agreed to be interviewed (sometimes twice) and let us observe their meetings. This observation led to the articulation of a relational model that guided this research program. Over time, we clarified the basis of this model: our shared interest in better understanding organizational change; mutual respect for our different areas of expertise on change; and a commitment to work together throughout the research process. By enacting this relational model, we developed a different line of sight into the more traditional research-practice gap, one that acknowledges and appreciates differences of researchers and decision makers and incorporates ways of relating that positively affect the quality of the research. In doing so, we affirm and join with recent conversations in organizational studies⁵ pointing to the “relational foundation of a research project as key to understanding how interesting and significant the project can become.”

Our program of research consisted of two phases.

Phase 1

In the first three years (July 2000 – June 2003), as a team of researchers and decision makers, we identified four initiatives of organizational change for investigation: *healthcare regionalization, transforming the delivery of continuing care, primary healthcare reform, and the introduction of the nurse practitioner role*. These initiatives were being implemented in different parts of the Alberta healthcare system at either provincial or regional levels and were relevant for our decision-maker partners. The following four questions emphasizing the study of change processes guided our investigations:

1. How did regional health authorities implement change strategies in ways that met their local context?
2. How were provincial recommendations for changes in long-term care implemented?
3. How was a new primary healthcare strategy implemented?
4. How were nurse practitioners integrated into the established healthcare system?

We also began to reflect with our decision-maker partners on the practices we were using that facilitated the sharing of emergent themes along the way and fostered the research collaboration.

Phase 2

In the last two years of our research (July 2003 – December 2005), we investigated two cross-cutting themes that emerged as significant in early data analysis: *restructuring organizational units and altering provider relationships*. Our earlier analyses suggested that change initiatives in these areas were more difficult to implement because they called upon individuals to alter established practices and re-interpret their professional and/or organizational identities.

We examined these central dynamics by investigating an additional four questions:

1. How did healthcare workers reconstitute service delivery practices and re-interpret identities in implementing change?
2. How did healthcare managers and other workers with managerial responsibility introduce and/or reconstitute organizing practices that were directed to implementing change?
3. How did these organizing practices facilitate the reconstitution of service delivery practices and re-interpretation of identities?
4. What organizing practices minimized the disruptive and negative impact for healthcare workers in implementing system change?

We also formalized our work on the relational model guiding our research program through publications^{6,7} and a presentation at an American funding agency.⁸

IMPLICATIONS

We developed two sets of implications, tailored for different audiences. First, we identify implications for implementing change in the health system at the provincial, regional, and organizational levels. These implications are oriented to policy makers, senior leadership of health authorities, and change leaders at all levels. Next, we identify implications of conducting a five-year program of research with a researcher-decision-maker team, noting in particular the need to develop a relational foundation that enhances collaboration and outcomes of research and adjust the structure of funding of “communication, dissemination, and linkage” efforts. These implications are oriented to researchers, decision makers, and funders.

Implication Set #1: Implementing Change in the Health System

Policy Makers

To encourage the successful implementation of health system change, policy makers should:

1. explicitly recognize the tension that exists between provincial standards and local variation and incorporate recommendations that facilitate adherence to provincial standards as well as accommodate region-based local variation; and

2. develop policies that acknowledge the financial, time, and staffing resources required to accomplish system reform. This implication points more concretely for the need to:
 - a. resource the implementation as well as the formulation of system reform;
 - b. for priorities of health system reform, establish long-term policy commitments with associated resources so that regions can reasonably plan for program continuity;
 - c. monitor attainment of reaching important and relevant outcomes rather than adherence to elaborate plans; and
 - d. foster learning across regional initiatives to implement reform by supporting small workshops oriented to sharing concrete details and important though difficult lessons learned.

Regionalization as a provincial policy has enhanced innovation in local areas. Changes to regional boundaries caused disruption and made it difficult for regional health authorities to focus on other priorities. Importantly, to realize benefits, strengthen innovation possibilities from regionalization, and facilitate the establishment of regions' unique cultures and contexts, boundaries need to become more predictable for lengthy periods of time.

Policy Makers and Senior Regional Health Authority Leadership

Merging creates a great deal of turmoil and difficulty at all levels and locations in the newly formed region. Policy makers and senior leadership in the health authorities can reduce the stress for front-line workers and managers by recognizing:

1. how long merging takes to complete; structural change is the beginning, not the end of merging; and
2. the importance of identifying, affirming, and actively tapping the strengths from local units and locations in developing the new region's policies, principles, and processes.

Middle-level managers especially are assuming much of the responsibility for implementing system change and are burning out in the process. To ensure the health system retains and develops strong middle management capacity, these individuals need to be given immediate support for their change work, including sufficient time and resources.

Change Leaders at All Levels

To create desired change, leaders should navigate the less remarkable, less visible, but nevertheless quite significant and essential everyday "change work" that involves:

1. seeking out, recognizing, and capitalizing on opportunities to implement system change from the bottom up and middle out, not just top down;

2. engaging in political work that involves convincing others and proving the value of changing;
3. engaging in cultural work that involves making change familiar and altering or creating symbolic forms, such as classifications and principles, that support change; and
4. celebrating small wins that consolidate gains in change while energizing continuing efforts.

Leaders will manage change more successfully if they cultivate the local unit's capacity for changing; in particular, there is an important need to develop individuals' capacity to effectively navigate the processes associated with everyday change work.

Leaders can encourage professionals to change behaviour by using multi-faceted approaches, such as explanation, encouragement, or creating circumstances and systems that make it easier for professionals to implement change or more difficult not to change.

Implication Set #2: Conducting a Research Program with Researchers and Decision Makers *Researchers and Decision Makers*

In embarking on a program of research, researchers and decision makers can meet their individual and joint needs by discussing how they envision their efforts playing out, especially the mutual benefits to each of involvement in the research, and the relational practices that enhance the quality of the collaboration and research. They can then plan to work collaboratively on actions that contribute to the research process.

Funders

In multi-year grants, funders should consider supporting communication, dissemination, and linkage efforts, especially sharing final findings and implications, for one year after the research grant is completed.

APPROACH

Research Approach

The questions guiding our research program concerned “how” change occurs over time. Thus, to access and analyse these fluid change dynamics, the research design incorporated both the investigation of specific changes over time (longitudinal) as well as the processes of changes themselves as they occur in real time.⁹ With its emphasis on rich description and members' experiences and interpretations,¹⁰ a qualitative approach is well-suited to the study of complex phenomena such as transforming delivery systems and implementing change. Such an approach necessitates entry into organizations to observe change initiatives, which was facilitated by our decision-maker partners. We used a process-based strategy of analysing organizational

phenomena that focused on developing explanations for how and why actions, events, and choices unfold over time in context.^{12,13}

Data Types

We collected three types of qualitative data: documents, interviews with people at all levels involved in the change initiatives, and observation of individuals' efforts in implementing change. We relied primarily on qualitative methods but also employed some quantitative indicators to examine the macro contexts of these changes.

During this five-year research program, we engaged in ongoing data collection and analysis efforts, using established protocols. We collected approximately 18,000 pages of data, including 6,000 pages of transcribed interview data for 275 interviews, and more than 1,500 typewritten pages of observational data comprising 80 days observing meetings. Our archival database now contains more than 12,000 pages of documents, meeting minutes, and formal reports, including all of the regions' annual reports and business plans from inception of regions in 1994 and continuing to the present.

Documents

With the assistance of our co-sponsors and partners, we collected an extensive amount of archival material (government and health authority documents, newspaper accounts, news releases, and other published statements from key players). These data provide a written record of past events as interpreted by various groups or individuals.

Interviews

We conducted initial interviews with key people involved in the changes who were selected based on their willingness to participate and on their knowledge of the change process. Depending on the project, we then used purposeful sampling strategies, random samples, or the snowballing technique to select additional people to interview. Levels of interviewees varied by project, but overall included members across different organizational levels, such as managers and senior administrators, professionals such as nurse practitioners, and front-line staff. All interviews were semi-structured and designed to provide in-depth, rich data about the change process. Interviews were tape recorded (with permission) and transcribed verbatim. If interviewees did not wish their comments to be tape recorded, we followed established protocols of note taking in developing a written account of the interview.¹⁴

Observations

We observed naturally occurring events such as meetings, being mindful not to disrupt the flow of these events by asking questions or otherwise drawing attention to our presence. These observations were invaluable for understanding the context and unfolding of change, something which can be incompletely transmitted during interviews.

Validity and Generalizability through Data Collection and Analysis Protocols:

To ensure validity, or the extent to which data collected were dependable and non-random representations of the change process, we implemented the following four protocols, taking into account the distinctive goals of qualitative research.^{15,16,17,18,19}

1. We collected multiple types of data to balance the different understandings of change represented in each data source. Interview data bring out different perspectives and experiences of change. Observations discern everyday action. Archival documents disclose a longitudinal/historical perspective on how change evolves in particular contexts.
2. We followed the practices of “theoretical sampling” and “constant comparison”²⁰ to collect and analyse interview and observational data. Thus, we collected data with the goal of developing and refining analytical categories that emerged and to assure that variation in those categories was captured.
3. We sought respondent validation or “member checking,” a practice that clarifies different viewpoints of change processes to most authentically and systematically represent them. This practice involves checking back with research participants to see how their account of events corresponds to the themes and accounts constructed by the researchers. This process also generated additional data.
4. Finally, we qualified our subjectivity as researchers through reflection on how our prior experience, background, and familiarity with people being researched shaped our work. We addressed this issue by having multiple researchers from our team study each change process and by holding discussions of our various assumptions and views of the change processes and how these might be shaping our analyses.

To ensure generalizability of results, we selected information-rich cases for in-depth study^{21,22} as well as different sites and types of change initiatives for maximum variability.²³ We conceptually generalized findings about change through controlled comparison^{xxiv} of patterns within and between sub-projects. Potential generalizations discovered in one case were tested against other

cases, and those that survived were claimed as generalizable to those types of cases, for example, identification of micro-processes of legitimizing a new role.

CDL Approach

We devoted a significant amount of effort to “communication, dissemination, and linkage” activities, developing three main areas of effort: (1) cultivating ongoing researcher-decision-maker relationships; (2) producing written communication material, a web site, and two-pagers developed in collaboration with the research team; and (3) presenting and publishing research findings. We develop each briefly here and provide fuller descriptions in the appendices.

Cultivating Ongoing Researcher-Decision-Maker Relationships

We sought to build continuing, trusting relationships with our decision-making partners who included East Central Health (lead decision-maker partner), Calgary Health, University of Alberta’s faculty of nursing (a key educational facility for nurse practitioners in Alberta), Capital Health, Crossroads Health Region, and David Thompson Health Region. We took care to establish quality connections with individuals in top-, middle-, and front-line positions in our decision-maker organizations. This enabled us to continue with our research activities in spite of the almost continual restructuring in Alberta that occurred during this research program. We have also sustained these relationships beyond the life of this research program: all regional health authorities are partners on a current multi-year grant (funded by the Canadian Institutes of Health Research and the Alberta Heritage Foundation for Medical Research, Professor Trish Reay, principal investigator) investigating organizational learning in primary healthcare innovation.

Developing a relational model

We reflected on and wrote about^{25,26} cultivating a distinctive relational model to guide our research relationships; one that acknowledged and appreciated differences of researchers and decision makers and sought to incorporate relational practices²⁷ that enhanced the quality of research and practice concerning the implementation of organizational change. In this model, ongoing two-way communication between researchers and decision makers helped ensure that the reality and needs of the practice context informed the research process and, in turn, that research findings informed practice. This model was characterized by the following:

1. Shared interest in organizational change in healthcare, and how change can be implemented for health gain. Our team was formed around the common interest of understanding organizational change in health organizations. Notably, it was conversations with our decision-maker partners that helped us identify changes to study that were

research appropriate, that is, “naturally occurring events” that we can study in “real time” and that are relevant for healthcare administrators, educators, clinicians, and policy makers in and beyond the province of Alberta.

2. Mutual respect for the different types of knowledge each team member brought to the research, and an awareness of how this enhances the research process and results. Our research collaboration was based on the idea that both research and practice knowledge are valuable for the conduct of research and its integration with practice.
3. Collaboration throughout the research process, including a willingness to participate in periodic dialogue about how the research was conducted and preliminary observations and themes, and occasionally presenting and writing together. Rather than dissemination being a stage of research, we worked with the understanding that to be useful and relevant, ideas about the research as well as insights and findings needed to be shared throughout the research process.²⁸

Producing Written Communication Materials

Two-Page Profiles

Early on, we sought guidance from communication experts at both the Canadian Health Services Research Foundation and the University of Alberta’s school of business to write short profiles of the overall research program and each project. These documents are included as Appendix 1 of this report. These two-pagers, as they became known, were designed to provide basic information about the research, such as goal, design, and names and affiliations of collaborating partners and researchers. We distributed the two-pagers when we discussed our research.

Web Site (www.bus.ualberta.ca/hos)

We created an extensive web site featuring research results and links to information relevant for healthcare professionals, managers, analysts, policy makers, and funders. We developed this site with the goal of making it an information-rich, non-linear site. That is, information is presented with numerous internal hyperlinks so users can readily navigate the site and download useful information. Initially, we established a separate web site, but to sustain it beyond the life of the grant we moved it onto a server at the school of business of the University of Alberta.

Two-Page Summaries

Following the success of our original two-pagers, in ending the research program we developed summaries of each project and relational model for further distribution among decision makers

(healthcare providers, managers, executives, and board members). Final versions of these documents are included as Appendix 2 of this report. These summary two-pagers were designed to introduce key findings and serve as a portal to more in-depth writing and communications related to the research program.

Three considerations guided the development of these summary two-pagers.

- First and foremost, their content had to have integrity with the study results.
- Second, their development was guided by what others have learned about writing research findings to increase utilization in health policy and decision-making.
- Finally, their content had to make sense not only to the researchers but more importantly to the primary target audience.

In collaboration with the research team, an independent writer interested in and with some knowledge on the research topic wrote the summaries. A person external from the research team was chosen to complete this task as it was thought that an independent person could better describe the findings in a way that resonated with the decision-maker audience. As well, to capture some of the elusiveness of the writing process, Appendix 3 of this report provides a description of some questions and reflections that were used to guide discussions between the writer and the research team.

Presenting and Publishing the Research Findings

For a list to date of the presentations and publications resulting from this research program, please refer to Appendix 4.

Presentations

We have presented to academic, practitioner, healthcare, and management audiences in Canada and internationally. At some workshops, researchers and decision makers co-presented. At others, doctoral students or researchers on the team presented. Also, our decision-making partners spoke about the research at events where researchers were not present, referring specifically to research methodology and findings.

Publications

We purposely targeted academics and practitioners in our publications from this research program. Thus, we developed analytic portraits of the changes we were observing,²⁹ applied organizational theories to the health context,³⁰ and advanced theorizing on change in the discipline of organizational studies.³¹ Some of these publications have been

co-authored with decision-maker partners, and others are co-authored with various members of our research team.

RESULTS AND FINDINGS

As indicated earlier in this report, the research in this program proceeded in two phases (July 2000 – June 2003; July 2003 – December 2005). Here we present the findings, organized according to these two phases.

Phase I

In the first phase (2000-2003), we investigated four key areas of organizational change: regionalization; long-term care reform; primary healthcare reform; and the introduction of nurse practitioners. Our general research questions were: (1) How did regional health authorities implement change strategies in ways that met their local contexts? (2) How were provincial recommendations for changes in long-term care implemented? (3) How was a new primary healthcare strategy implemented? and (4) How were nurse practitioners integrated into the established healthcare system?

Project #1: Healthcare Regionalization

In 1994, the Alberta government made structural changes to the healthcare system by disbanding more than 200 hospital, nursing home, public health, and other boards. Assets and responsibility for providing healthcare services were transferred to 17 newly created geographic regional health authorities. In 2003, a second phase of regionalization reduced the number of health authorities to nine. We investigated the relationship between regionalization and changes in healthcare delivery, attempting to understand how structural changes affected the delivery of services.

Our analysis of archival data showed how a government-legislated change evolved in unintended ways because of loose coupling and inherent ambiguity.³² We expanded on existing theories of institutional change to show the importance of not only structural change, but also cognitive change. We also showed³³ how the government mandated a significant, structural change to the system and used a coercive approach to push through the first stage of implementation. That is, legislative changes were enforced through budget allocations and the appointment of leaders who agreed to follow the government's desired course of action. From this point forward, it was critical that key actors in the system changed their way of thinking (cognitive change) to alter their values and beliefs about how the system should function and how key actors should relate to each other. We illustrated one way that key actors (in particular physicians and health authorities) resolved some of their differences by

developing co-operative working strategies at the front line, even though they maintained fundamental disagreements at the system level.³⁴

Investigating the perspectives of multiple stakeholders to regionalization (both during initial regionalization creating 17 regional health authorities and the subsequent reduction to nine regional health authorities), we found that interpretations varied widely.³⁵ While government portrayed the structural changes as necessary to meet efficiency and effectiveness goals, workers at the front line perceived these efforts as only a drive for efficiency. And while the government claimed they were decentralizing authority, the public saw the reduction of regional health authorities as a centralization effort. In the move to create fewer, larger regional health authorities, the government view espoused the creation of a more efficient system, while smaller regional health authorities saw only the loss of connection with communities served. Ultimately we find that perspective matters. Put another way, where one sits in the system shapes how one experiences regionalization.

Project #2: Transforming the Delivery of Continuing Care

Continuing care is a major component of the health system, providing ongoing health services for the elderly and clients with special needs. There has been much discussion in the media and literature about the importance of redesigning the delivery of continuing care. Often, this discussion places a strong emphasis on implementing client-centred care that enhances the quality of life and independence. As well, seniors themselves are placing greater importance on quality of life and have become increasingly dissatisfied with long-term care facilities that foster dependence.

At the beginning of this project, we sought to understand how provincial-level long-term care reform in Alberta was being implemented at the regional level. Through analysis of regional planning documents, we noted that regions differed in their response to this provincial reform, based on the proportion of elderly in their overall population.³⁶ This suggested that policy directives would initiate change processes that would be tailored to regional contexts.

To focus on the implementation of continuing care transformation at the local level, we collected intensive data in the East Central Health region as well as in a long-term care facility of a different region. Data included observation of meetings and special events as well as interviews with people implementing change across the region. Over a four-year period, our research at this micro level pointed to the importance of conceiving this reform as cultural in origin. That is, rather than focusing exclusively on the redesign of care, and assuming that changing structure would by default create cultural change, transforming the delivery of

continuing care required central attention to culture. In particular, the areas we studied that sustained this initiative, in spite of shifting provincial priorities and resource allocation, consistently articulated and enacted principles that honoured choice and control of the elderly and disabled.³⁷ Moreover, the “cultural work” of managers at all levels not only enlivened the principles, they also strengthened organizations’ and community members’ capacity to transform the delivery of continuing care based on client independence and quality of life. Middle managers worked persistently with front-line supervisors to translate the new cultural principles into practice. Front-line supervisors worked every day with staff to change routines and cultivate new care practices that realized the desired culture. And senior managers co-ordinated principle-based relationships among community and staff.

Project #3: Primary Healthcare Reform

Primary healthcare has been a priority item across Canada as well as in Alberta. However, in spite of great attention there have been few significant changes. We investigated the development and implementation of an innovative primary healthcare partnership strategy in the Calgary Health Region. The goal of this strategy was (and continues to be) improvement in the delivery of healthcare services in physicians’ offices, patients’ homes, and other publicly accessible clinics. Significant resources were invested in developing strong working relationships between family physicians and the region.

Our research showed the importance of physicians in developing and implementing new approaches to primary healthcare.³⁸ While many studies point to physicians as cost-drivers and resisters of change, we found that their input and support were essential for reform efforts in primary healthcare. When physicians become part of the solution, we observed that service delivery innovation was enhanced. By focusing on implementation strategies,³⁹ we found that leadership activities were important in developing the appropriate supportive context for change. Although top management provided guidance and support, decisions about how to implement new strategies for primary healthcare were left to mid-level managers in collaboration with service providers. These people were able to use their understanding of the front-line work and develop initiatives that fit with the delivery of services while also meeting organizational goals. Managing the middle was pivotal to change, but it also required significant organizational support and encouragement. We also found that learning to provide services in new ways was facilitated by drawing on dynamic capabilities already existing within the organization.⁴⁰ In particular, learning occurred through experimentation, and the use of pilot projects provided a mechanism for encouraging creative approaches. This organization-wide approach to learning through experimentation required significant

managerial involvement — especially to manage the tension between the unrestricted development of local initiatives and organizational needs for guidance and control.

Project #4: Introducing the Nurse Practitioner Role

When we started following this initiative, nurse practitioners worked in a few healthcare locations under a range of unofficial titles. Over time, the popularity of these special nurses grew. Universities developed new educational programs and *nurse practitioner* became a legislatively protected title. We observed exponential growth in the number of Alberta nurse practitioners from approximately 15 in 2000 to 130 in 2005.

We worked in partnership with Capital Health to focus and ground our research. Based on our interviews, meeting observations, and archival data, we explained the importance of front-line health professionals and middle managers in implementing a new role in an established system. We found that nurse practitioners and their managers took advantage of the newly regionalized health system to advance the role. Regional health authorities had incentives to employ nurse practitioners to cover some physicians' responsibilities. Extra government funding from provincial initiatives to improve continuity of care became available to fund this role. Nurse practitioners and nursing management had been waiting for the right time to act — and they did, showing that knowledge of their context was critical in introducing and expanding the new role.

We developed a model of change that theorizes how embedded actors, in this case nurse practitioners, take actions to institutionalize a new role.^{xli} We proposed that embedded actors (those who are enmeshed in their context) use three micro-processes of change to accomplish their goals: (1) use every available opportunity to advance the change initiative; (2) carefully fit the desired new way of working into established organizational structures and systems; and (3) consistently prove the value of the innovation to others. Through our investigations, we also found that nurse practitioners and their managers engaged in a change strategy of “small wins” that celebrated efforts accomplished while providing a platform for energizing continuing efforts. That is, in making incremental changes over time that ultimately resulted in significant achievements, nurse practitioners and their managers took time to celebrate the accomplishment of each small step that moved them closer to their goal of institutionalizing the new role, which in turn catalyzed further action.

In related research,^{42,43} we found that middle managers made important contributions to the change process by assisting with the reallocation of tasks that occurred with the addition of the nurse practitioner role. These managers provided guidance that helped team members develop

new working relationships with the nurse practitioner, and they kept a focus on the advantages of introducing nurse practitioners that was critical in moving through the disruption of integrating a new team member. We also studied the implications of introducing a nurse practitioner into a rural physician clinic⁴⁴ and found that physicians, clinic staff, and community members experienced advantages. The benefits of the nurse practitioner role included additional clinic patients because of well woman services and her role as a link between physicians, the health authority, and the community.

Phase 2

In the second phase (2004 – 2005), we investigated two cross-cutting themes that emerged as significant in early data analysis: *restructuring organizational units and altering provider relationships*. Specifically, we found that these areas of change are more difficult to implement because they require altering established practices and reinterpreting professional and/or organizational identities. Our research questions were (1) How did healthcare workers reconstitute service delivery practices and re-interpret identities in implementing change? (2) How did healthcare managers and other workers with managerial responsibility introduce and/or reconstitute organizing practices that were directed to implementing change? (3) How did these organizing practices facilitate the reconstitution of service delivery practices and re-interpretation of identities? and (4) What organizing practices minimized the disruptive and negative impact for healthcare workers in implementing system change?

Cross-Cutting Theme #1: Restructuring Organizational Units

Through data analyses in the first phase of the research program, we began to notice the cultural dimension prevalent across projects, especially concerning restructuring. Thus, in the second phase of our research, we took efforts to disclose the cultural dynamics in merging, recognizing we would continue with analyses after formal completion of this program grant.

We collected new, real-time interview data at two points in time (2004 and 2005) on the merging of multiple prior regions that created the new David Thompson Health Region. Through preliminary data analyses, we identified five innovative cultural practices that helped to achieve merging by recognizing and using prior region and local unit strengths to develop policies, principles, and business processes. These are recognizing region-wide staff expertise regardless of their particular location in the region; facilitating flexible application of policies by different locations within general standards and consistency expectations; capitalizing on opportunities to evolve some centres outside of the regional hub location when it makes business sense; engaging in intensive relational work, especially early on, so that colleagues

who will work together but not be physically co-located can get to know one another; and creating cross-cutting committees that bring together members from different prior regions and different locations and sectors of the new region.⁴⁵

In a second effort, we investigated how leaders used culture as a resource for implementing organizational change in challenging times. We defined culture as consisting of symbolic forms, such as language, goals, mission, and beliefs, through which individuals experience and express meaning in the workplace. Our research⁴⁶ shows how cultural symbols not only shape individuals' capacity to develop positive organizational relationships, but that positive relationships keep symbolic forms alive and re-infuse them with meaning and significance. This reciprocal dynamic between culture and positive relationships creates a type of resilience or capacity for a system and its members to endure conditions of extreme change. These relationships became a life-enriching and energy-producing resource that broadened individuals' repertoires for dealing with change and helped them reframe experiences from helplessness and lack of control to hope and purposeful action.

We also joined with collaborators from the University of Montreal and its HEC business school to conduct comparative analyses of identity dynamics in merging. Drawing on stories told by participants in healthcare mergers in Alberta and Quebec, we are examining both the forms of "identity work" used to navigate the merger as well as their antecedents and consequences. Individual identity work refers to the coping strategies of individuals within the merging groups (and also groups themselves) aimed at reaffirming, defending, or adjusting their own and others' identities. Organizational identity work refers to management or the dominant coalition's attempts to intervene to construct an organizational identity. Using this story-based approach, our analyses have so far identified a reaffirmation pattern, an integrative pattern, and a withdrawal pattern of identity dynamics across the two cases. These dynamics, including possible mediating mechanisms such as status, along with their possible consequences for the evolution of mergers, are currently being examined.

Cross-Cutting Theme #2: Altering Provider Relationships

In the later stages of our research, we began to look for patterns of change that existed across the original projects undertaken. We also joined with collaborators at the University of Lethbridge who had conducted research following a large-scale change initiative at a rural physician clinic. We examined data (interviews, meeting observations, and archival data) from all projects and found that we could trace the evolution of institutional change through inception, initial trials, and legitimated changes. (Following the expected path of institutionalization, the next stage is

for the change to become taken for granted.) We evaluated each of the change efforts we followed as having been legitimized but not yet taken for granted. The findings from this research remain a work in progress, but will be presented at a conference this year.⁴⁷

We found that in each initiative (introducing nurse practitioners, reforming long-term care, reforming primary healthcare, and restructuring the rural physician clinic) key actors at the organizational, group, and individual levels attempted to institutionalize new ways of working. That is, they identified new valuable practices and took purposeful actions in an attempt to spread these practices throughout their organization. We identified the role of institutional change champions and found that they invested heavily in the process. They used three complementary approaches as they attempted to influence the institutionalization process: (1) they managed the meaning of the desired changes; (2) they focused attention on desired changes; and (3) they created physical situations that encouraged people to try the new ways.

We suggest that the role of institutional change champion is critical to the long-term success of organizational change initiatives. Currently, there is more attention given to entrepreneurial activities (developing new ideas and experimenting), but to implement changes and gain widespread acceptance, a longer-term more nuanced and patient agent of change is required. Through our focus on actions designed to spread change rather than initiate it, we draw attention to a critical component of the overall change process. Our findings are very much in line with practical recommendations from the Institute for Healthcare Improvement in pointing out, “While achieving breakthrough performance is great, sustaining and spreading improvement is enormous.” The institute suggests, and we concur, that more attention to “spreading change beyond its original venue” is “crucial to transforming your organization.”⁴⁸

Additional Resources

Please see our web site, www.bus.ualberta.ca/hos for additional resources on implementing change. We have developed a number of downloadable written products oriented for healthcare leaders, including:

- Stewart, T., Harmata, L., and Bzdel, L. 2005. The researcher – decision-maker resource guide. Edmonton, AB: Health Organization Studies. Available at the HOS web site: www.bus.ualberta.ca/hos/resources/resources_guides.htm

- Golden-Biddle, K., Reay, T., and Thomson, D. 2003. Implementing Change: The Crucial Role of Middle Managers. *Health Organization Studies Research Program Web Site*: www.bus.ualberta.ca/hos/resources/resources_articles.htm.
- Golden-Biddle, K., Reay, T., and Thomson, D. 2003. Communities of practice. *Health Organization Studies Research Program Web Site*: www.bus.ualberta.ca/hos/resources/resources_articles.htm.
- Reay, T., Golden-Biddle, K., and Pablo, A. 2002. Implementing Evidence Based Decision Making as an Organizational Change. *Health Organization Studies Research Program Web Site*: www.bus.ualberta.ca/hos/resources/resources_articles.htm.

In addition to the commonly read journals such as *Harvard Business Review*, there are a couple of other journals that publish thoughtful and well-developed articles on change implementation. In particular, please examine:

<i>Academy of Management Perspectives</i>	http://journals.aomonline.org/amp/
<i>California Management Review</i>	http://cmr.berkeley.edu/
<i>Sloan Management Review</i>	http://sloanreview.mit.edu/smr/

Further Research

Most generally, our findings in this research program contribute to theory on organizational change by identifying and showing the importance of micro-processes and their collective effect on macro-level observations. We see our research program as one of the first concentrated attempts to empirically link micro-level change activities with macro-level outcomes. We suggest that further research in this area is needed, in particular to investigate other types of mechanisms and micro-processes involved in achieving change beyond those identified in our projects.

Our findings across a variety of the research projects point to an important role for middle managers in implementing change initiatives. Future research could investigate the change work of middle managers in varying locations. They also point to the important role of connecting the efforts of senior, middle, and front-line managers. Future research might profitably examine, for example, the linkage between change-savvy senior leaders and their critical support for middle management action.

In this research we found that the strategy of small wins was important in introducing the role of the nurse practitioner. It would be interesting to find out whether this strategy holds in other

healthcare change initiatives, in use by different types of actors such as physicians who have greater system power, or at a later point in the change initiative. Based on our general knowledge of other work settings, we believe that a strategy of small wins would occur in organizational change initiatives that are driven by the desires of front-line workers and encouraged by middle managers. Further research will assist in determining the extent of generalizability of this important change strategy.

Most research on change suggests that the way to change culture is to first change structure. That is, culture changes as a result of structural change. However, our micro-level research on change showed that cultural change does not necessarily result from structural change. For example, it takes concerted and intentional efforts in merging regions to mix the cultures and symbols of prior regions in creating the new region. Thus, we learned how cultural change is produced through dedicated cultural work of change leaders. More research needs to examine this cultural work that produces cultural change to understand of what it consists, how it can best be implemented, and how it works as a full partner with structural change initiatives.

Finally, this research points to a number of issues associated with the question “What does it take to sustain health system change in the longer term?” We observed a number of very dedicated people trying to sustain their efforts in change over multiple years. They persistently, patiently, and with expert context knowledge sought to implement desired change initiatives. But we wonder how people continue to deal with such change work over long periods of time? Does it lead to exhaustion? Does change cynicism set in? What system support is used to nourish people’s efforts along the way so that cynicism does not set in and they do not become exhausted? What is required of a system to strongly support long-term change that requires so much individual effort? Finally, how are individuals in different units, organizations, regions, and provinces learning from each other’s change implementation efforts? What infrastructures encourage the transfer of learning about change system capability for implementing effective, desired change is strengthened?

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