Change Readiness of Laboratory Leaders in the System-Level Organization

By

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Abstract

Successful organizational change hinges on active engagement and endorsement by the change recipients. This research evaluated the change readiness of laboratory leaders from each of British Columbia's public health authority laboratory organizations as they entered a period of significant change affecting laboratory service delivery. Using an action research engagement methodology, individual interviews were conducted to determine the cognitive and affective change readiness attributes of these leaders, followed by a focus group session to collectively develop strategies to assist them in becoming ready for change. The findings suggest trust is the underlying factor when building the relationships necessary for organizations to undergo transformational organization change. Healthcare organizations need to think and act differently in order to be successful in times of rapidly changing environments and organizational uncertainty. Building readiness for change into the culture and character of the organization will enable it to respond nimbly to both planned and emergent change.

Keywords: individual change readiness, collective change readiness, laboratory leaders, organizational identity, transformational organization change, organizational culture, relationships, trust.

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List of Abbreviations

Agency	BC's Agency for Pathology and Laboratory Medicine
AR	Action research
ARE	Action research engagement
BC	British Columbia
CPDO	Chief Provincial Diagnostics Officer
FHA	Fraser Health Authority
HALLs	Health authority laboratory leaders
IHA	Interior Health Authority
IT	Inquiry team
LM	Lower Mainland
LM Labs	Lower Mainland Pathology and Laboratory Medicine
LSP	Laboratory service provider
MoH	Ministry of Health
NHA	Northern Health Authority
PHC	Providence Health Care
PHSA	Provincial Health Services Authority
PLMS	Provincial Laboratory Medicine Services
SLs	Senior laboratory leaders
TLO	Transformation Leadership Office
TOC	Transformational organization change
VCH	Vancouver Coastal Health
VIHA	Island Health Authority

Executive Summary

Healthcare delivery in British Columbia (BC) is at a crossroads as the current way of operating cannot sustainably meet the expanding demands into the future. To remedy this, the BC Ministry of Health (MoH) has given the Provincial Health Services Authority (PHSA) a foundational mandate to make fundamental changes to the way healthcare service is delivered. The laboratory medicine services across the province have been attempting to reform their service delivery for many years with limited success. With the new mandate, PHSA, and the newly formed Provincial Laboratory Medicine Services (PLMS) under it, are poised to implement transformational change to laboratory service delivery.

Even with a viable plan, support from the members of the organization is vital for achieving change successfully (Hiatt & Creasey, 2012). Becoming prepared to support an organizational change initiative is a necessary process individuals undertake as they respond personally to the change environment (Stevens, 2013). Change agents do not have the ability to make the change recipients ready for change, yet they have significant influence in assisting the change recipients to be willing to support the change. With much at stake for the PLMS to be successful, the PLMS leaders were willing to partner with me, the researcher, to discover mechanisms that would enable the key change recipients to become ready to embrace the major organizational change to a single consolidated provincial service.

Scholars have described change readiness as a condition in which the change recipients "adopt, embrace, and endorse" (Holt, Armenakis, Harris, & Feild, 2015, p. 326) the change. Before they reach that stage, they each experience a wide variety of emotions and beliefs that shape their attitudes. Scholars have studied a number of different attitudes found between the constructs of change readiness and resistance to change. Much of the research has centred on the processes of minimizing the change resistant attitudes, which can limit change readiness, and of encouraging change ready attitudes.

To become ready for change cognitively, the change recipient needs to believe the change is the right approach for the organization, the plan as designed can be successful, and to have faith that the leaders have the ability to successfully lead the organization to achieve its objectives (Holt, Armenakis, Feild, & Harris, 2007). They also need an emotional attachment to the change initiative, which is best accomplished through developing strong personal relationships between the leader and the organization's members (Agote, Aramburu, & Lines, 2016).

As these key stakeholders engage individually with the initiative, they also participate actively in building change readiness collectively throughout the organization (Rafferty, Jimmieson, & Armenakis, 2013). The ability to visualize the personal and organizational benefits of contributing to the success of the change initiative increases individual and collective ownership of the outcomes (Oreg, Vakola, & Armenakis, 2011). Yet success may still be limited if the quality of the relationships is poor (Peccei, Giangreco, & Sebastiano, 2011).

Anderson and Ackerman Anderson (2011) argued that accomplishing transformational change requires new behaviours, culture, and mindset for the people in the organization to function more effectively together. Facilitating trusting relationships takes on greater importance when

individuals need highly functional relationships to address complex tasks together. Individuals must first be open to differing perspectives before progress can be made toward developing mutually beneficial solutions. Patvardhan, Gioia, and Hamilton (2015) encouraged individuals to shift from valuing what makes them distinct to what joins them together. When there is a sense of belonging to the collective, individuals begin to develop a strong commitment to the success of the organization.

Armed with this knowledge, I conducted a qualitative action research (AR) study using an action research engagement (ARE) method (Rowe, Graf, Agger-Gupta, Piggot-Irvine, & Harris, 2013) to examine the change readiness of health authority laboratory leaders (HALLs) toward the pending change. I conducted individual interviews and a focus group discussion to answer the overarching research question, which asked how BC's individual HALLs could prepare to become collaborative partners within a single provincially coordinated laboratory service system.

I designed the research to answer three specific subquestions. First, I sought to determine the current state of change readiness of HALLs. Second, I asked them to identify the enablers that would help them become more ready for this organizational change. Finally, I enlisted their help to develop recommendations to facilitate the formation of an identifiable, cohesive province-wide laboratory service system. Using the attributes across the change readiness–change resistance spectrum, I evaluated the current state of change readiness of these key stakeholders. During the interviews, these HALLs described the numerous tensions and barriers to change readiness toward this change plan. Together we discussed mechanisms to create a more cohesive identity with the newly formed PLMS.

From these discussions, key themes emerged, which led to several recommendations. Trust was found to be a theme underlying all aspects of HALLs' change engagement. They needed to accept that the plan, as designed, would overcome several barriers that have prevented successful laboratory reform in the past. They also needed to develop trust in the leader's ability to achieve the change objectives. Trust can develop and mature by having a rich, personal relationship between the leader and the led. Third, previous relationships that had maintained disparities among the individuals could be made more cohesive by focusing on achievement of a common purpose (Patvardhan et al., 2015). By instilling trust throughout the organization, the new PLMS builds change readiness into its culture and character, enabling it to weather future planned and emergent change environments and ensure its sustainability into the future (Vakola, 2013).

These findings have relevance to organizations beyond the PLMS. As PHSA embarks on converting other diagnostic services into their own provincial streams, the PHSA leaders can use this study to inform their efforts in those areas as they provide change enablers proactively. Avoiding the pitfalls of not providing these enablers will put them one step closer to building change engagement within those service leaders. Additionally, this work adds to the body of knowledge relating to change readiness by positing that high levels of trust are necessary to prepare an organization to be ready for both planned and emergent transformational organizational change.

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Chapter One: Focus and Framing

Healthcare service delivery in British Columbia (BC) is on the cusp of transformational change. Projected political, financial, demographic, and technological pressures make the current service delivery model unsustainable (Forest & Martin, 2018). The BC government has recently taken steps to make healthcare rapidly responsive, adaptable, and sustainable by setting the stage for healthcare to be managed as a single comprehensive, coordinated system.

Such a significant organizational change presents an opportunity to investigate the individual and collective change readiness of public health authority leaders as they focus on developing a new provincial mindset. In this thesis, I establish the context of the research and provide a brief review of the current scholarly literature regarding such a change initiative. I, then, define the purpose, objectives, and methodology and methods that I used in the project. I report my findings and conclusions developed through data analysis. Next, I suggest specific recommendations intended to facilitate the change readiness of these laboratory leaders to be prepared to fully support the change to a new provincially coordinated service stream. Finally, I show how this research stands to benefit me, my organization, and other organizations undergoing similar transformational organizational change while adding to the existing body of knowledge of leading change in a complex and dynamic environment.

As a member of BC's Agency for Pathology and Laboratory Medicine (Agency), I partnered with the Chief Provincial Diagnostics Officer (CPDO), head of the newly formed Provincial Laboratory Medicine Services (PLMS), and Provincial Health Services Authority (PHSA) leaders to discover the supports the regional medical and operational laboratory directors from each public health authority may need to fully engage in and endorse this

transformative organizational change. The purpose of inquiry for this project is captured in the overarching inquiry question: How might BC's individual public health authority laboratory leaders (HALLs) prepare themselves to become collaborative partners within a single provincially coordinated laboratory service system? The research was specifically designed to answer the following subquestions:

1. What is the current state of individual change readiness of HALLs?
2. What are the enablers that could increase HALLs' engagement with the new PLMS?
3. What strategies can we recommend to facilitate the formation of an identifiable, cohesive province-wide laboratory service?

Significance of the Inquiry

Healthcare reform in BC has been a priority for many years. Increasing demand for service and the pressures to incorporate rapidly evolving, more expensive technologies have exceeded fiscal capacity. Innovative solutions are necessary to develop a system that keeps pace with those needs. The BC Ministry of Health (MoH) has recently given PHSA the mandate to create a single provincially coordinated healthcare system that is operationally efficient while improving the lives of the people of BC (PHSA, 2019). Action must be taken now as PHSA intends to have made significant progress toward achieving its goals within the next 3 years (PHSA, 2019).

Given the need to make progress quickly, it made sense that the PHSA leaders began by focusing on converting the regionally distributed laboratory medicine service model to a single provincial service stream. Laboratory medicine service is a frontrunner in becoming a provincially coordinated service after having already formed a consolidated service among the

Lower Mainland (LM) laboratory service provider (LSP) organizations in 2012. With the enactment of the Laboratory Services Act in October 2014, the Agency began working with all LSPs in the province to envision a shared future.

A key element for success will be for the regional HALLs to develop a provincial mindset for coordinating service while they remain responsible for service delivery within their geographic region. This project supported the PHSA mandate by revealing the existing mindsets of these leaders, their attitudes and beliefs about the change, and then assisting them to develop specific strategies that they indicated would help them successfully migrate to the new entity. PHSA will benefit from understanding the perceptions experienced by key change recipients at the outset of this significant organizational change. The findings from this study can inform PHSA leaders as they begin the transformation process with other service streams whose change processes have not yet progressed as far.

The action research (AR) approach taken in this project was expected to provide a number of benefits. The process of working together during this project should benefit those involved by promoting highly collaborative relationships among these regional laboratory leaders as they work toward mutual goals. Further, participation in the development of the recommendations to help them become ready for the change was expected to increase HALLs' ownership of the change process. Finally, the process is helpful for building trust, transparency, and authenticity into the newly structured relationships and serves as a foundation for collaborative and cooperative interactions into the future when the operational change is implemented. By valuing the recommendations and insight produced by this investigation, the PHSA leaders have embraced the action-oriented approach to the project.

Organizational Context and Systems Analysis

Public healthcare systems in Canada are massive and complex. That complexity tends to make organizations sluggish to respond to changing operating landscapes, at a time when nimble, responsive, learning organizations are what healthcare needs. Innovative solutions have been tried by many different provincial governments of the day through a variety of mechanisms. Prior to 2001, BC had 52 local health areas, which led to an unwieldy distribution of authority and created significant inequities of service delivery (Woodward, 2016). At the end of 2001, BC reduced that number to one provincial and five geographic regional health authorities. Despite the new structure, disparities in healthcare spending per capita and in total by each health authority continued (BC Office of the Auditor General, 2012).

On a smaller scale, laboratory service is a small (consuming approximately 2% of the overall healthcare budget) yet pivotal part of the total healthcare system, as it provides up to 70% of the diagnostic information clinicians use to make medical decisions for their patients (Rohr et al., 2016). LSPs across BC face pressure to keep pace with increasing test volumes due to rising numbers of seniors with more complex and chronic healthcare needs (Institute of Public Administration Canada, MNP, & Fasken Martineau DuMoulin, 2013), as well as increased demand to offer more expensive tests using highly specialized and increasingly advanced technologies.

For over 30 years, laboratory leaders have recognized the need to improve the delivery of laboratory services (Bayne, 2003; Lawson, 2012; Manning & Bellamy, 2013). Despite repeatedly outlining similar recommendations in three separate laboratory reform reports over 20 years, little progress has been made, and what has been implemented has had limited success

(Agency Staff, personal communication, October 1, 2018).[1] One reason to explain the lack of progress is the absence of a system-wide approach to service delivery. Back in 2003, Bayne recognized, "If lab services operated as a system, roles and responsibilities would be clearly defined and understood, and service delivery would be seamless and integrated within the broader health care system" (p. 9).

Laboratory Medicine and the Lower Mainland Consolidation. There is historical precedent indicating that the transition to the new model would not be enthusiastically embraced. Previous efforts to consolidate local health area accountabilities under the BC regional health authorities were met with strong resistance by those whose authority and autonomy were essentially being reduced (Davidson, 1999). Similarly, previous laboratory change initiatives have left many laboratory personnel at all levels in their organization with a certain amount of apathy, at the very least, or, worse, antipathy toward yet another change program.

In 2009, the BC MoH asked PHSA to consolidate the Greater Vancouver area (also called the LM) ancillary services to create operational and financial efficiencies in what was termed the LM Consolidation. Laboratory medicine services from Vancouver Coastal Health (VCH), Providence Health Care (PHC), Fraser Health Authority (FHA), and the PHSA were consolidated under an administrative body called Lower Mainland Pathology and Laboratory Medicine (LM Labs; PHSA, 2014).

While accomplishing some measure of success, many barriers prevented the achievement of full consolidation along the way. Laboratory budgets remained under the control of the

[1] This personal communication is used with permission.

individual health authority leaders, distinct electronic information systems did not communicate with each other for sharing patient information, laboratory leaders were accountable to both the LM Labs leaders and their individual health authority leaders, and laboratory medical professionals were accountable only to their individual health authority medical advisory committees. Without the necessary enablers, service delivery remained tethered to the individual health authorities.

In 2014, the BC government passed the Laboratory Services Act, which transferred provincial oversight responsibility for laboratory services to the people most knowledgeable about every aspect of the service delivery—those in the laboratory (BC MoH, Laboratory, Diagnostic, & Blood Services Branch, 2016). The Agency was formed as the oversight body. Although the Agency assembled a collaborative body of laboratory leaders and relevant subject matter experts to envision a united future for laboratory medicine, without the authority to implement recommendations, it fell short of its goal to create a provincially coordinated service.

PHSA foundational mandate. In March 2018, the BC MoH reorganized the system by mandating the PHSA senior executive leaders achieve PHSA's (2019) vision of providing one "system of care" (para. 2) across the province within 3 years. The BC MoH specifically charged all the health authority leaders to share responsibility for optimizing healthcare from a whole-system perspective (PHSA, 2019). As the individual regional health authorities are best suited to understand the needs of the people within their geographic region and will continue to operate as the deliverer of integrated care accordingly, PHSA will partner with these leaders. Service will be coordinated across the whole province but delivered locally by the regional health authorities. To accomplish this, PHSA must carefully cultivate effective relationships among the other health

authority leaders in order to eliminate the siloed thinking that previously served as a barrier to improvement.

The mandate specifically targeted clinical service delivery for provincial coordination and oversight by PHSA to eliminate duplication and redundancies, implement operational efficiencies, and optimize equitable and sustainable service. One of the first steps taken was to pull the Agency under the PHSA umbrella. The PHSA laboratory leaders are now in the process of consolidating service in a stepwise fashion, beginning with the LM. Being one of the first service delivery areas to transition to a provincial service stream presented an opportunity for laboratory leaders to be at the forefront of designing the new model, which can then be followed by other service streams such as diagnostic imaging and pharmacy.

This model essentially creates dual lines of accountability for laboratory leaders to both the local health authority and PHSA. Some challenges remain. PHSA will purportedly hold the conflicting roles of overseeing laboratory operations of the other health authorities while also being the health authority responsible for the Agency, LM Labs, and for the three individual provincially mandated labs (BC Centre of Disease Control, BC Children's and Women's Hospital, and BC Cancer). To be clear, laboratory medicine service in BC is delivered by both public and private LSPs. However, the two private LSPs serve only the community and outpatient populations and operate under separate contract with the BC MoH. Unless and until that changes, full oversight of laboratory medicine service delivery by PHSA will be limited to only the public health authority LSPs.

Under this new structure, the PHSA senior leaders (SLs) in Laboratory Medicine plan to work collaboratively with the regional medical and operational laboratory leaders from each of

the public health authorities. Since the time that the regional health authorities were formed, the Laboratory Medicine departments of each health authority have been managed through a dyad leadership model comprised of one regional medical and one regional operational leader. As part of the engagement strategy, these organizational stakeholders need to feel they were included in the process, recognizing that the eventual success of any organizational change may be limited if it is not supported by the people in the organization (Hiatt & Creasey, 2012).

This project aimed to assist PHSA with building engagement with its vision by focusing on preparing these regional HALLs for change. Change of this magnitude requires a significant shift in mindset from a strictly regional focus to viewing laboratory service delivery from a provincial system lens. Recognizing that organizational change involves both a logistical and a human component (Hiatt & Creasey, 2012), this project focused specifically on the human side by revealing the current state of change readiness of HALLs, identifying the enablers for them to envision a new provincial laboratory service, and developing strategies and recommendations that would facilitate collective development of a new organizational identity as equal members on a provincial team.

Providing a forum for them to examine individually their thoughts and feelings regarding the organizational change and then working together to develop a provincially focused mindset meets one of the objectives to facilitate the formation of a high-functioning collaborative team of top laboratory leaders. Since the transition will take several years to accomplish, the scope of this project was restricted to the early phase of the change management process by discovering the change readiness of the medical and operational laboratory leaders and in the process creating an environment conducive to gaining their engagement and endorsement with the change initiative

(Self & Schraeder, 2009). It was in this early stage of the change process that this project began, while there was still ample time to adjust the course of the change implementation to maximize the engagement of these individuals.

The first step entailed surfacing existing mental models of the key stakeholders affected by the change in order to anticipate barriers to change and devise strategies to achieve change readiness (Rowe, Graf, Agger-Gupta, Piggot-Irvine, & Harris, 2013). The goal was to reframe their thinking and strengthen the collaborative capacities of each stakeholder so that the group could become a highly adaptive team prepared to meet the known and unknown complexities of delivering service from a provincially coordinated perspective (Heifetz, Grashow, & Linsky, 2009).

This latest reform initiative is at risk of being heavily influenced by the past. Failure to achieve a highly coordinated service despite recent attempts at laboratory consolidation may lead to significant skepticism on the part of these laboratory leaders toward this new initiative. The PHSA leaders have anticipated this reaction. Recognizing this, I partnered with the PHSA CPDO to develop a plan for successfully supporting these individuals through the transition to a consolidated service stream and build change capacity in the LSP organizational leaders in the process.

Chapter Summary

This chapter established the foundational context upon which this research was based. Given the extensive historical context of organizational change to healthcare within PHSA and throughout BC, the readiness of these key stakeholders was a highly relevant avenue for research, as PHSA is invested heavily in its ultimate success. In the next chapter, I present an

extensive discussion of relevant literature necessary to gain a deeper understanding of the current thinking about the major concepts of individual and collective change readiness, enablers of change readiness, and the role of trust in accomplishing transformational organizational change. The third chapter describes the methodology and methods used during the study. Chapter 4 discusses the actual findings, conclusions gleaned from the data, and some limitations of the project. The final chapter describes specific recommendations to better prepare laboratory leaders for change and the opportunities this research presents for future inquiry.

Chapter Two: Literature Review

Integrating the separate public sector health authority LSPs within one unified PLMS represents a transformational organizational change to laboratory service delivery in BC. Given the high stakes for this reform initiative to be successful, the PLMS SLs are carefully planning to attend to those elements that evidence shows will bolster their efforts. This project focused on the change readiness of the HALLs as their support of this initiative was critical to the future success of the change plan implementation.

Recognizing that change readiness is a potent predictor of future change initiative success and staying within the scope of this project, this literature review looks specifically at change management concepts related to change readiness and transformational organizational change. Given the abundance of research in this area, I chose to limit this first discussion to the spectrum of attributes identified in the literature between the constructs of change resistance and change readiness that I used to measure change readiness. In the second topic, I examine the enablers of individual and collective change readiness. The final topic explores change readiness from the perspective of the macro- and system-level organization.

Attributes of Change Readiness

The word "change" implies something will be different. Lewin (2016) described the process of change in the context of organizational life as an "unfreezing" (p. 35) from the familiar—the status quo—to move toward the beneficial new future. Individual change readiness is widely viewed as an internal process of moving toward a state where the change recipient is willing to change (Devos, Buelens, & Bouckenooghe, 2007; Stevens, 2013).

People change willingly every day without any necessary intervention (Choi & Ruona, 2011; Dent & Powley, 2003; Oreg, Vakola, & Armenakis, 2011; Self & Schraeder, 2009) when they consider it more beneficial to go to the new state than to remain in the current state. This study will assess the change recipients' current state of change readiness and investigate the enablers that would increase their willingness to support actively the PLMS's transformational change effort.

Change readiness constructs. Holt, Armenakis, Feild, and Harris (2007) described change readiness as follows:

> A comprehensive attitude that is influenced simultaneously by the content (i.e., what is being changed), the process (i.e., how the change is being implemented), the context (i.e., circumstances under which the change is occurring), and the individuals (i.e., characteristics of those being asked to change) involved. (p. 235)

A person's attitude is shaped by the underlying thoughts, beliefs, emotions, and feelings. As such, an individual's change readiness is a construct of the separate cognitive and affective internal responses to external change conditions and interventions (Bruckman, 2008; Holt, Armenakis, Harris, & Feild, 2015; Weiner, Amick, & Lee, 2008). In order to accept the change rationally, the key stakeholders must come to believe the plan makes sense, it will be good for the organization, and it is the right approach to accomplish its objectives (Holt et al., 2015).

Oreg (2006) noted that what individuals think and what they feel about the change initiative can be qualitatively different. Peccei, Giangreco, and Sebastiano (2011) found individuals who may seem psychologically accepting of the change may still be passively disengaged or, worse, actively resistant. The change recipient may simultaneously harbour

attitudes and display behaviours that would hamper them from embracing change (Peccei et al., 2011). There needs to be something more that motivates the individual to support the change initiative voluntarily and actively (Stevens, 2013). Peccei et al. (2011) suggested emotional attachment to the change initiative is the vital and necessary contributor toward change readiness. Emotional attachment forms the basis for the individual to see the personal value, which Armenakis, Bernerth, Pitts, and Walker (2007) referred to as "personal valence" (p. 488), of embracing the change.

Before displaying behaviours that would indicate the key stakeholders are ready to "adopt, embrace, and endorse" (Holt et al., 2015, p. 326) the change initiative, they must first develop an intention to support it (Armenakis, Harris, & Mossholder, 1993; Holt et al., 2015). Once individuals are psychologically and emotionally prepared for the change, they need to progress to the point where they would act on their thoughts, feelings, and beliefs.

Not all scholars agreed with including intention as part of the change readiness definition. Rafferty, Jimmieson, and Armenakis (2013) argued that intentions should not be considered because any evaluation of intentions should also take into account the motivation. However, intention is relevant, particularly in this study, since it is indicative of the change recipient's mindset when assessing attitude. While not specifically investigating key stakeholders' personal motivations for supporting the change, this study examined mechanisms that scholars have demonstrated serve to increase motivation toward committing to the change initiative (see the "Enablers of Change Readiness" section later in this chapter).

Change resistance is often discussed in the literature as the opposite of change readiness (Bruckman, 2008; Dent & Powley, 2003; Self & Schraeder, 2009). Even now, scholars have not

attempted to develop a consensus definition for change resistance, in part because it is considered a mostly negative label assigned to the change recipient by the change agent (Thomas & Hardy, 2011).

Individuals may have numerous reasons for being resistant to change, and they may present this resistance in various ways in their organizational lives. Change recipients may have defensive reactions when asked to change from what is familiar or when responding to a perceived threat to job security. Employees may display resistance as passive noncompliance, such as reluctant participation, or through overt behaviours, such as opting to leave the organization (Oreg, 2006), or actively undermining the change through wilful opposition or negative talk and rumour-mongering (Bouckenooghe, Devos, & Van den Broeck, 2009; Dent & Powley, 2003).

Resistance to change should not be construed as wholly negative. Frahm and Brown (2007) argued that change resistance could be both negative and positive. From a systems perspective, change resistance could simply indicate lack of sufficient applied organizational energy to overcome the inertia of staying the same (Pardo del Val & Martínez Fuentes, 2003). Dent and Powley (2003) showed that people do not inherently resist change itself. Rather, the individual's response to change necessarily needed to be understood within the context of the change (Burnes, 2015; Dent & Powley, 2003). In fact, change resistance was found to benefit the organization when change agents approached change recipients' comments as legitimate feedback on the change process with the intention to help, not hinder the change effort (Ford, Ford, & D'Amelio, 2008; Piderit, 2000; Thomas & Hardy, 2011). As the researcher assessing

change resistance attitudes, it was important that I bear this in mind so as not to assume negative intent, knowing that HALLs may still see positive value in the organizational change.

At the same time, the criticism is only helpful if the change agents value those sentiments and use them to improve the plan. If the change agents do nothing to address stakeholders' criticisms, the negative comments could fuel mistrust among the change recipients and stall the progression toward engagement (Allen, Jimmieson, Bordia, & Irmer, 2007). The persistence of undesirable attributes over time could serve as a limiting factor on the degree of potential success of the change initiative (Bruckman, 2008; McKay, Kuntz, & Näswall, 2013).

Change readiness–change resistance spectrum. Change readiness and change resistance are frequently presented as opposite ends of a continuum. Most scholars agreed with Armenakis et al. (1993) who found an inverse relationship between change readiness and change resistance. When the forces for change increased, change resistance necessarily diminished (Burnes, 2015). Others found the attributes that comprise the change readiness–change resistance spectrum to be influenced independently by change agent interventions (Holt et al., 2007; Stevens, 2013). In order to measure the current state of change readiness of HALLs in this study, I needed to understand the relationship of those attributes within this continuum.

A large battery of attributes indicative of change readiness has been examined over the years (Choi, 2011; Holt et al., 2007; Oreg et al., 2011; Rafferty et al., 2013; Stanley, Meyer, & Topolnytsky, 2005; Stevens, 2013; Thundiyil, Chiaburu, Oh, Banks, & Peng, 2015). In many of these studies, the researchers selected one resistant attribute to compare with change readiness. For example, Grimolizzi-Jensen (2018) examined the relationship between ambivalence and change readiness, Wanberg and Banas (2000) studied openness and change resistance, Choi

(2011) compared readiness, commitment, openness, and cynicism, and Thundiyil et al. (2015) observed the dynamic between cynicism and change readiness. These studies did not take into account the multitude of finely nuanced attitudes between change readiness and change resistance.

In order to assess individual change readiness, I selected those frequently mentioned individual attributes across the continuum. Although scholars have made specific distinctions for each attribute (Bouckenooghe et al., 2009; Choi, 2011; Piderit, 2000; Stanley et al., 2005), for this study, I have paired similar attributes: resistance–opposition, cynicism–skepticism, uncertainty–doubt, hope–optimism, openness–receptivity, and commitment–readiness.

Scholars have described ambivalence as an attribute between change readiness and change resistance as the stakeholder experiences conflicting positive and negative attitudes simultaneously toward the change initiative (Grimolizzi-Jensen, 2017; Klonek, Lehmann-Willenbrock, & Kauffeld, 2014; Miller & Rollnick, 2013; Piderit, 2000). As an all-encompassing term, ambivalence is often seen in the early stages of change implementation when the individual is naturally responding to the competing tensions of seeing the benefits and the drawbacks of change concurrently (Miller & Rollnick, 2013). Accordingly, ambivalence was not used in this study as it represents any of the many opposing attitudes that fall within the spectrum.

A more fitting term to represent the attitude between change resistance and change readiness was used by Staren and Eckes (2013) who described a noncommittal attitude as one in which the individual had concerns about the plan but balanced those concerns with faith in the leaders and the organization. As a more neutral term than ambivalence, noncommitment was used in this study to indicate the midpoint in the continuum.

Each of the chosen attributes has emotional and cognitive components that correspond to the degree of intensity and intentionality of the attitude across a spectrum. Figure 1 illustrates how the cognitions, emotions, and intentions lead to change behaviours (Armenakis et al., 1993). The more overt, observable intentions and behaviours are visible at the extremes with less intentional thoughts and feelings manifesting toward the centre. Committing to or opposing the change initiative each conveys an intention to act. Uncertainty and hope are more benign feelings and attitudes toward the change with low intentionality. A noncommittal attitude, while not precluding the presence of both positive and negative thoughts and feelings, is indicative of relative indifference toward the change plan.

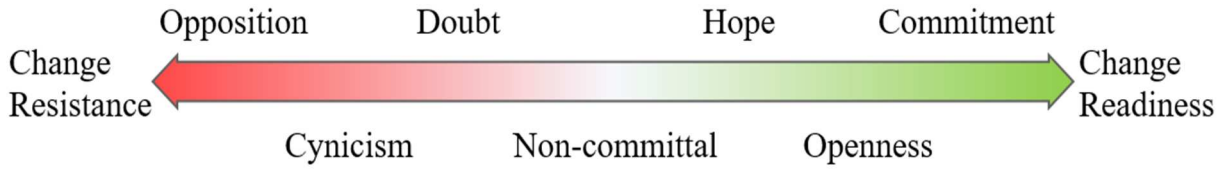

Figure 1. Spectrum of attributes from change resistance to change readiness.

The illustration in Figure 1 suggests that as individuals move toward one or the other extreme along the spectrum, their beliefs (objective thoughts), feelings (subjective emotions), and attitudes become less malleable once they reach a state at which there is intent to act (McCartt & Rohrbaugh, 1995). Moving HALLs to the point of actively supporting the change was one of the objectives of this project. As key influencers, SLs rely on HALLs to champion the change plan, magnifying change readiness as they socialize the change initiative throughout their own organizations (Armenakis et al., 1993; Holt et al., 2007). Consequently, establishing where HALLs fall along the change readiness spectrum is an important indicator of how much organizational energy will be required by SLs to prepare HALLs for change (Pardo del Val & Martínez Fuentes, 2003).

Individual attributes across the change readiness spectrum. The selected list of attributes indicates a progression from belief and feeling to intent and, finally, to behaviour. Recognizing that each change resistant attribute is not negative in and of itself, the persistence of those attitudes is considered a poor prognosis for successful organizational change (Bruckman, 2008; McKay et al., 2013). When describing the attributes beginning at the far left end of the spectrum, resistance could be evident as a change recipient's attitude, intention, or behaviour in response to a proposed change (Dent & Powley, 2003). Given the variety of ways resistance is manifested, for this study, resistance will be assessed when there is an indication of intention to engage in an actual behaviour to resist the change.

Closely related to resistance but with less intentionality, cynicism and skepticism have been described as a pessimistic attitude toward change (Thundiyil et al., 2015; Wanous, Reichers, & Austin, 2000). Skepticism was characterized as a more generalized mistrust that the change plan can achieve the desired objectives (Thundiyil et al., 2015). Cynicism, on the other hand, was related to more context-specific factors such as mistrust of the leader's ability to accomplish change (Choi, 2011; Stanley et al., 2005) or a pessimism based on past change experience (Thundiyil et al., 2015).

Less intense forms of change resistance have been described by various terms. Piderit (2000) included reluctance and frustration as forms of change resistance. Doubt, ambiguity, and uncertainty were found by Rafferty et al. (2013) to be greatest during the initial stage of a change initiative when the details are least developed and there is little information to share. These change resistant attitudes, if left unchecked, can erode change readiness over time and contribute to change resistance (Petriglieri, 2015).

Stevens (2013) and Holt et al. (2015) pointed out that change readiness is not merely the absence of change resistant attitudes but has its own unique constructs. Moving toward the positive attributes of change, Kool and van Dierendonck (2012) found optimism to be a necessary precursor to commitment to change, in which the individual has hope for a better future based in the context of the change initiative. Openness and receptivity, characterized as a willingness to support organizational change (Choi, 2011; Devos et al., 2007), has a more intentional aspect than a simply optimistic attitude and necessarily precedes active support of the change. When the individual is open to change, he or she can see the benefits and opportunities that the change presents (Bruckman, 2008; Devos et al., 2007).

Holt et al. (2015) indicated change readiness is finally achieved when the change recipient is willing to "adopt, embrace, and endorse" (p. 326) the change effort. Commitment represents the resilient state of change readiness in which the individual begins to share ownership of the change outcomes (intention) and openly support (behaviour) the change initiative over time (Rowe et al., 2013; Shin, Seo, Shapiro, & Taylor, 2015).

The work of Gigliotti, Vardaman, Marshall, and Gonzalez (2018) revealed building change readiness early in the change implementation yielded higher postimplementation success than attending to change readiness later in the process. As well, Jones, Jimmieson, and Griffiths (2005) found change readiness was a good predictor of eventual support for the change, which makes the evaluation of the HALLs' current state of change readiness at the preimplementation stage an important consideration for this change initiative.

Becoming ready for change follows the change recipient's decision-making process throughout the change event in response to external and internal inputs (Stevens, 2013), enabling

the individual to reach a point at which she or he is fully committed to supporting and promoting the change initiative. The process is influenced by the mechanisms that motivate the change recipients to become change ready. The next topic explores those various mechanisms to motivate change recipients to become champions of the change initiative.

Enablers of Change Readiness

Motivation has been characterized as an individual internal process that drives people to act (Maslow, 1943). In organizational change, the key stakeholders are more willing to engage in change-ready behaviours when they perceive the new state as more advantageous than maintaining the status quo (Peccei et al., 2011). In the second research subquestion, I wanted to uncover the specific enablers these HALLs would need to motivate them to become ready for this context-specific organizational change.

Change enablers are a double-edged sword. When done well, they can build change readiness (Armenakis et al., 1993); however, when done poorly, they can increase or even reinforce resistance to change (Stanley et al., 2005). Persistence of negative or pessimistic attitudes toward a specific change initiative can be a factor in hampering commitment to change, which can ultimately undermine the potential success of the organizational change (Bruckman, 2008; Gilley, Gilley, & McMillan, 2009; Oreg et al., 2011; Peccei et al., 2011; Thundiyil et al., 2015; Wanous et al., 2000).

In the particular context of BC laboratory transformation, there is evidence that a history of past failed efforts has resulted in well-entrenched skepticism on the part of the HALLs that this effort will be any different (Wanous et al., 2000). These HALLs will have difficulty overcoming their skepticism unless the factors contributing to their pessimism have been

effectively mitigated and minimized (Wanous et al., 2000). Additionally, change readiness is not static, as suggested by Walinga (2008), but is subject to both growth and deterioration. Human emotions and cognitions are dynamic, especially in times of uncertainty, and adjust independently to events occurring during the change process (Stevens, 2013). Armenakis et al. (1993) warned that the change agents must intentionally plan to maintain change readiness for the duration of the change implementation. To do so, they will need to engage in strategies to mitigate the negative causes of resistance, skepticism, and doubt that perpetuate change resistance (Thundiyil et al., 2015), even as they actively promote positive attitudes toward change.

Communication about the plan. The first way to enable change readiness is through high-quality information about the change plan. Gilley, McMillan, and Gilley (2009) linked quality of leader communication to higher levels of change readiness in the change recipients. Communication about the context and content of the change plan has been shown to reduce uncertainty and increase openness to change when the information provided addresses the cause of uncertainty (Allen et al., 2007).

Within the context of this change initiative, inadequate governance structure with corresponding lack of authority to implement decisions and an unsustainable and inequitable funding model are the sources of much of the skepticism and doubt about this change initiative. These long-standing legacy barriers to laboratory reform have effectively thwarted successful change in the past. The HALLs need to know the details of what is proposed and also what makes this proposal different from the previous unsuccessful laboratory reform initiatives in

order to have confidence that the change is the right one and have trust in SLs' ability to accomplish it (Oreg et al., 2011; Thundiyil et al., 2015).

It is particularly important at the outset of a change initiative, when uncertainty is high and details are scarce (Allen et al., 2007; Bruckman, 2008; McKay et al., 2013; Oreg et al., 2011), for SLs to deliver meaningful information. However, simply presenting the rationale for the change does not mean HALLs will automatically be willing to embrace the change. Change recipients may feel the change adversely affects them, which could increase change resistance. Allen et al. (2007) found this type of uncertainty could be avoided through direct conversations between the change agent and change recipients. If change recipients' questions have not been adequately answered, negative beliefs can persist, ultimately affecting the success and long-term sustainability of the initiative (Gilley, Gilley, et al., 2009; Thundiyil et al., 2015).

At the same time, information must be forthcoming regularly to prevent erosion of change readiness (Allen et al., 2007; Gilley, Gilley, et al., 2009). In the absence of information, HALLs will grasp at other sources of information such as rumours (Patvardhan, Gioia, & Hamilton, 2015), which have a tendency to focus on the negative aspects of the change and ultimately have a detrimental effect on change readiness (Elving, 2005). When information is inadequate or infrequent, the informal sense-making among peers often increases change-resistant attributes (Stanley et al., 2005). Allen et al. (2007) demonstrated, although change agents frequently think they are providing adequate information, change recipients often do not share this perception.

Emotional commitment to change. In addition to their cognitive responses about the change initiative, change recipients respond emotionally to external change interventions

(Elfenbein, 2007). First, they respond to their own internal fears: fear of the unknown, fear that stems from disturbing the status quo, fears over altered organizational relationships, and concern over how the change will personally impact their job duties, roles, and responsibilities, all of which negatively affect their change readiness (Self & Schraeder, 2009). Perceived threats to HALLs' authority, autonomy, and sense of organizational ownership were found to also be enough to produce resistance to change (Self & Schraeder, 2009). The HALLs have previously operated with a high level of autonomy within their own organization. Transferring decision-making authority represents a significant risk to each of the HALLs. Voluntarily relinquishing that authority will require a strong "psychological bond" (Seggewiss, Straatmann, Hattrup, & Mueller, 2019) between SLs and HALLs. These studies suggest that in order to attach emotionally with the change initiative, HALLs would benefit from strengthening their emotional commitment to the leader before they would be willing to engage in change supportive behaviours.

Trust in the leader. Different from confidence in the leader's ability to accomplish the change objectives, trust in the leader is dependent upon the relationship HALLs have with SLs (O'Neill, 2018). Colquitt, Baer, Long, and Halvorsen-Ganepola (2014) described trust as a relational construct between individuals whereby the fulfillment of psychological contracts between them creates a willingness to engage in beneficial behaviours. They went on to point out, cognitive trust is earned when one party demonstrates trustworthy behaviours (Colquitt et al., 2014). In their study, Agote, Aramburu, and Lines (2016) linked authentic leadership behaviour to higher levels of trust and stronger emotional attachments between the leaders and their followers. To generate positive emotions toward the change, the leader needs to be

perceived as acting fairly, honestly, transparently, objectively, and authentically in the best interest of all parties (Lines, Selart, Espedal, & Johansen, 2005). Through these actions, the change recipients can deem the change agents to be trustworthy (Lines et al., 2005).

Devos et al. (2007) found higher levels of trust in the leader were closely related to increased openness to change. Once SLs demonstrate that they are deserving of trust, "both in word and in deed" (O'Neill, 2018, p. 295), HALLs may more willingly share in the risks that come with the organization's uncertain future (Allen et al., 2007). According to Elving (2005), "Trust guides the actions of individuals in ambiguous situations" (p. 133). Without trust, change recipients are "more likely to be critical of the information or justification they receive in the context of organizational change" (Allen et al., 2007, p. 191). As HALLs go through the highly ambiguous early stages of the change implementation, their perceptions of the trustworthiness of SLs will have a significant impact on their readiness to embrace the change.

Collective engagement. While change recipients are undergoing the process of individual sense-making about the change plan, they are also interacting with others in the organization to collectively make sense of the change. Emotional attachments made in relationship with others begin the process of collective sense-making. The dyad between two individuals forms the smallest unit of a collective. In this change management process, the most important dyad is between the change agent and the change recipient (Maslyn & Uhl-Bien, 2001).

Face-to-face conversations between the leader and the follower conducted in psychologically safe environments accomplish several objectives (Bushe & Marshak, 2016). These dialogues begin the development of a rich personal relationship, build long-term trust, and

create mutual respect between the two (Bushe & Marshak, 2016). Informal, unstructured conversations provide the opportunity for each HALL to understand how the change will affect him or her personally, to ask questions for clarity, and to have concerns addressed by the SL in real time. Engaging in discourse allows for mutual meaning-making so that the two can be aligned with the same shared purpose (Bushe & Marshak, 2016). A shared vision is collectively developed, incites excitement, and motivates the members of the organization to commit actively to the organization's success (Kouzes & Posner, 2012).

Taking part in the change process builds connectedness between the participants and furthers their joint engagement with the change. Individual and collective engagement occur simultaneously in an accelerated process of group sense-making, as group dynamics influence individuals' beliefs and emotions (Barsade, 2002). Several authors suggested participation and inclusion in the change process builds individual ownership of the plan (Allen et al., 2007; Armenakis et al., 1993; De Vose, 2014; Gilley, Gilley, et al., 2009; Oreg et al., 2011; Self & Schraeder, 2009). Bouckenooghe et al. (2009) found the quality of these interpersonal interactions positively influenced the change readiness of the individuals within the group.

Participation becomes even more important as the degree of impact of the change on the individual's work increases (Bruckman, 2008; Burnes, 2015). Thomas and Hardy (2011) found participation yielded the added benefit of promoting a nonadversarial relationship between the change agent and change recipient. However, Bruckman (2008) warned against the appearance of including change recipients in the process of change only to disregard their suggestions. This manipulation could undermine trust and make change compliance even more difficult (Schoorman, Mayer, & Davis, 2007).

At the same time, providing an opportunity to collaborate does not necessarily lead to a positive outcome (Piggot-Irvine, 2012). Group discussions are often marked by lack of openness to differing points of view and individual withdrawal from participation while still seeming to agree, possibly leading to unpredictable outcomes (Piggot-Irvine, 2012). For interpersonal relationships to be productive, they must function effectively.

This section has shown how high-quality information about the change initiative, inclusion in the change process, and development of key organizational relationships have a significant impact on motivating the individual to actively commit to the change. Organizational change is accomplished through the aggregate efforts of the individuals (Holt et al., 2007; Schneider, Brief, & Guzzo, 1996). As each individual moves toward change readiness so too does the collective (Patvardhan et al., 2015). The momentum generated when sufficient numbers of individuals endorse the change can help lead to change readiness at the collective (meso) level.

As the stakeholders most affected by the change as well as the key influencers within their respective organizations, HALLs' commitment is vital to socializing change readiness throughout their respective organizations (Allen et al., 2007; Rafferty et al., 2013), setting the stage for long-term success and sustainability of the change initiative. The final section of this chapter examines what is required to accomplish organizational change within the macro- and system-levels of the PLMS organization.

The System-Level Organization

The final topic explores the new level of thinking needed to answer the project's third subquestion: How might we transform into a new provincial laboratory medicine service? To

answer this question, I looked at the concept of transformational organization change, the differences between the macrolevel and metalevel organization, and the roles of organizational identity, culture, and trust in transformational organization change.

Transformational organization change. Past laboratory reform attempts mainly took the form of transactional organization change, relying on consensus decision making and limited structural changes within organizations. Clearly, those efforts were unable to meet the increasing demands on laboratory service delivery. Accomplishing transformational organization change (TOC) will require changing the content, people, and process (Anderson & Ackerman Anderson, 2011). Focusing solely on the human component, Anderson and Ackerman Anderson posited leaders and followers must learn new ways of working together to change the organizational behaviour, culture, and mindset in order to accomplish transformational change.

One of the primary influencers of TOC is the behaviour of the leader. By providing the vision for the future and empowering others, transformational leaders motivate followers to engage in organizationally supportive behaviours (Herold, Fedor, Caldwell, & Liu, 2008). McCleskey (2014) argued transformational leaders convince followers to focus on a future oriented to the possibilities for the benefit of all.

Agote et al. (2016) emphasized the fundamental role of trust between the leader and follower as the motivator to act positively toward the change. Transformational leaders have the ability to share ownership and distribute leadership among followers to develop organizational capacity to manage complex issues (Gilpin-Jackson, 2015). These leaders recognize that complex, adaptive systems perform better through the collaborative, innovative thinking of many individuals rather than the singular abilities of one leader (McCleskey, 2014).

Empowered followers are more likely to partner with others and take responsibility for the future success of the organization. This distributed leadership counterintuitively strengthens the leader by inspiring followers to forego their own perceived best interest for the benefit of the whole (McCleskey, 2014). In their research, Tsasis, Evans, and Owen (2012) determined removing structural relational boundaries imposed by organizational charts gave stakeholders the freedom to be more creative, innovative, and generative, which they found more rewarding. By incorporating a transformational mindset into the organizational culture, the leader builds change readiness for not only one context-specific organizational change but also the organizational change capacity and resilience to manage emergent change in the future (Agote et al., 2016).

Building a culture of TOC shifts the focus from managing change to managing organizational relationships (Burns, 2001). Anderson and Ackerman Anderson (2002) noted TOC brings higher levels of conflict and stress on human relationships than does a structural or transactional change. Given the impact TOC has on the people involved, greater importance must be placed on the functionality of interpersonal skills (Anderson & Ackerman Anderson, 2011). Gilpin-Jackson (2015) asserted the deeply ingrained dialogic habits that often dominate during stressful change initiatives needs to be disrupted so new ways of communication are free to happen and critical thinking can emerge. Successful TOC is largely dependent upon the quality and functionality of these new ways of interacting (Burns, 2001). The transformational leader is fundamentally responsible for leading the followers to the new way of thinking and acting.

Organizational identity. The second powerful facilitator of organizational change is the formation of an identifiable organizational identity. The PLMS will likely operate as a new

macrolevel organization as it implements a new organizational structure. This transactional change will bring the individual health authority LSPs under some form of governance in order for the SLs to have the authority to enforce decisions.

Elving (2005) found sharing details about the change plan can begin the formation of a sense of community among the organizational members at this macrolevel. Maslow's (1943) hierarchy of needs indicated the need for social belonging was a powerful intrinsic personal motivator. Forming an organizational identity in these early stages, even though details of the actual structure are unclear, provides a collective concept around which individuals align, thereby improving the change recipient's ability to accept the change (Drzensky, Egold, & van Dick, 2012). Patvardhan et al. (2015) further discovered disseminating the organizational vision helps to provide greater clarity of the organizational identity. Including HALLs in the process of defining the identity helps them to align with the organizational vision and values, a key factor to long-term sustainability of the new organization (Haque, TitiAmayah, & Liu, 2016; Patvardhan et al., 2015).

As HALLs are involved in forming the macrolevel identity, they are, at the same time, not forgoing their existing organizational relationships. They must continue to work effectively within their home organization to deliver laboratory service. Structural elements, such as lack of common provincial information systems and continued operational responsibilities within their geographic service areas, serve to maintain that strong connection. These factors serve to reinforce HALLs high ownership of and identification with their home health authority. Drzensky et al. (2012) found that strong attachment to past organizational identity made it difficult to fully embrace the new organization. The HALLs may, in fact, feel those relationships

are threatened by the new PLMS (Patvardhan et al., 2015). Bolman and Deal (2017) warranted that individuals may need to undergo a grieving process before change recipients can begin to see their future in the new organization. By recognizing and honouring both identities, the change recipients can begin psychologically separating themselves from their old identity as they form a sense of connectedness to each other (Brewer & Gardner, 1996). As Brewer and Gardner (1996) noted, HALLs will need to extend their sense of self to associate with the collective PLMS identity before they are able to commit themselves to the future success of the PLMS.

Gioia, Schultz, and Corley (2000) found the collective interpretation of organizational values was a way of defining "who we are" (p. 68). When the individuals extend their self-perceptions to identify as members of a group (i.e., the collective self; Brewer & Gardner, 1996), they become willing to contribute to their common future. Understanding that all individuals within the macrolevel organization have a shared destiny will help the individual move from a personal self-concept to a collective, from "'I' to 'we'" (Brewer & Gardner, 1996, p. 84). Once there is an identifiable organizational identity, social attachment can form without the need for individual personal relationships with each member (Brewer & Gardner, 1996).

Establishing the identity of the new organization is important because a "strong group identity has been shown to be a major influence on member's commitment to collective action" (Patvardhan et al., 2015, p. 408). An identifiable entity serves as a focal point around which the organizational members can align, satisfies the need for a sense of belonging to the group, and sets the stage for engaging in collective action at the system level (Patvardhan et al., 2015).

Metalevel organization. The PLMS is not simply forming a collective of macrolevel LSP organizations; rather, it is in the process of creating a system (i.e., metalevel organization)

responsible for fulfilling several functional roles encompassing the full scope of laboratory services: authority and governance, regulatory, administrative, and operational. In this respect, the PLMS resembles an organizational field, which Hinings, Logue, and Zietsma (2017) described as a network of interrelated organizations with common resources, consumers, and regulations within a formal or informal (socially constructed) governance structure. This moves the focal point for cooperation necessary to function effectively from the individual HALL (micro) and collective LSP organization (macro) levels to the PLMS, or metalevel, as a whole. Formation of the metalevel PLMS organization represents a TOC in laboratory service delivery.

Prior to the formation of the PLMS, the Agency attempted to form the LSPs into a single coordinated service stream based on consensus processes. Patvardhan et al. (2015) argued consensus-based relationships maintain distinctiveness, perpetuate organizational siloes, and entrench personal perspectives, hindering formation of a strong, collective identity. A different tactic must be taken to encourage the individual LSPs to connect with the larger entity. Gioia et al. (2000) found, while it is possible for the macro- and metalevel identities to coexist, the challenge for the HALLs is to expand their self-concept to view themselves as partners working to optimize efficiency and effectiveness for the benefit of the system. In these early stages, when the new organizational identity is still nebulous, the constituent organizations should concentrate on the advantages of working together as a service stream rather than maintaining their individual uniqueness (Patvardhan et al., 2015).

Identity at the metalevel is formed through a different process than the macrolevel organization (Patvardhan et al., 2015). Patvardhan et al. (2015) indicated the system-level organization requires a more holistic mindset that takes into account the complex

codependencies and interdependencies throughout the system. Tsasis et al. (2012) found, despite willingness to reform healthcare, system change has been rarely accomplished because change agents' traditional ways of problem solving are ineffective in complex-adaptive systems. Fitzgerald and McDermott (2017) suggested development of this new mindset is accomplished by focusing the system on the possibilities rather than the problems. For the PLMS, the new metalevel organization presents the opportunity to coordinate all laboratory activities from a system-wide lens in which improving patient care serves as its central guiding force.

Organizational decisions will still require action at the local health authority level. When decisions are made that closely impact the service provider, the provider's first reaction is to protect its domain (Cygler, Sroka, Solesvik, & Dębkowska, 2018). Mayer, Davis, and Schoorman (1995) noted participants may appear to cooperate when they feel they have no other choice. In this case, cooperation is a product of coercion, not trust, and gives the illusion of buy-in without any real sustainability.

Rowe et al. (2013) argued TOC is best accomplished by developing a new collaborative mindset in which participants are "more open to accept other points of view, change their own understanding, form new ideas and solutions and adopt new practices related to the change initiative" (p. 15). The individual LSPs will no longer deliver service in isolation. Their actions will impact the rest of the service, making strong collaborative partnerships an essential component of this change initiative. Effective collaboration will require motivation to elevate the needs of the whole over their individual interests. Cooperation among organizations for the good of the whole is possible when trust exists between the partners. High levels of trust improve the

degree of success that is possible to achieve collectively and establishes a foundational resilience to weather the inevitable conflicts as they appear (Brito & Costa e Silva, 2009).

Role of trust in transformational organizational change. Schoorman et al. (2007) defined trust within the context of relationships as "a willingness to be vulnerable to another party" (p. 347). They further argued, "Level of trust is an indication of the amount of risk that one is willing to take" (Schoorman et al., 2007, p. 346). Foregoing the interests of the individual LSPs in favour of benefiting the collective PLMS is a risk-taking venture from the HALLs' perspective. The individual HALLs will need to trust that their contributions to the success of the PLMS will benefit their organization in the long term before they are willing to work together effectively with their fellow participants in the system.

In order to do that, there must first be trust between HALLs and SLs. Since SLs hold authority over the system, successful TOC depends to a large degree on HALLs' perception that SLs deserve their trust. Leaders are perceived to be trustworthy when they display integrity by reliably acting on what they say they will do and competence by meeting their commitments (O'Neill, 2018). Violation of that trust can have long-term detrimental impacts on followers' openness to other actions by the leader (Schoorman et al., 2007).

Secondly, LSP organizations require high levels of trust among leader–peers before they can engage in open, nondefensive collaboration. Trust builds collaborative strength through a step-wise, iterative, process (Piggot-Irvine, 2012). Each positive interaction can contribute toward higher levels of trust, which is necessary in order for individual HALLs to work willingly toward the good of the collective (Brito & Costa e Silva, 2009).

Trust will not eliminate competitiveness. The goal of the PLMS is not to quash conflict since competition is useful as a means to stimulate innovation within the system (Bengtsson & Kock, 2000). Rather than LSP organizations competing against each other as rivals over common resources and consumer base, the new PLMS would benefit from the type of thinking that leads to innovation, embodied in healthy competition and productive conflict around ideas, rather than defensiveness and opposition. In order to have an innovative laboratory system with long-term sustainability, the goal of the PLMS should be to develop trusting interpersonal relationships in which the tensions of cooperation and competition are balanced for the mutual benefit of the entire system (Vakola, 2013). Failure to both cooperate and innovate threatens the future viability of the entire system (Cygler et al., 2018).

System sustainability is dependent upon high levels of trust, commitment, and cooperation (Lines et al., 2005) while managing a beneficial competition among members. It requires a new system-level mindset to realize highly efficient and effective service delivery through truly collaborative and supportive personal interactions. The SLs can begin the process by establishing an identifiable system-level identity formed around the common goal of providing laboratory service that meets the needs of the people of BC now and into the future.

Summary

In this literature review, I examined the constructs of change readiness at the individual and collective levels, the enablers for successfully facilitating change readiness at the individual and collective levels, and the development of a new mindset necessary to create a new system-level organizational identity and generate system-oriented behaviours. The ultimate goal of the PLMS organizational change initiative is to form a new entity that is truly transformative,

innovative, and cooperative as the LSP leaders work toward a laboratory service system that best provides for the needs of the patients of BC into the future. Building engagement with the change initiative early sets a solid foundation for meeting these long-term challenges. This review served to inform the design of the project and the subsequent conclusions drawn from the research. In the next chapter, I discuss the methodology and methods used to conduct this research project.

Chapter Three: Methodology

In this chapter, I provide the rationale for choosing the methodology upon which this project was specifically designed, as well as the individual methods used for data collection and analysis. Next, I detail how the project actually unfolded in the study conduct section, and how reliability and validity were incorporated throughout the project. In the final section, I address the specific ethical considerations that apply and how concerns were mitigated.

Action Research Methodology

After considering several methodologies, methods, and approaches, I chose AR as the methodology as I believed it was best suited to answer the research question (Agee, 2009; Saldaña & Omasta, 2018). I based this project on the ontological and epistemological principles that each participant's perceptions contribute to the truth about reality, leading toward a qualitative, interpretivist methodology rather than a quantitative, positivistic paradigm (Glesne, 2016; Slevitch, 2011).

The participatory nature of AR develops a partnership between the participants and the investigator as coresearchers and colearners in the process of "knowing-in-action" (Coghlan & Brannick, 2014, p. 22). With AR, all participants experience the inquiry and analysis together as they collaboratively design practical solutions to a real-world issue, with enhancement of the quality of those relationships as an additional outcome (Coghlan & Brannick, 2014; Stringer, 2013). At the same time, each individual experiences personal growth through insight drawn from critically questioning assumptions and beliefs as they engage in Stringer's (2013) "look-think-act" (p. 9) cycle of inquiry. Through development of the skill of personal reflection throughout the course of the project, AR could facilitate the participants' ability to change how

they think about issues which they can use to address future challenges, acknowledging that once the research is done, the learning and adapting process continues (Bradbury-Huang, 2010; Coghlan & Brannick, 2014). In other forms of qualitative research, such as phenomenology or ethnography, the researcher remains more detached, attempting not to influence the natural behaviour (Creswell & Creswell, 2018).

Finally, AR incorporates practical application as a critical component of the methodology so that it does not become simply an academic endeavour, but rather results in positive change for the organization and creates useful knowledge (Bradbury-Huang, 2010; Coghlan & Brannick, 2014). Without discernible benefit, this project, as a form of intervention, runs the risk of increasing change resistance in HALLs rather than building engagement (Self & Schraeder, 2009). Together, these factors closely align with the purpose of this research project, making AR the preferred methodological choice.

Nonetheless, AR is not without its drawbacks. As an active coparticipant embedded in the process of discovery and relationship-building, the researcher loses the arm's-length objectivity to be able to interpret the data and determine the findings, conclusions, and recommendations without the strong influence of personal bias (Coghlan, 2013). Being one of the more highly subjective of the qualitative methodologies, the propensity for personal bias often blinds the researcher to alternate interpretations. In addition, AR projects and their results are difficult to reproduce, critically limiting an objective assessment of the validity of the findings. Finally, AR projects are highly context-specific, which restricts the applicability of the learning to other organizations or contexts.

Subjective interpretation of qualitative data will always be unique to the individual. Scholars indicated AR addresses researcher bias by incorporating active reflexivity throughout the concurrent processes of research and problem solving (McKay & Marshall, 2001). Having the coparticipants arrive at shared conclusions serves as a validity check on the process. The researcher must carefully incorporate elements of credibility and reliability into the design of the research project to allow for meaning to be cocreated with the reader (Booth, Colomb, & Williams, 2008). Rich descriptions of the study conduct, data analysis, findings, and conclusions provide the reader with the tools to understand the rationale behind the decisions that were made. As Jonsen, Fendt, and Point (2018) argued, the researcher's job was to build a convincing argument to influence the reader to accept the interpretations as reasonable conclusions based on the evidence provided.

Finally, McKay and Marshall (2001) noted AR is successful when the outcome of the research leads to effective solutions to an existing problem. As a continuous learning tool, AR is participatory in nature, building engagement among the participants and promoting shared ownership of the solution. Achievement of desired outcomes serves as a validation of the approach within the context of the specific problem it was designed to address, as "improved understanding of complex human issues is more important than generalizability of results" (Marshall, 1996, p. 524).

Action research engagement approach. The action research engagement (ARE) method (Rowe et al., 2013) met several criteria for successfully discovering how to effectively increase the change readiness of this select group of participants in anticipation of significant organizational change. First, the ARE model specifically investigates the change readiness of key

stakeholders affected by the change initiative, which is the core premise of this project. Forming the new PLMS entity requires a change in mindset to enable laboratory leaders to work collaboratively as they optimize service across the province. The ARE model was useful for uncovering the underlying attitudes of the participants, identifying the barriers to engagement, and developing strategies to enable them to participate collaboratively in forming a new PLMS identity (Rowe et al., 2013).

Second, transformational change to how laboratory service is delivered in BC will take years to accomplish, so restricting the scope of the project to understanding HALLs' state of change readiness in the early stages of the change initiative, as the ARE model does (Rowe et al., 2013), made it achievable within the timelines established for completion of the Royal Roads University Master of Arts in Leadership program. Third, the ARE model (see Figure 2) incorporates the action-oriented, participatory approach of "planning, acting, observing, and reflecting" (Stringer, 2013, p. 9) into its four phases, which form the first iterative cycle of the ARE process (Rowe et al., 2013).

The "focus and framing" (Rowe et al., 2013, p. 20) phase of ARE establishes the historical background of laboratory and healthcare reform initiatives in BC, as well as reviews the current literature into organizational change management. This establishes a clear understanding of the context, issues, barriers, and concerns participants might be experiencing.

Stakeholder engagement begins with individual interviews, inquiring into their thoughts, feelings, beliefs, and attitudes toward the organizational change plan (Rowe et al., 2013). Discussion of the predominant themes that emerge from those interviews serves as the starting point for the participants to reflect individually and collectively, using their insights from the

discussions of themes to identify the opportunities and possibilities presented by the change (Van der Voet, Groeneveld, & Kuipers, 2014). During the fourth phase of ARE (Rowe et al., 2013), the group formulates those opportunities into recommendations and strategies, which they determine would set the stage for successfully achieving not just transactional but transformative change, as a result of conversations and relationships that stimulate new ways of thinking and acting (Bushe, 2013). I was actively immersed throughout the entire ARE process as researcher, facilitator, and equal participant, a necessary component of AR (Rowe et al., 2013).

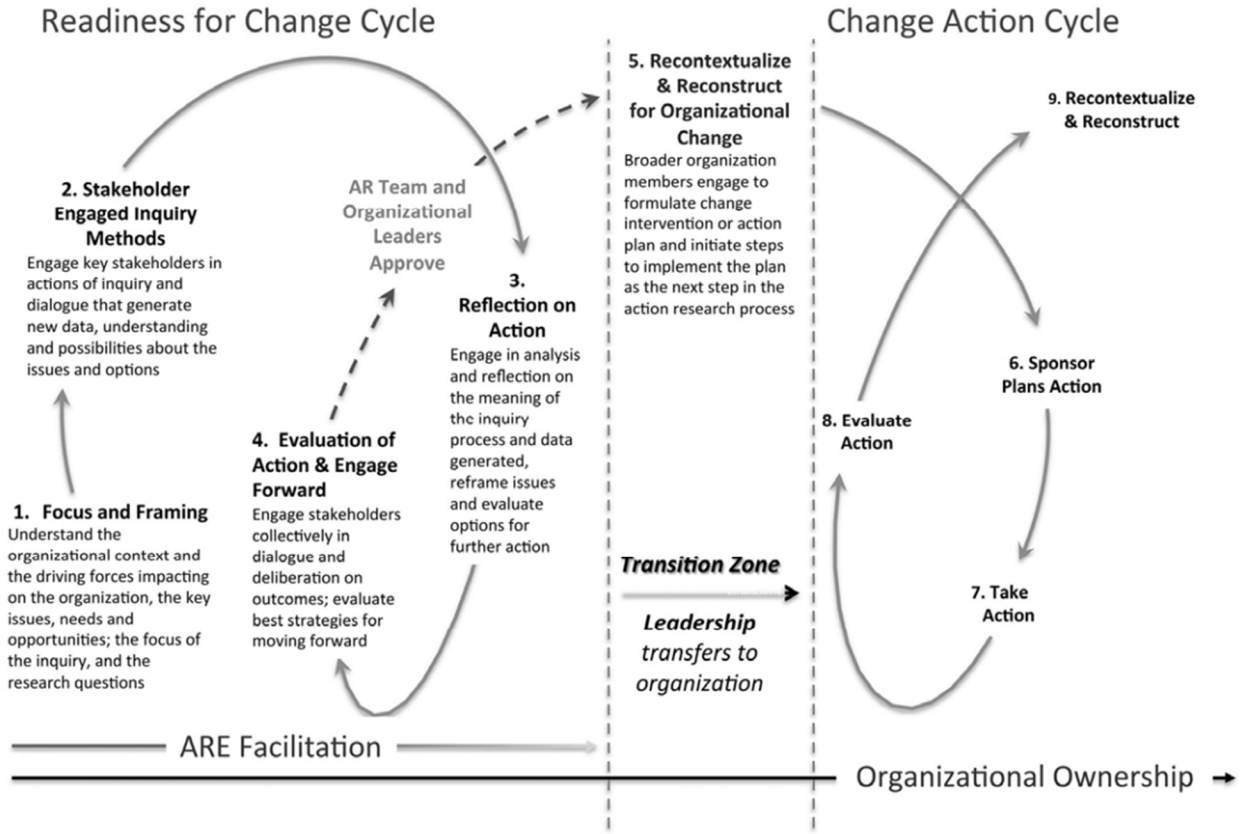

Figure 2. The action research engagement model.

Note. AR = Action Research; ARE = Action Research Engagement.

From *Action Research Engagement*, by Rowe, Graf, Agger-Gupta, Piggot-Irvine, & Harris, 2013, *ALARA Monograph Series No. 5,* p. 20. Copyright 2013 by Rowe et al. Reprinted with permission.

The fifth phase of ARE is designed to continue the action cycle by transferring responsibility to act on the recommendations to the project sponsor (Rowe et al., 2013). By actively engaging HALLs, SLs benefit from a return on investment in the form of strong collaborative capacity among those stakeholders and high levels of individual and collective engagement in the consolidation plan, both of which are antecedents of becoming a nimble, adaptive organization as staff and leadership create the new PLMS.

The objectives of this research were to answer the inquiry questions and create new knowledge (third person), to cocreate learning and build relationships amongst the group members to become a highly functional team (second person), and, finally, to stimulate personal growth and change within each participant (first person; Coghlan & Brannick, 2014). I anticipated the AR methodology and ARE approach could meet these objectives as the stakeholders and I developed practical solutions to the present issue and built skills and knowledge for future interactions.

Data Collection Methods

This study utilized two main data collection methods: individual interviews and a focus group teleconference. I purposefully selected these data-gathering methods to build trust between the participants and me, as the researcher, which is necessary to mitigate defensiveness before a degree of openness can be reached in a psychologically safe environment (Bushe & Marshak, 2016).

Individual interviews. The first data collection method sought to capture underlying emotions, attitudes, and beliefs toward this organizational change. Individual interviews have several advantages over a quantitative method such as a survey. Personal interviews allow each

participant the opportunity to be more fully involved in individual self-discovery of his or her own current level of understanding, thoughts, feelings, beliefs, and perceptions regarding the consolidation plan (Rafferty et al., 2013). The act of listening to each person articulate his or her particular concerns conveys the message that the individual's thoughts and perspectives are valued (Schein, 2002, 2013). In-person interviews also afford me, as the researcher, the opportunity to promote an informal, psychologically safe environment for sharing feelings about the change initiative (Schein, 2002), and to build rapport with interviewees that would be conducive to open, honest, high-quality responses (Agger-Gupta, 2014; Bushe & Marshak, 2016; Castillo-Montoya, 2016; Jorgenson & Steier, 2013; Schein, 2002, 2013). Further, semistructured interview questions have the advantage of allowing individuals an opportunity to lead the conversation into areas that they consider most important while the interviewer keeps the interview focused on the research objectives (Taylor, Bogdan, & DeVault, 2015).

I determined a survey format for gathering individual responses to a standardized set of questions would be less effective than interviews, as I sought to gain a deeper understanding of the underlying attitudes about change readiness. Even though individuals often answer objective instruments such as surveys according to their thoughts and beliefs, the responses are limited to the choices provided (Taylor-Powell & Renner, 2003). Individuals are less likely to reveal underlying emotions unless they elaborate in free text answers, which might not provide the depth necessary to draw relevant conclusions. Finally, a meta-analysis of survey participation, particularly among organizational leaders, estimated response rates to be low (32%) and trending lower (Cycyota & Harrison, 2006). In wanting to capture a balanced mix of both medical–operational and rural–remote–metropolitan perspectives from a small number of participants

with varying degrees of experience in BC laboratory service delivery, I chose an option with a likelihood of greater participation that would cover the full breadth of perspectives.

I based my interview questions on the work done in two relevant studies. Devos et al. (2007) evaluated change readiness by assessing the change recipient's level of trust in the change agents, and history with previous change initiatives, in this case, previous laboratory reform efforts. Holt et al. (2007) developed several other criteria, which included change recipient belief that the change was necessary, the change plan as designed could achieve its objectives, the initiative was the right approach to change, and that the leaders have the ability to accomplish their change objectives. Holt et al. (2007) also included the change recipient's dispositional attitude toward change as a relevant measurement. The interview questions were designed to reveal the individual's thoughts and feelings for each of these parameters.

Focus group method. Through conducting this project, I sought to engage laboratory leaders in socially constructing a new provincial mindset; as such, I selected the focus group method. Conversations held during focus group meetings have the advantage of being generative as participants dynamically respond to each other's comments, stimulating insight which goes beyond basic problem solving (Bushe & Marshak, 2016). Guided focus group conversations can help HALLs begin to see the opportunities presented in the new PLMS. Informal settings are conducive for individuals to present differing or conflicting perspectives, even as they encourage connectedness among the participants (Onwuegbuzie, Dickinson, Leech, & Zoran, 2009).

Ideally, the focus group discussions happen face to face, as so much of socially constructed meaning relies on nonverbal communication (Schneider, Kerwin, Frechtling, & Vivari, 2002). This project occurred during a time of dynamic change within the PLMS.

Although previously HALLs met in-person monthly, those meetings no longer occurred during the timeline of this project. The challenge of gathering busy laboratory leaders from across the province into one room for a meeting and still meet the project deadlines caused me to look at other viable options for conducting the focus group.

A teleconferencing method offered the major advantage of being able to schedule the 1-hour meeting at a time convenient for all participants (Schneider et al., 2002). In addition, the geographically distributed leaders were familiar with teleconference meetings, as it is the PLMS's alternative method of choice. Dallas Allen (2014) suggested actively improving the quality of teleconference interactions and conversations would offer long-term benefits to the PLMS, as the realities of work locations makes it impossible for these leaders to meet in-person on a regular basis. Limiting the group size to a maximum of six participants increases the opportunity for richer social engagement among the participants (Dallas Allen, 2014).

In order to enhance the collaborative experience, several additional conditions needed to be addressed. As the meeting facilitator, I needed to take a more active role to fill gaps in conversations to keep the discussion active, and to ensure discussions stayed focused on the research question, participation was balanced, each attendee contributed to the conversation, and that answers were sufficiently detailed to express the depth of the individual's perspective (Dallas Allen, 2014). This method also warranted that I consciously canvas the participants for their agreement or disagreement with the content and context of the discussions (Schneider et al., 2002).

Since the potential pool of participants was limited to a small group of leaders, I scheduled only one focus group session. As no other individuals met the sample criteria, I was

unable to conduct a second focus group as a means to assess data saturation (Onwuegbuzie et al., 2009). All group interventions are person- and context-specific, making the interactive, dynamic flow of conversation and the eventual outcomes unique to the constituency of the group (Onwuegbuzie et al., 2009).

Project Participants

The total population of individuals whose perspectives were relevant to this study was small, so I used "purposive sampling" (Etikan, Musa, & Alkassim, 2016, p. 1) to invite all 14 regional or provincial medical and operational leaders from each of the public health authority Laboratory Medicine departments in BC, as they fell within the scope of this project. Excluded from the study were the leaders from the two private LSP organizations in BC. These two organizations were not, at the time of this inquiry, directly impacted by the laboratory service consolidation under the oversight of PHSA. Also excluded were any members from the First Nations Health Authority, as they do not provide laboratory medicine services.

When establishing the minimum number of interview participants required to reach data saturation, I considered the various perspectives that needed to be represented (Boddy, 2016). Each health authority Laboratory Medicine department uses a dyad model of leadership, making the perspectives of both the medical and operational leaders relevant to this study. The geographic regions covered by the regional health authorities cover a mix of population density areas. Island Health (VIHA), Interior Health (IHA), and Northern Health (NHA) range from rural–remote to urban areas. The health authorities FHA and VCH span rural–remote to metropolitan areas, and PHSA covers the entire province. The third category was the individual's experience history (time in laboratory service, time in healthcare, time in BC, and time in role).

Considering 14 potential participants fit the selection criteria, I chose eight to be the minimum number of participants necessary to capture a representative mix of attributes and perspectives.

I also used purposive sampling to select the focus group participants. This data collection method drew from the same total population of laboratory leaders because they are the ones who will eventually form the team of provincial laboratory leaders in the PLMS. I considered six to 10 participants as the ideal number of focus group participants as this provided a representative diversity of perspectives to answer the research question (Boddy, 2016). The actual number was dependent upon the individuals who chose voluntarily to participate.

Inquiry team. I formed an inquiry team (IT) of four colleagues from the Agency, with me in the role of primary investigator. These individuals had extensive knowledge of the issues related to medical laboratories and the history of laboratory reform in BC. None of the IT members had any direct power-over relationship with the participants. As Castillo-Montoya (2016) recommended, three IT members and I conducted a pilot test of the interview questions, with one member, who was instrumental in the LM Labs consolidation, serving as the interviewee. I refined each interview question based on the input from the IT members to ensure the answers applied directly to the research question and yielded the desired information (Castillo-Montoya, 2016; Taylor-Powell, 1998).

One IT member conducted the first interview session. I also attended as a quality measure. It became evident that by conducting all interviews personally I would have better control of the consistency of any follow-up questions needed to probe deeper to understand each individual's perspectives, subsequently safeguarding the quality of the data and the reliability of the resulting conclusions (Creswell & Creswell, 2018). One IT member assisted with coding and

theming the interview data. All IT members signed a confidentiality agreement prior to participating in the research activities (Appendix A). An external editor assisted with formatting of the final thesis.

Study Conduct

This study consisted of data collection methods of individual interviews of the participants to generate the first data set and constituted Phase 2 of Rowe et al.'s (2013) ARE cycle. Following Holt et al.'s (2007) recommendations, I analyzed the interview data to identify the a priori (deductive) themes, which were the direct answers to the interview questions, and emergent (inductive) themes, which appeared through data analysis. The themes served as the starting point for the third ARE phase focus group, during which the group collectively reflected on the several themes from the interviews, immediately followed by taking those collective insights to identify collaboratively the opportunities and possibilities presented by the organizational change. During the fourth phase, the group formulated those opportunities into recommendations and strategies, which they determined would set the stage for successfully achieving not just transactional but transformative change.

Individual interviews. Having no power-over relationships with any of the potential participants, I sent each an email with the invitation to participate in an individual interview as the body of the email (Appendix B). I included the research information letter (Appendix C) and the consent form (Appendix D) as attachments. Returning the signed consent form indicated the invited individual's willingness to be interviewed for this project.

Upon receipt of the signed consent, I scheduled a suitable time and place to conduct the interview. I conducted individual 1-hour interviews either in-person or via teleconference

spanning a 2-week period. I framed the semistructured interview questions to capture the individual's demographic attributes, attitudes toward past change initiatives, baseline attitude toward change, attitudes toward the current change plan, faith in the organization and SLs' ability to accomplish the plan, and the impact the change might have on their many healthcare partner relationships (Appendix E).

At regular intervals throughout the interviews, I took a moment to paraphrase what I heard and sought affirmation of my understanding. Although each interview was recorded, one recording failed, so I asked the interviewee to reconstruct the answers based on my contemporaneous field notes. I transcribed the audio-recordings using the online transcription program, Otter.ai (n.d.).

Focus group. Using the same purposive sample of potential participants as the individual interviews, I sent each individual an email with the invitation to participate in a focus group teleconference as the body of the email (Appendix F). I included the research information letter (Appendix C) and the consent form (Appendix G) as attachments. I then sent a Doodle (n.d.) poll to all individuals who returned the consent form to determine a date and time that was acceptable for everyone.

I also emailed a consolidation of the interview themes (Appendix H) 4 days in advance of the meeting along with the meeting agenda (Appendix I). This informed the participants of the format of the meeting and allowed them to familiarize themselves with the interview findings and themes in advance (Dallas Allen, 2014).

I began the teleconference by first reviewing the themes from the individual interviews, allowing attendees to validate whether those themes were a good representation of the main

concepts and concerns voiced during the individual interviews. This constituted Phase 2 of Rowe et al.'s (2013) ARE cycle. Next, I asked the group to focus on answering the second subquestion, representing ARE Phase 3 (Rowe et al., 2013). As such, participants considered how they could, as a group, work together to create a new provincial identity and cohesiveness as a team before they moved to designing solutions (Kumar, 2013). Once participants had identified the opportunities, the group engaged in a final activity intended to answer the third subquestion (i.e., ARE Phase 4; Rowe et al., 2013), which was to collaboratively develop recommendations and strategies that would be helpful to enable these leaders to begin changing their mindset to adopt a new identity with the PLMS. Participants discussed recommendations that would help them socially construct a new provincial organizational identity and culture.

Data Analysis

Following Thomas's (2003) advice, I applied a qualitative data analysis approach to deductively answer the research questions and inductively draw deeper meaning from the data through the discovery of emergent themes. I began the data analysis by reviewing each recording while editing the raw transcript for better accuracy and eliminating unnecessary words or redundant phrases. As Birt, Scott, Cavers, Campbell, and Walter (2016) recommended, I emailed these condensed transcripts, representing the data corpus, to the appropriate participant for review as a member check to ensure the information accurately captured his or her perspective. Following confirmation by the interviewee, I further consolidated the condensed transcripts to leave only the segments relevant to answering the research questions, as Onwuegbuzie et al. (2009) suggested. The abridged transcripts plus any field notes formed the data set.

I conducted multiple cycles of listening to the audio recordings while following the abridged interviews and field notes (Herzog, Handke, & Hitters, 2019). I captured segments of responses on a Microsoft Excel spreadsheet, according to each interview question. In the first review of the data set, I coded segments of text that were illustrative of change attributes across the change spectrum: opposition, cynicism, doubt, noncommitment, hope, openness, and commitment (see Chapter 2, Literature Review for a discussion of these attributes). In the second review, I applied emergent codes based on the evidence. In the third review, I drew deeper insights by categorizing the codes into patterns of thinking. I conducted iterative cycles of review and reflection as I went back to the transcripts to ensure clarity of understanding within the context of the actual conversations. Following scholars' advice, one IT member and I separately analyzed the data set to corroborate the major themes (Bradley, Curry, & Devers, 2007; Glesne, 2016). Once codes were independently assigned, the IT member and I compared codes until we found close agreement between the two sets of themes.

When analyzing the individual interview data, I referred to Holt et al.'s (2007) comprehensive review of change readiness assessment instruments. Of the instruments that assessed individual attributes, all based their assessments on general dispositional attributes. These were not suitable within the context of this study, as I was investigating stakeholders' change readiness within the specific context of this organizational change. Subsequently, I created an instrument to assess individual change readiness attributes as displayed by each person during the interviews based on the attributes described in the literature review.

I determined the dispositional attitude toward change according to each individual's answer to a specific interview question, asking the interviewee to state his or her general

approach to change. Following that, I assessed participants' responses to the inquiry about their current attitudes toward this specific change initiative for the degree of intent to act and its cognitive or affective intensity (see Chapter 2 for a more thorough discussion of these change attributes). Table 1 provides the basis for evaluating each attribute during the data analysis.

Table 1

Definitions of Change Readiness Attributes

Attribute	Definition	Degree of Intention/Intensity	Examples of Key Words or Phrases
Resistance/ Opposition	Intent to actively oppose the change plan	High	I would leave
Cynicism/ Skepticism	Deep pessimism directed toward the change plan or the change agent	Moderate	It's never going to happen Why should this be different?
Doubt/ Uncertainty	General pessimism toward the change plan or change agent	Low	Uncertain Cautious Hesitant Anxious Frustrated
Noncommittal	Neither positive nor negative attitude toward the change	Neutral	Indifferent
Hope/Optimism	Positive attitude toward the change plan	Low	This could work Hopeful
Openness/ Receptivity	Willingness indicating openness to possibilities	Moderate	I am open I see the opportunity
Commitment/ Readiness	Intent to actively support the change plan and the change agent	High	Let's do this Engaged

One IT member and I separately evaluated the individual responses to the interview questions to identify which change attribute would best describe the participant's statement and then compared the results for agreement. When discrepancies of assessment deviated by more

than one attribute along the spectrum, the IT member and I discussed our reasoning and adjusted the score according to our consensus. The final scores showed approximately 80% agreement.

The focus group teleconference began with a discussion of the individual interview themes (Appendix H). The participants affirmed that these themes represented their collective concerns regarding the pending organizational change. The second part of the meeting was a reflexivity process, in which participants analyzed the themes as they evaluated the several tensions that needed to be managed in the new provincial laboratory landscape and contemplated the particular enablers that would help build their change engagement. A final participatory analysis occurred as they socially constructed recommendations that would help them create a new identity as the PLMS.

I transcribed, condensed, and abridged the focus group audio recording using the same online program and process used for the interview data. I conducted "thematic analysis" (Herzog et al., 2019, p. 385) via constant comparison analysis (Onwuegbuzie et al., 2009). I made an effort to capture points of disagreement or consensus among the group to give depth to the analysis and add interpretive validity (Bazeley, 2009; Onwuegbuzie et al., 2009). To confirm the accuracy and validity of the findings, conclusions, and recommendations (Fereday & Muir-Cochrane, 2006), I sent a survey to the focus group participants for their review and comments (Appendix J). I received three responses, two of which directly agreed with all statements and one agreed with added comments.

Research Quality and Validity

Qualitative research being more subjective than quantitative studies makes attention to concerns about trustworthiness and credibility paramount (Glesne, 2016). This chapter provides

evidence to build trust in the process and the conclusions. Beginning with the data collection, I designed the semistructured interview questions to answer the research question and refined them through a rigorous pilot test process, as Castillo-Montoya (2016) described. I also ensured each participant reviewed his or her interview transcript to member check that data and verify their thoughts and perspectives were accurately represented (Birt et al., 2016).

I ensured the credibility of the data analysis by incorporating "consistency checks" (Taylor-Powell & Renner, 2003, p. 7), which entailed comparison of data coding and theming with another IT member, and "credibility checks" (Taylor-Powell & Renner, 2003, p. 7), in which the focus group participants confirmed the findings and conclusions. As a qualitative, inductive researcher, my own perspectives influenced how I interpreted the data, developed the findings, and conceived of the conclusions and recommendations. This was mitigated by personal reflexivity throughout the process and through discussions with IT members, my project partner, and members of the PHSA Transformation Leadership Office (TLO) to gain differing perspectives on my interpretations and conclusions.

Qualitative rigour is evident in the extensive detail of the research process provided in this chapter, along with the rationales for making critical methodological choices as warranted in response to emergent conditions (Herzog et al., 2019). Finally, carefully tying the data to the findings and eventual conclusions ensured the research established interpretive validity (Fereday & Muir-Cochrane, 2006). The multiplicity of these elements throughout the study builds confidence that the interpretations are credible and that the research is trustworthy.

Ethical Implications

As my research project involved humans as the main source of data, I paid particular attention to three core ethical principles: respect for persons, concern for welfare, and justice (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2014).

I addressed issues related to informed consent and respect for privacy and confidentiality in the research information letter (Appendix C), the Letters of Invitation (Appendices B and F), and the research consent forms (Appendices D and G). These documents thoroughly outlined the objectives and conduct of the study, clearly informed each potential participant that taking part in the inquiry was voluntary, and described the process to decline or withdraw consent at any time without any harm. By being transparent about the process, I ensured individuals received enough information to give informed consent.

I protected their privacy and the confidentiality of their information by only allowing individuals who had signed a confidentiality form access to any research data or personally identifiable information. I stored information in password-protected files (electronic data) or in a locked cabinet in my office (paper copy). I anonymized participant comments used in this thesis to protect individuals' identities.

I treated all possible participants fairly and equitably by ensuring no one was excluded who might benefit from contributing. This principle was met by inviting all individuals who met the demographic criteria for the study to participate. The private laboratory leaders and any members from the First Nations Health Authority were reasonably excluded, as they will not be affected by the formation of the PLMS.

Finally, any individual who perceived there to be a power-over relationship may have felt pressured to participate. Although I had no direct power-over positionality, as an employee of the Agency, which has an oversight role of laboratory services, and because the project partner is the PHSA's CPDO, the potential participants may perceive they were expected to participate. Additionally, there may have been peer-to-peer pressure to participate in the focus group as all participants were well known to each other, having worked together as part of the Agency's regional leadership team. Absence of any of these stakeholders would be noticeable during the group session and could be perceived as a lack of desire to actively contribute to the solutions or unwillingness to be part of the team. I discussed these concerns in the research information letter (Appendix C), which advised that all participation was voluntary, all had the option to withdraw from the study at any time, and absence was not to be interpreted as an unwillingness to contribute.

Proposed outputs. At the time this thesis was being written, a face-to-face meeting of the laboratory leaders and the CPDO, billed as a Laboratory Leaders Forum, was held. My presentation of the findings, conclusions, and recommendations served as the starting point for the meeting. One of the study recommendations was for SLs to provide a forum during which HALLs would have the opportunity to build collaborative skill while engaging in brainstorming activities to contribute to developing the actual content and context of the organizational change plan. The remainder of the day was spent engaging the leaders in accomplishing this objective.

A member of the PHSA TLO was also in attendance, as she was planning the TLO's change management measures addressing the personal aspect of change that PHSA will employ

across all the newly coordinated provincial service lines. Discussions to further define the action plan as part of the implementation phase of Rowe et al.'s (2013) ARE process are scheduled.

Finally, each of the project participants was sent an executive summary of the final thesis. It provided a more detailed description of the project, which served to reassure them that their input was worthwhile and was valued by the project partners.

Contribution and application. This research provides evidence that change-specific enablers are necessary to assist the key stakeholders prepare to endorse the project in the early stages of significant organizational change. The conclusions and recommendations from this project have broad applicability as PHSA undergoes further service integration efforts in other areas. Members of the PHSA TLO are eagerly awaiting the final report as they prepare to initiate the transformation process with leaders from other healthcare service delivery streams. This is the first time change readiness has been critically evaluated within PHSA during the early stage of a change process of this type and can be helpful to warn the change leaders of pitfalls to avoid and inform them of the actions that can fan or amplify the desired attributes (Bushe, 2005) which are antecedents to change readiness.

As the key influencers within their own organization, successful change implementation depends largely on HALLs' ability to convey their belief that the change makes sense, it will result in benefits to their followers, and they endorse the change. The learnings from this project help support the body of knowledge by showing that engaging the participants in their own solutions and building trust throughout the organization enables them to become better prepared to form a system-level organization.

Chapter Summary

In this chapter, I described the foundational AR methodology (Stringer, 2013), the ARE approach (Rowe et al., 2013), and the specific data collection and data analysis methods used during this project. I provided a detailed description of how the study was conducted and gave specific attention to how the research met acceptable quality and validity requirements to ensure the results are supported by the evidence, can be broadly accepted by others, and are not simply a reflection of my own opinions. In the next chapter, I present the research findings and the conclusions drawn from those findings based on the evidence and relevant literature.

Chapter Four: Research Findings and Conclusions

This chapter contains an in-depth discussion of the study findings and conclusions drawn from the data to answer this main research question: How might BC's individual HALLs prepare themselves to become partners within a single provincially coordinated laboratory service system? While conducting the research, I focused on answering the following subquestions:

1. What is the current state of individual change readiness of HALLs?
2. What are the enablers that could increase HALLs' engagement with the new PLMS?
3. What strategies can we recommend to facilitate the formation of an identifiable, cohesive province-wide laboratory service?

I present the findings based on the analysis of actual comments given during the individual interviews and focus group session. Each participant's comments have been anonymized using codes P1 through P16 to separately distinguish each person's input. Next, I discuss the conclusions I have drawn from those findings. I finish the chapter with a discussion of the scope of the inquiry and the limitations of this project that would impact the generalizability of the conclusions.

Study Findings

Participation in the individual interviews was 71% (10 of 14 possible participants) and 43% for the focus group (six of 14). Examination of the demographics of the participants indicated balanced distribution across all categories from medical to operational, urban and metropolitan to rural and remote service delivery areas, LM to non-LM, and length of experience within BC laboratories (from 2 months to several decades). The high participation rate for both data collection methods and the balanced distribution of each category for each method allowed

for a comprehensive understanding of the overall attitudes, concerns, and suggestions of these primary change recipients, giving greater confidence in the validity of the findings and conclusions.

The following key findings emerged from analysis of the interview and focus group data:

1. Although inherently positive toward organizational change, HALLs displayed a broad range of both positive and negative attitudes toward this change initiative.
2. The HALLs displayed a wide range of attitudes across the change readiness–change resistance spectrum regarding their faith in the plan to accomplish its stated objectives.
3. The HALLs' attitudes varied regarding their faith in SLs' ability to successfully accomplish the change objectives.
4. The HALLs exhibited difficulty engaging with the change initiative knowing that previous barriers to successful laboratory reform still exist.
5. The HALLs struggled to understand the relationships and multiple identities within PHSA and the new PLMS organization.
6. Multiple complex tensions currently exist, which limited HALLs' ability to envision a new PLMS.

Finding 1: Although inherently positive toward organizational change, HALLs displayed a broad range of both positive and negative attitudes toward this change initiative. The first individual interview question assessed HALLs' dispositional attitudes toward change as a baseline measurement indicative of their natural response to change. Participants' answers indicated seven out of 10 participants enthusiastically welcomed change initiatives (P1;

P2; P4–P7; P9). Some participants took a more pragmatic view that change is a continuous process that one deals with as it comes (P8; P10). One participant admitted to being naturally anxious about change but recognized it as a necessary process that would ultimately yield positive outcomes (P3). Collectively, participants' general dispositional attitudes toward organizational change were overwhelmingly positive.

When asked about their attitudes toward this particular change initiative, participants' responses showed a clear distinction from their dispositional attitudes toward change. Several participants had a cautious and noncommittal attitude toward this particular change initiative (P8; P9). Many participants were both encouraged at the prospect of improvement while at the same time uncertain and skeptical (P1–P3; P5; P6).

An assessment of the range of attributes expressed during the interviews revealed that all participants expressed some degree of conflicting positive and negative attitudes toward the change initiative. During analysis, I noted indications of participants' frustration at lack of progress, anxiety due to lack of information over time, and nervousness about how the change might impact HALLs personally. I found evidence of strong negative feelings, particularly when participants discussed past attempts at laboratory reform. From the tone and context of the individuals' responses, skepticism and uncertainty strongly influenced their overall attitudes and levels of change readiness toward this specific change effort.

Finding 2: The HALLs displayed a wide range of attitudes across the change readiness–change resistance spectrum regarding their faith in the plan to accomplish its stated objectives. This finding surfaced through the analysis of HALLs' responses to the interview question that asked them to state the concerns they had and the opportunities they saw

with this change initiative. When asked to describe their faith that the plan will effectively accomplish its objectives, participants' attitudes were mixed. Without more information about the plan, they were unable to commit to the change initiative. P5 voiced the sentiment of many of the participants (P1–P5; P8; P10) by stating, "I don't know what the plan looks like, if there is a plan, or how detailed it is, or what it covers, so [it is] too early to comment." Several participants showed high levels of skepticism based on their historical knowledge of past laboratory reform efforts (P6; P8; P10). P6 stated, "It hasn't been clear to me why it failed 18 times and why it's going to work now."

At the same time, many participants found reason to be optimistic that real change was possible this time (P1–P8). Participants saw this as an opportunity for them to work together as a group to achieve common goals and to take a systems approach to service delivery. Several participants indicated they could support the change initiative as long as the focus was for the good of the patient (P4; P6; P7). This shared purpose suggests an avenue for the SLs to explore when they begin working to unify the separate LSPs into a single partnership organization.

A number of the participants were disappointed with the delay in action (P1; P2; P5; P6). Having been informed months beforehand that the laboratory would be forming a single service delivery stream, HALLs anticipated action would begin imminently. However, within the timeframe of this project, no action was forthcoming. Participants expressed frustration at the lack of progress (P2; P5; P6). P6 stated, "There's been a lot of talk. It's almost like, 'Let's start. Let's start again, and then it stops.'. . . Let's just get on with doing what is doable." Participants' expressions of impatience due to lack of action signified HALLs' perceptions that there was a

loss of momentum that was actively eroding their change readiness (P6) as levels of doubt, anxiety, and uncertainty increased (P1).

> Perceived lack of communication further contributed to loss of engagement.
>
> It's kind of been crickets since those first meetings. In the absence of information, people make it up. [I] keep hearing these rumours that there's something coming and that some people seem to know more than others [do]. I've started to get more anxious about it. Not that I'm being obstructive or planned to be, but I am a bit more nervous than I was when this first started. I was very—I don't want to say excited—but I was engaged and interested to see where this is going to go. And now I'm a little bit more cautious. (P9)

Even small pieces of new information caused participants to engage in peer sense-making (P13; P15). Not everyone agreed that communication was insufficient, however. P4 noted SLs were following a template that was proven to be effective.

Finding 3: The HALLs' attitudes varied regarding their faith in SLs' ability to successfully accomplish the change objectives. When asked if they had faith in SLs' ability to accomplish the plan, participants offered mixed responses. P10 had tremendous confidence in SLs' abilities to accomplish the plan based on his positive working relationships with them. Some were skeptical that more than "cosmetic change" (P8) could be accomplished, as "lack of transparency and a lack of communication inevitably leads to rumours and fears, and unwillingness to participate in anything because it's being perceived as enforced" (P8). One participant reported the SLs were initially transparent and inclusive, but since that time HALLs were no longer involved in the process. P9 stated,

> It was a really great process where they brought us all together, so we felt like we were listened to. It didn't seem like it was a lip service. But now it seems like it is more PHSA doing the next step on their own. . . . In the absence of us meeting and in the absence of knowledge I just don't know if those voices include ours.

These two comments reflect a sense that HALLs' input was not valued by the SLs, which ultimately affected their attitudes about their relationship with the SLs. This finding suggests that HALLs' relationships with SLs are not strong. Building stronger relationships with the SLs and inviting HALLs to become more involved in the change process offers another important avenue for improving organizational change readiness at the individual and collective levels.

This finding illustrates the internal struggle HALLs experienced as each tried to find his or her own way toward engaging with the change initiative. High levels of skepticism, doubt, and ambivalence show the degree of personal apprehension regarding the change. At the same time, their own natural optimism toward organizational change was gradually being eroded. The preponderance of anxiety and fears indicates poor emotional engagement. Based on the literature, the strong presence of both cognitive and emotional change resistant attitudes indicates that without intervention HALLs cannot become change ready on their own.

Finding 4: The HALLs exhibited difficulty engaging with the change initiative knowing that previous barriers to successful laboratory reform still exist. The participants identified the persistence of several previous barriers to laboratory reform as preventing or limiting their readiness to commit to this change initiative. Without knowledge that these legacy barriers would be mitigated, HALLs continued to doubt that this current change initiative would be successful. The first barrier participants identified was the current mechanism for funding the

public laboratories. In the current state, the health authority Laboratory Medicine departments depend on budgets distributed from the health authority global budgets. Long periods of budgetary restrictions have resulted in their departments struggling to provide service on aging equipment and outdating technology, and unable to offer new innovative technologies in the absence of any additional funds. P16 summed this up by saying,

> You have a system that has largely been constrained over a significant period of time. The challenge is, we have massive technology changes, we have an aging workforce, we have a terrible transport system, and if you want an innovative system, you can't ignore those things forever.

Without seeing any change to how laboratories are funded, HALLs found it difficult to believe that this change initiative would successfully improve laboratory service delivery.

The second barrier to achieving the change successfully was the need to have a governance structure that would give the SLs the appropriate authority to make the decisions necessary on behalf of the whole organization. Several focus group participants named the need for a defined governance structure to help mitigate their doubts that success was possible (P14; P15).

One participant countered this sentiment. P3 feared that handing authority to the PLMS SLs would necessarily diminish HALLs' own authority to make local decisions by creating a new level of bureaucracy. The HALLs previously had a great deal of autonomy to act on behalf of their department within their health authority. One HALL already saw evidence that this new layer of accountability introduced a delay in the ability to respond quickly to changing conditions

(P9). This individual indicated the organization was losing nimbleness in exchange for decision-making ability on behalf of the SLs.

Lastly, participants identified several structural ties to their health authority as mechanisms that reinforced the status quo. The HALLs pointed out laboratory medical professionals will necessarily remain accountable to the Medical Advisory Committees within their own health authority (P10; P15; P16). Additionally, LSPs will continue to operate within the health-authority-specific electronic information systems. These structural barriers "perpetuate those silos that we're trying to break down and a lot of the site-specific resistance that you're seeing to developing a provincial model" (P13).

The HALLs viewed these structural barriers as significant impediments to successful organizational change. Their experiences with past laboratory reforms led them to presume that the continuation of legacy barriers would effectively prevent the success of this change initiative. Without evidence that these barriers will be removed, HALLs are deeply skeptical of this change initiative, which severely limited their cognitive engagement with the plan.

Finding 5: The HALLs struggled to understand the relationships and multiple identities within PHSA and the new PLMS organization. Across the interviews and focus group session, a common theme regarding the lack of clarity of the many identities of PHSA and PLMS served as a barrier to their engagement with the change initiative. Tied to their concerns about identities was the confusion about the impact the new organizational structure would have on HALLs' own roles, responsibilities, and relationships within their health authority.

First, HALLs were unable to conceive of what the unified PLMS would look like and expressed confusion about the identities of the various organizational entities currently

encompassed by the PHSA and PLMS (P3; P4; P9; P10). In particular, the terms "PHSA" and "PLMS" encompassed a number of different organizational responsibilities, such as (a) oversight, (b) regulatory, (c) operational, and (d) direct service delivery. Some participants pointed to PHSA's conflict of interest, since it is both a deliverer and an overseer of laboratory services (P6; P10; P14). Together, this resulted in a lack of clarity over roles, responsibilities, and relationships within PLMS, with each HALL trying to understand how these would function together.

During the focus group meeting, I asked participants to take a forward look to begin forming a new PLMS identity. Unanimously, the HALLs indicated they were unable to begin the process of forming a system-level identity of the PLMS due to the lack of a clear plan (P11–P16). Some participants were still trying to develop their identity at the local level (P13), to which one respondent pointed out that identity formation was a long process (P14).

In the absence of an identifiable PLMS entity, HALLs struggled to envision a shared future. However, the beginnings of forming a new provincial identity were evident when one participant articulated a shift in thinking. P15 offered, "It's a Provincial Lab system we're working towards, not health authority system anymore."

Other participants were most concerned about the impact to their existing relationships within their own health authority. Several participants mentioned their emotional connection to the health authority and the people in it (P2; P4, P6; P9; P10). P9 considered the health authority to be "family" and experienced a sense of loss that came as a consequence of joining the PLMS.

Finding 6: Multiple complex tensions currently exist which limited HALLs' ability to envision a new PLMS. This final finding highlights the many disparate perspectives that have

hampered progress toward consolidation over the past several years. Laced throughout the individual interviews and the focus group session, participants identified multiple competing tensions that complicate their ability to fully embrace the new PLMS. Each HALL had his or her own deeply personal perspective on how laboratory service should be delivered. The main tensions participants identified included their need to (a) take a provincially coordinated approach while still delivering laboratory service locally within their geographic health authority operations, (b) maintain close clinical partnerships within their home facilities while working under the PLMS, (c) balance the interests of academia and research necessary for innovation with the needs to be operationally efficient and effective, (d) maintain the uniqueness of each individual LSPs while collaborating effectively within the new partnership, (e) compete with each other for the limited specialized testing in the province, and (f) have an equal voice within the collaborative process without perceptions of unequal treatment within the PLMS.

These tensions manifested themselves in the functionality of their working relationships. The HALLs noted the existing working relationships were not truly collaborative despite wanting to accomplish the same end goals. P9 pointed out,

> People [were] digging their heels in and then getting away with digging their heels in. . . . They all didn't have to play in the sandbox, so it really makes you nervous about how this is going to go now that you're adding more people to that sandbox.

Participants also expressed concerns that the balance of voices posed a threat to forming a cohesive group identity. Several participants had concerns that the Vancouver-based members had greater influence over the direction of laboratory service provincially. However, another participant noted those voices outside the LM were getting stronger as their health authorities

have grown in size and significance (P10). At the same time, HALLs from within the LM also expressed concerns about being excluded from discussions that could be beneficial for them to hear. These perceived inequities illustrate the need to address the balance of voices before HALLs would be willing to embrace enthusiastically the new organizational model.

In addition to those tensions listed above, the data indicated several issues of great concern specific to the laboratory medical professionals. The participants identified inequities of compensation mechanisms among the laboratory medical professionals throughout the province (P4), concerns for maintenance of expertise in the face of consolidation of testing to a limited number of laboratories (P7), concern regarding maintaining relationships directly with clinical colleagues (P8; P10; P14), and continued need to report directly to their respective health authority medical advisory committees (P12; P14). These issues take on greater importance as several participants suggested that endorsement by the laboratory medical professionals was pivotal to successfully forming a single coordinated laboratory service (P14; P16).

Overall, HALLs have faced many of these tensions during their interactions over the years with little progress made toward becoming a true partnership. The implication is that HALLs and SLs will have to change how they interact in order for a unified PLMS organization to be fully realized.

Summary of findings. The study findings revealed HALLs have a generally positive approach to change; however, when determining their state of change readiness toward this particular change, HALLs were simultaneously cynical, skeptical, doubtful, uncertain, ambivalent, hopeful, and optimistic. Participants perceived the level of communication and content of the information shared over time to be insufficient, and this factor negatively impacted

their change readiness. Participants indicated they required more concrete details of the change plan, including indications that long-standing barriers to laboratory reform would finally be addressed, in order to be able to engage with the plan. Participants further indicated that they needed clarity of the PHSA and PLMS identities, and how the new model will impact their roles, responsibilities, and relationships. Finally, HALLs lacked an ability to envision a shared future in a single laboratory service system due to the continued existence of multiple competing tensions that have not yet been adequately resolved. The findings showed the pervasiveness of their change resistant attitudes due to their past experiences, their current state, and their perceptions of the future. Converting these attitudes to change readiness will require active intervention to encourage HALLs to be more open to the planned organizational change.

Study Conclusions

Based on the findings outlined above, I drew several conclusions about the state of change readiness of the HALLs, the enablers which they identified to help them become more ready for change, and the strategies that could help them form a new system-level PLMS identity:

1. The HALLs' confidence in the plan can increase when they know the existing barriers to successfully forming a provincial laboratory service stream are addressed.
2. The HALLs' change readiness can increase when there is clarity of the multiple roles, functions, and identities of the PLMS.
3. The HALLs' change readiness can increase when they perceive that existing tensions can be resolved and the many working relationships can be managed.

4. Change readiness can be incorporated into the organizational culture by building trust at every level.

Conclusion 1: The HALLs' confidence in the plan can increase when they know the existing barriers to successfully forming a provincial laboratory service stream are addressed. Individual change readiness can improve when HALLs have confidence that the plan will remove the barriers that are limiting their change readiness. Although HALLs expressed hope for the change plan to succeed, almost all are reserving judgement on the plan's expected success until they have a clearer understanding of what the plan entails. Further, HALLs seek some assurance that legacy barriers that have prevented success in the past will be mitigated in order to accept that the plan has a chance to succeed.

While not inherently cynical, knowledge of past laboratory reform efforts that underachieved their change objectives factored heavily in HALLs' skepticism relating to this change initiative. Lacking clarity, HALLs are understandably skeptical that this plan will differ from any other laboratory reform or change attempt.

High levels of conflicting thoughts and feelings were to be expected at the early stage in the change process when details of the plan are least well developed (Miller & Rollnick, 2013). Given HALLs' decidedly mixed attitudes and cautious approach to this specific change effort, SLs will need to be intentional about increasing HALLs' level of change readiness. In this case, I advise SLs acknowledge past failed laboratory reform efforts and explain how this change initiative differs. Further, they will need to address the other barriers HALLs identified. These include lack of authority for decision making, lack of a defined governance structure, a funding structure that maintains dependence of the separate regional LSPs on their local health authority,

and structural barriers such as information technology systems and medical accountability that maintain strong connection to their health authority.

The HALLs desired greater inclusion in the process of defining the change plan. The evidence in this study supported the literature that showed participation is a primary enabler of change readiness (Lines, 2004). High levels of participation in both the individual interviews and in the focus group discussion indicated HALLs' desire to be included in the process. The individual interviews offered HALLs an opportunity to share freely their thoughts and concerns about the plan with the expectation that those would be delivered to SLs for their consideration. The focus group discussions provided an opportunity for participants to collectively process their thoughts and feelings about the change initiative and, in so doing, begin the formation of an identifiable group centred on their common interest. Finally, these sessions gave HALLs a sense that they were consulted in the change process, which increased the likelihood of ownership and endorsement (Schein, 2013; Self & Schraeder, 2009).

This investigation found that the quality and quantity of information from SLs to the HALLs was inadequate to enhance or even maintain levels of change readiness. During periods without significant information sharing, HALLs engaged in individual and peer sense-making, which the literature showed generally exacerbates negative perceptions about the change (Elving, 2005). These HALLs expressed their opinion that high-quality, consistent messaging would build and sustain positive levels of engagement. This finding supported the conclusions of Allen et al. (2007), who argued change readiness increased when the leader supplied strategic information to followers. In the absence of information, HALLs saw their change engagement slowly eroding as fears and anxiety began to grow.

The HALL participants also cautioned SLs to ensure that everyone gets the same messaging at the same time. When shared with a select group of individuals, those who heard the information secondhand experienced a variety of emotions such as exclusion, isolation, and diminished value. These emotions can sabotage their change readiness (Patvardhan et al., 2015). When peer group sense-making became the biggest source of information, collective resistance increased. The implication is that more organizational energy will need to be expended to change that momentum back toward engagement (Pardo del Val & Martínez Fuentes, 2003).

Elapsed time between communications also decreased HALLs' level of change readiness. The findings showed that these HALLs have a high natural degree of engagement but that engagement diminished as time between information inputs from SLs became longer. The participants specifically tied lack of communication with increasing doubt, which in turn led to greater anxiety and skepticism. This conclusion was consistent with the literature, which pointed to delays between information touchpoints as sources of change engagement erosion (Elving, 2005).

Conclusion 2: The HALLs' change readiness can increase when there is clarity of the multiple roles, functions, and identities of the PLMS. The findings indicated HALLs' level of attachment to the new PLMS was low at the time of this inquiry. During the focus group session, I asked HALLs how they might begin forming the PLMS identity. With very few details about the plan and no conception of what the PLMS means, participants had difficulty socially constructing the identity of the PLMS. This finding was not in concordance with the results discovered by Drzensky et al. (2012), who noted identity formation would help engage the organizational members even when details of the new identity were vague.

The HALLs' deep emotional connection to their home health authority and to their local site made it difficult for them to transfer allegiance to the unknown entity that is the PLMS. This was evident when P9 mentioned that when she was "applying for the job at [the health authority], I actually aligned myself with their values." The HALLs' perception that the new organization will require them to disconnect from those close relationships and realign with the new organization necessitates a "grieving process" (Bolman & Deal, 2017, p. 383) as they psychologically separate from their old identity. Without an identifiable entity to move toward, HALLs were unable to begin the process of extending their sense of self toward the new collective entity (Brewer & Gardner, 1996).

Participants also experienced great difficulty understanding the multiple identities that constituted the many roles held within PHSA. The moniker PHSA was used interchangeably to mean the PHSA executive leadership team, the new PLMS, the PLMS SLs who oversee laboratory services, LM Labs as the entity under PHSA that coordinates operations in the LM, the three provincially scoped individual labs under PHSA, and the Agency. To complicate this further, the PLMS will eventually encompass the Laboratory Medicine departments of all six health authorities. This represents an "identity crisis" (Patvardhan et al., 2015, p. 406) that the HALLs noted needs to be resolved in order for them to begin the process of understanding these roles and how each fits within the new organizational structure.

Patvardhan et al. (2015) advised developing a shared organizational purpose from which the organizational identity could emerge. This suggests a change in approach to allow a more emergent identity to form rather than trying to attempt this directly. Clearing up this confusion

would enable the formation of a collective PLMS identity, serve as a focal point for connectedness, and ultimately improve collective change engagement (Patvardhan et al., 2015).

Conclusion 3: The HALLs' change readiness can increase when they perceive that existing tensions can be resolved and the many working relationships can be managed. The relationship of primary importance during organizational change is between the SL and the HALL. The findings showed HALLs have reasonable trust in SLs' ability to accomplish their objectives, but with many caveats to their endorsement. Lines et al. (2005) drew a strong link between increasing trust in leaders and increasing the change readiness of their followers.

Followers need high levels of trust in their leader in order to commit willingly to the change initiative (Oreg, 2006). The literature showed change recipients' relationships with their leader significantly influenced their ability to endorse an organizational change initiative, even in environments with high levels of ambiguity (Elving, 2005). Agote et al. (2016) found leadership behaviour that was authentic, trustworthy, and ethical led to high levels of trust in the leader by the followers. As observed in this study, HALLs will be actively evaluating the consistency between the leader's words and actions to determine whether they will participate actively in promoting organizational change (O'Neill, 2018).

The participants noted the many existing relationships that will be impacted by moving from their health authority to a system-level laboratory organization. They will have to adapt their relationships with their health authority executive leadership team, their laboratory peers, their clinical colleagues and operational peers, and with the SLs. Since these organizational leaders must continue to work functionally within their regional health authority while working

together in a provincial framework, it will require them to reframe their existing relationships while simultaneously developing new ones.

One way to manage these relationships would be to develop a sense of cohesiveness. There are perceived inequities within the current laboratory leaders' working relationships. One point of contention has been how each of the LSP organizations has been represented within the laboratory leaders' group at the Agency. The HALLs expressed fears that decisions will favour Vancouver-area LSPs due to the proximity and relationships of the LM LSPs to the PLMS. At the same time, participants within the LM area also expressed concerns regarding inequities of representation. The HALLs recommended SLs consider how best to balance those voices so that each LSP is an equal partner with no preferential treatment.

At the same time, HALLs have been interacting with each other on a provincial scale through the Agency's advisory groups. The current working relationships have maintained HALLs' distinctiveness and perpetuated siloed-thinking. Those interactions have encountered areas of contention, as the consensus process allowed them to maintain their own personal perspectives. Consensus, while high in participative value, often yields slow or no progress, can be manipulated by the loudest voices, and allows the LSPs to hold tightly to their individual uniqueness without challenging them to place a higher priority on the good of the whole (Patvardhan et al., 2015). These distinctions have prevented HALLs from feeling like a cohesive group.

Maintaining relationships as they are will reinforce the status quo, serving as a barrier to changing the mindset to one of openness to the perspectives of others. The new mindset is required to shift the organizational focus from serving local interests to benefitting the whole

system. In their research, Patvardhan et al. (2015) indicated a shift to a cohesive mindset was accomplished in the system-level organization as the members work together to achieve common goals based on shared interests and coordinated practices, yielding a "*coherent* identity, rather than a *consensual* identity [italics in original]" (p. 425).

The participants' varied perspectives showed the numerous competing tensions that prohibited them from forming a cohesive identity. They are looking to the future, but at the same time, it is not clear if they are all looking in the same direction. Each brings a different perspective—(a) academic–research and clinical–operational, (b) rural–remote and urban–metropolitan, and (c) within or outside the LM—that maintains their distinctiveness. The approach taken to resolve these tensions should not attempt to eliminate conflict but rather to manage it in a healthy manner (Bengtsson & Kock, 2000; Choi & Ruona, 2011).

Creation of a new organization represents a significant transformational change to HALLs' existing way of operating and their current operational relationships (Coghlan, 1993). Transformational change is stressful, especially for those experiencing the greatest impacts to their current operational duties (Anderson & Ackerman Anderson, 2011). Before they can work together for everyone's mutual benefit, HALLs need to be open to understanding the perspectives of others. Understanding leads to openness, openness to relationship, and relationship to collective support for each other along this change journey. These issues are challenging to resolve and in many cases are contentious given the number of diverse perspectives.

These HALLs will need to take a different approach to working together if they are to form a cohesive group. They will need to value the common purpose above their own self-

interests. Van der Voet et al. (2014) suggested focusing on the possibilities instead of the problems. By shifting their approach, they can make progress and build healthy relationships in a safe environment. Once they become less entrenched in their own perspective, the relational equity built through this process provides a buffer when it comes time to tackle the challenging issues. The HALLs need a solid sense of connectedness within the same system before they can go back to recognizing their distinctions (Patvardhan et al., 2015). Even then, competition and cohesion need to be balanced in a mutually beneficial manner.

Piggot-Irvine (2012) acknowledged that managing competing tensions and perspectives is not easy. It is messy, painful, and slow. HALLs will need to expand their worldview to understand how they fit within the larger picture of the system-wide organization to value the good of the organization ahead of their own interests. Much of the PLMS's future success rests on how well these interrelationships function. The hard part, now, is not how to change the operating structure, but how to work together for the good of the whole. In order to accomplish this difficult task, the individuals involved need to have high levels of trust in each other.

Conclusion 4: Change readiness can be incorporated into the organizational culture by building trust at every level. The underlying theme throughout all of these findings has been the importance of trust at every level. This initiative is only the first of many changes to face the PLMS going forward. Investing in strong, trusting relationships among key leaders can incorporate change readiness into the culture of the new PLMS and bring the necessary resiliency and adaptability needed for future planned and emergent changes. Trust is necessary to guide the system-wide organization along the same trajectory. Trust involves taking a risk that

HALLs and SLs shared future will be better when they all work together (Schoorman et al., 2007).

The PLMS is in the process of creating a system whose main focus is to optimize the province's laboratory service delivery to be efficient, effective, equitable, and sustainable from the patient's perspective. The LSP organizations are now component parts within that system. Decisions are made based on the impact and benefit to the entire system, not to the individual components. This change initiative requires HALLs to adjust how they view themselves as a part of a system. Ackerman and Ackerman Anderson (2011) said, "Mindsets and collective culture must transform in unison" (p. 55).

Commitment to the system-level identity does not come without high levels of trust in the plan, process, and people (Anderson & Ackerman Anderson, 2011). Building trust requires real, authentic relationships. This early point in the change implementation process should begin a period of intense trust-building among all the stakeholders. The data clearly indicate there is work to be done to achieve the level of cooperation and commitment to the PLMS needed for transformational organizational change. In order to reach the level of trust necessary to support change readiness, SLs need to demonstrate trustworthiness (O'Neill, 2018). They do so by sharing information candidly, timely, and inclusively, and by including HALLs in the process of defining the change plan and the new organizational identity.

When authentic trust increases, HALLs reward those efforts by increasing their willingness to focus more on their shared purposes than on the individual interests of their home organization. Building trust into the culture and character of the organization ensures that change

readiness is always present at all levels to handle any emerging changes. It enables the PLMS to become a nimble, responsive system-level organization.

Scope and Limitations of the Inquiry

The scope of this project was limited to those laboratory leaders throughout the public sector health authorities who will be instrumental in creating a single coordinated provincial laboratory service delivery stream. As a qualitative project, the findings and conclusions are dependent upon the specific people involved and the context of their responses to study questions. Only health authority regional laboratory leaders participated in this study, as these individuals will be responsible for implementing the service delivery plan within their own health authority's geographical boundaries. This study notably did not include the private LSP leaders who will also coordinate their services with the PLMS but in a different capacity, with different roles and responsibilities.

This research was conducted over a 2-month period during a time when organizational change was highly anticipated but no observable progress was apparent at the level of these laboratory leaders, yet the situation remained dynamic. For example, the new CPDO, and this project's partner, joined the organization only shortly before the research data collection began. Existing meeting patterns and organizational dynamics were disrupted as new foundational conditions for improvements were set up. Background meetings with individual laboratory stakeholders were taking place; however, at the time of the research, the focus group meeting itself was the first real opportunity for these leaders to discuss the organizational change as a group. The findings and conclusions from the research might have been different had it been conducted over a different 2-month period. Given that the data showed engagement by these key

leaders was actively eroding over time, a different timeframe might have shown a much different picture. Continuing to monitor the ebb and flow of individual and collective change readiness would be a revealing exercise as HALLs respond to new information over the course of the change implementation.

This project did not engage the change agents along with the change recipients in the focus group discussions of creating a new provincial laboratory identity, even though they are a significant partner in creating the new PLMS. When all members participate in its social construction, the PLMS's identity can be more clearly envisioned and the likelihood of sustaining the new provincial organization improves.

Finally, as a qualitative AR undertaking, the findings and conclusions may be highly context-specific and, therefore, have limited generalizability to other organizations. Having said that, others could learn from the experience of these HALLs as they began the process of TOC. Additionally, interpretation of the data was subjective and prone to the biases of the IT member and me. The reader must consider the reliability of the interpretation in terms of my interpretive skill and the degree of confidence that he or she draws from the richness of the descriptions included in this report (Glesne, 2016). Given that the judgement of trustworthiness lies in the hands of the reader (Booth et al., 2008), I endeavoured to illuminate my thinking processes for making methodological or interpretive decisions throughout the document to enable others to have confidence in my abilities.

Chapter Summary

In this chapter, I described six findings and four conclusions drawn from this study. This inquiry revealed change recipients are currently at a stage at which they neither endorse nor

actively oppose the change. Numerous factors contribute to their current attitude which, when adequately addressed, could influence them to more actively endorse the change initiative. Their endorsement is pivotal to making the change initiative successful and sustainable, as they will be the change champions to extend change readiness throughout the rest of their organizations. The overall scope and limitations of this research indicated this study reflected the change readiness of a select group of participants within a context-specific change initiative and should be interpreted accordingly.

In the next chapter, I discuss the recommendations to apply these learnings to enable the organization to effectively increase the change readiness of the HALLs. One final section discusses the organizational implications as well as avenues for future research to extend the learning beyond this study.

Chapter Five: Recommendations and Organizational Implications

After presenting this study's findings and conclusions, I focus this final chapter on providing recommendations that can be integrated into an action plan specifically designed to increase change readiness of HALLs within the context of this change initiative. I further discuss the leadership implications presented by the project findings and the implications for future research. Finally, I conclude this thesis with a summary of this work and the hope for the enduring legacy that might result from it.

Study Recommendations

The PLMS is beginning the process of realizing a single laboratory service delivery stream. Change readiness has been demonstrated to be a significant predictor of the eventual degree of success of any change project (Rowe et al., 2013). Given the high stakes of this large system transformation, this thesis is the culmination of my partnership with the PLMS leaders to examine HALLs' current state of change readiness, discover the barriers they encountered that have hampered them from being more ready for change, and design some strategies for developing a system-level mindset as a single laboratory service delivery stream.

I conducted this inquiry to explore the following overarching research question: How might BC's individual HALLs prepare themselves to become partners within a single provincially coordinated laboratory service system? I also designed this inquiry to answer the following subquestions:

1. What is the current state of individual change readiness of HALLs?
2. What are the enablers that could increase HALLs' engagement with the new PLMS?

3. What strategies can we recommend to facilitate the formation of an identifiable, cohesive province-wide laboratory service?

The conclusions drawn from the study findings revealed just how important trust is at every level of organizational change. Through this work, I was able to link trust to the three pillars of transformational change management described by Anderson and Ackerman Anderson in 2011: trust in the plan (content), the process (context), and the people. The recommendations that follow provide strategies for building change readiness by integrating trust at the micro-, meso-, macro-, and metalevels of the organization (Vakola, 2013).

1. Build change readiness by creating trust in the plan.
2. Increase change readiness by developing trust in the process.
3. Spread change readiness by strengthening trust and improving the quality of relationships with the people throughout the organization.
4. Sustain change readiness by incorporating trust into the culture and character of the PLMS.

Recommendation 1: Build change readiness by creating trust in the plan. The HALLs are more likely to be change ready when they believe this change plan can effectively overcome long-standing limitations to success and has the potential to achieve its objectives (Devos et al., 2007; Holt et al., 2015). They need a plan that makes sense and ignites enthusiasm toward the new PLMS. Individual change readiness begins with access to meaningful information about what the change initiative is, how and when it will happen, and, most importantly, how it will affect each one personally (Oreg et al., 2011). Access to high-quality

information facilitates the individual's internal decision-making positively toward change readiness in response to change events (Stevens, 2013).

First, HALLs need to believe that the plan has been set up for success. They realize removing the legacy barriers to laboratory reform is a complex process beyond the internal capabilities of the SLs. However, HALLs are asking to be kept informed of any progress made that would give them confidence that real change is possible. They made it clear that the frequency of information had been insufficient to prevent doubt, anxiety, and misunderstanding to erode their natural optimism toward change. With little information being directly provided, even small pieces of information shared with one or two individuals became a source of rumours and negative sense-making, a sentiment that was articulated during the focus group discussion (P1; P3).

To remedy these concerns, these HALLs suggested they receive consistent messaging delivered to everyone at the same time. The PHSA TLO currently posts key change messages applicable within a PHSA context on the PHSA intranet but the HALLs are looking for information specific to the laboratory consolidation plan. This could be accomplished by providing regular updates on a suitable website that is accessible to all the HALLs, such as the Agency website, since the PHSA website contains information intended for a broader audience. As well, important messages could be delivered directly to HALLs' email inboxes.

This recommendation is designed to prepare the individual to accept and embrace this organizational change plan. Collective change readiness occurs concurrently as the HALLs engage together in designing the process, facilitating the formation of healthy working relationships at the same time.

Recommendation 2: Increase change readiness by developing trust in the process. At the time of the project, there was no clear process for how this organizational change will happen. The HALLs indicated their desire to be included in the process of designing the new future. The literature showed that individual ownership and collective engagement increased when the change recipients were able to participate in the change process (Rafferty et al., 2013). In order for the HALLs to have greater confidence in the process, SLs should provide a forum for HALLs to contribute their ideas and assist in developing the plan. At the time of this writing, the SLs have already conducted this forum and obtained input from HALLs. The PLMS SLs are now developing the process of moving forward based on these recommendations.

The HALLs also voiced concern about how the organizational voices will be balanced within the PLMS leadership structure. The current mechanism for meetings maintains the representative consensus process. Instead, Patvardhan et al. (2015) advised organizations to form cohesive groups around issues of common interest rather than functional lines. For the PLMS, this could mean bringing the pathologists together along discipline lines rather than health authority lines, or having operational leaders meet to develop specific strategies, such as one for rural and remote service delivery or to address specimen transportation across the province.

Changing how these groups meet would also help facilitate more cohesiveness among the groups. Geographically, Vancouver is and will remain the locus of the majority of LSPs. In order to counter the perception of Vancouver-centrism, SLs are encouraged to conduct face-to-face meetings in locations outside LM. Considering also that most meetings occur by teleconference, effort should be made to make certain those not in the room are involved actively in the conversation. Recognizing that conversation during most teleconference meetings happens most

easily among the people seated face-to-face, care should be taken to improve the functionality and effectiveness of those meetings (Dallas Allen, 2014). Adding the phone-in participants' image on the screen would give a small semblance of inclusion and better ease with which the leader can include them in the conversation.

These are small changes that can be made to earn the trust of HALLs in the process. Further work needs to be done to improve the functional relationships among the people involved. Once HALLs endorse the rationale for the plan, and have participated in the process, improving the quality of their relationships increases the trust they have in each other (Oreg, 2006).

Recommendation 3: Spread change readiness by strengthening trust and improving the quality of relationships throughout the organization. Strong relationships are critical for organizations to be able to accomplish transformational change (Burns, 2001). The elemental foundation of relationships is the bidirectional communication between individuals. As the most influential individuals within an organization, SLs can build change readiness by developing a personal relationship with each HALL. The CPDO has already begun to build those relationships by travelling to each of the HALLs' workplaces and spending time in face-to-face communication. This offered HALLs an opportunity to ask questions for clarity and address their personal concerns in real-time in an informal atmosphere (Bushe & Marshak, 2016).

Transformational change puts greater stress on the individuals most impacted by the change (Anderson & Ackerman Anderson, 2011). Once solid relationships have begun forming, HALLs will need to change how they interact with each other in order to take on the difficult task of finding common ground on the many tensions that exist. Past interactions have often

resulted in stagnation rather than meaningful progress. Further, if HALLs perceive that solutions are developed and enforced only by the SLs (P1), they may choose to withdraw their cooperation, their relationship with the SLs will become contentious, and organizational cohesiveness may be threatened. Group interactions will have to be more functional, respectful, and open.

In order to accomplish transformational change, Anderson and Ackerman Anderson (2011) proposed the need for a new mindset, worldview, and behaviour. Bruckman (2008) noted trust was a key ingredient for group cohesion. He suggested SLs engage in "teambuilding, trust building, and open, honest communication prior to the introduction of the change" (p. 215). A sense of cohesiveness can begin when groups form based on shared problems to arrive at mutually determined solutions (Patvardhan et al., 2015).

To facilitate this, SLs should investigate different methods of hosting dialogue during meetings. New methods are available, designed to be both collaborative and innovative at the same time. For example, Lipmanowicz and McCandless (2013) described a number of different methods called liberating structures designed to yield collaborative, productive results in limited amounts of time. One such method is called "1-2-4-All" (McCandless & Lipmanowicz, n.d., para. 1), which asks each individual to independently consider solutions to a particular issue. The participants then form pairs and are asked to expand on the individual ideas generated. Finally, four participants join to identify the most viable options. They then present their findings to the full group for final selection of the best ideas worth promoting. The entire process can be accomplished within 12 minutes (Lipmanowicz & McCandless, 2013). This type of activity

engages everyone simultaneously, is focused on solutions, and breaks the pattern of repetitive thinking that normally accompanies group dynamics.

Other novel engagement methods can assist organizations to engage in systems thinking. Kumar (2013) suggested an activity called "Principles to Opportunities" (pp. 204–205), which asks the participants to consider all the possibilities around an issue before they develop strategies to resolve them. It gives the participants an opportunity to take a system-wide lens to the broader picture of change and expand their perspective prior to deciding on a strategy for action.

Finally, healthy relationships depend on respectful interactions, constructive dialogue, and openness to others' perspectives in a safe environment (Bushe, 2013). Effective teams take advantage of developing a group charter to clearly define the expectations of each member. The charter could set guidelines such as requiring respectful communication, encouraging everyone's participation to ensure all voices and perspectives have an opportunity to be heard, and specifying mechanisms to resolve interpersonal conflicts. Employing any or all of these suggestions can improve the functionality of leaders' working relationships as they experience new ways to interact in a safe and trusting atmosphere.

Recommendation 4: Sustain change readiness by incorporating trust into the culture and character of the PLMS. The final recommendation looks at how trust can become a part of the organizational culture. One of the biggest struggles articulated by HALLs was the inability to conceive of the new PLMS identity. Herold et al. (2008) showed that establishing the new organization's vision and values would help change recipients develop or enhance their conceptions of what the organizational character will be. As a starting point, HALLs identified a

need to develop a defined framework for making decisions (P3; P9; P13). In answer to those concerns, the CPDO announced that, going forward, decisions would be based on the clinical value proposition of each laboratory activity. This aligns strongly with HALLs' collective desire to make decisions based on the best interest of the patient (P14; P15).

In addition, Patvardhan et al. (2015) advised, at the beginning, when the new system-level organization is forming, the emphasis should be on what joins the member organizations together, rather than their distinctiveness. These authors encouraged leaders to collaborate to achieve a common mission as a means to help them to develop a "sense of 'we-ness'" (Patvardhan et al., 2015, p. 424). In the process, HALLs can gain a collective mindset that comes from recognizing that they are partners in their shared future (Brewer & Gardner, 1996). That sense of belonging helps to generate an identifiable entity formed around their shared purpose.

Leaders can further facilitate collective identity by working to solve common issues. Tsasis et al. (2012) showed that complex, emergent issues can be addressed by forming work groups of short duration but high intensity to address specific issues with all parts of the system in the room. In the new PLMS, groupings based on regional or provincial laboratory representation could give way to emergent, task-specific work groups. Laboratory medical professionals throughout the province could connect along discipline lines, as suggested by P8. Operational leaders could form issues-based groups, such as one for the purpose of working toward an innovative rural–remote service strategy, one to discuss options to streamline transportation across the province, or one seeking to optimize the workforce while advancing sustainability strategies. Their focus on resolving these issues together will help to create cohesiveness, blur the existing barriers, eliminate silos, and focus on what is best for the patient.

Each positive interaction builds their connection and trust in each other and a willingness to become partners to achieve provincial goals.

The need for change readiness does not stop once the plan has been implemented and the new organization has been formed. Long-term sustainability relies on the ability to maintain high levels of change readiness. They can accomplish this by incorporating a complex-adaptive system mindset into the culture and character of the PLMS (Tsasis et al., 2012). The solutions to complex issues are not straightforward. Individuals will need to learn to operate in environments of great ambiguity, as the process and the results are not always predictable (Tsasis et al., 2012). The SLs should establish a long-term goal of building and sustaining functional relationships that are strong enough to function in volatile, uncertain, complex, and ambiguous environments.

These final recommendations will begin the process of developing the PLMS character and the long-term process of creating a desirable organizational culture. Having shared vision, mission, and values gives the HALLs an entity that they can feel is trustworthy and empowers them to willingly support their common objectives, placing the needs of the patient and of the collective above their own self-interests.

In today's healthcare reality of limited resources and increasing demands, innovation is necessary for organizational sustainability. Patvardhan et al. (2015) warned that competition between LSPs stimulates innovative thinking but if managed poorly can create new tensions related to perceived inequities. Once the individuals have mutually supportive relationships that truly work toward a common purpose, they are better equipped to thrive through conflict and adapt to the always changing internal and external environments of rapidly changing technology, client needs, and fiscal constraints. This nimbleness is arguably the most important attribute

necessary for organizations to be adept at responding to emergent change. Future viability and sustainability of any organization will rely on its ability to manage change rapidly. Once the foundational relationships work well together, change adaptability becomes a part of the organization's culture and character (Vakola, 2013).

Organizational Implications

On the subject of change efforts, researchers often quote Beer and Nohria's (2000) 70% failure rate for organizational change, yet that figure is dependent upon how success is measured. Do all change objectives need to be met in order to be considered a success? Is success measured early in the process or after several years? Stroh (2015) pointed out that it takes time for a system to come to a stable equilibrium, yet organizations are constantly responding to changing environments so even the concept of stability is a misnomer. How will organizational leaders, then, in this change context, measure success?

Public sector healthcare organizations have different change drivers than private, for-profit organizations. They must constantly respond to fluctuating political, financial, and human resource demands while providing safe, efficient, effective, equitable, and sustainable service as viewed from the patient's perspective. The members of the PLMS will need to see their place as partners within the larger system and provide services that are best for the patient, not what is best for the LSP. The SLs should promote system-level thinking to shape PLMS into a cohesive organization able to achieve the common purpose of providing patient-centred laboratory service within the context of the whole healthcare system in BC. Transformational change requires a new way of thinking and working together. Success, then, becomes evident when the organization's relationships function productively to collectively meet the needs of the patient.

Leaders need followers just as much as followers need leaders (Jackson & Parry, 2011). Both hold the keys for organizational success or failure, but the responsibility to earn the trust of the followers falls to the leader (Caldwell, Hayes, & Long, 2010). Burnes (2015) posited that in order to change the follower's behaviour, the leader needed to change how he or she managed change. The leader earns trust by being humble, honest, vulnerable, trustworthy, and accountable (Lencioni, 2011). When referring to his five behaviours of a cohesive team, Lencioni (2011) stated,

> Trust is at the core of all five temptations. Trust makes people feel comfortable when engaging in productive conflict. Conflict makes decision-making easier, since leaders know that they've heard the opinions of employees. Clear decisions with buy-in make it easier for a CEO to hold employees accountable for doing what they said they would do. And accountability makes results a matter of predictability and planning, not speculation. (p. 17)

In this study, I have provided evidence that building trust is the single most important attribute of change readiness at each level of the organization. The presence of high levels of trust is the single biggest predictor of successful organizational change since it enables the change recipients to take the risk of endorsing and committing to the change initiative, supporting the change agents as they implement organizational change, and valuing the good of the organization over their own individual self-interests. When trust is high, change recipients are willing to link their future to the success of the organization. The organization gains resiliency as it becomes nimble, responsive, and sustainable when faced with the need for future changes.

The members of the PLMS are working to create an organization that is stronger than its constituent parts. The transformational organization must learn to value the contributions of its members in order to succeed (Tobias, 2004). The PLMS can mature into a nimble organization when its people engage in mutually respectful, trusting relationships. Complex change is not solely accomplished through the efforts of the leader at the top but also through the contributions and engagement of everyone in the organization (Tobias, 2004).

I undertook this research to discover steps that will help build the engagement of HALLs as the laboratory medicine service in BC undergoes transformational change. The AR approach employed for this research emphasizes the need to incorporate some form of these recommendations into an action plan (Stringer, 2013) that will help make successful achievement of the organizational goals realistic. The recommendations, derived from strategies specifically articulated by HALLs and developed from the study findings, provide a roadmap for SLs to create a climate of change readiness among HALLs, which will set the organizational change plan on a trajectory for success.

As the first step in transitioning responsibility for future action to the SLs, these recommendations were presented at a meeting with the SLs and the HALLs from which the SLs could base an action plan. Successful organizational change relies on the willingness of the members of the organization to support the new initiative. Failure to consider acting on these recommendations risks hardening change-resistant attitudes, and possibly instigating passive resistance or outright oppositional behaviour toward the new organization (Peccei et al., 2011). The long-term effects of choosing not to act could ultimately undermine the magnitude of success that is potentially achievable. As a member of the PLMS, I will have the opportunity to

interact with SLs and HALLs as we journey together toward creating the new organizational identity and culture.

Although this study is highly context specific, there are learnings that can contribute to the larger scholarly audience regarding change readiness. Through this study, the key stakeholders had an opportunity to explore collectively the common themes that acted to limit their ability to endorse the change initiative and to develop recommendations. These findings and conclusions could inform similar organizations undergoing a metalevel, system-wide transformation.

Additionally, this study found that trust at all levels of the organization serves as the foundation for change readiness. It showed just how difficult it was for these individuals to begin to see themselves within a new system-level organization while the plan and process remained highly ambiguous. What became apparent was the degree to which trust at all levels of the organization was necessary for HALLs to begin the process of identifying with the organization, engaging with the plan, and working in truly cooperative relationships for the collective achievement of a larger purpose. Incorporating change readiness into the character and culture of the organization sets the PLMS on a trajectory for being nimble, responsive, and sustainable when faced with future planned and unplanned change (Vakola, 2013). While the context of this change is specific to this group, the premise presented here could be applied to any group undertaking transformational organizational change.

Implications for Future Inquiry

The findings from this study suggest several possible avenues for future inquiry. The literature is rich with studies that looked specifically at the attributes that contribute or hinder

change readiness but fewer focused specifically on how the construct of trust itself affects change readiness. This study also did not directly examine levels of trust as the primary indicator of successful organizational change. Trust emerged from examination of the data as the foundational element for creating and sustaining change readiness at all levels of the organization. The effect of trust at the micro-, meso-, macro- and metalevels of organizational change represents a possible avenue for future research.

In addition, this study developed a model of attributes across the change readiness–change resistance spectrum and a means to evaluate those attitudes to make a determination of relative change readiness in the individual. This is a highly subjective assessment model, which has not been tested rigorously. Further investigation is necessary to examine the interrelationships of these attributes along the spectrum and determine if the definitions used and the order in which they were placed in this study were, in fact, valid. The mechanism for assigning a change readiness attribute was entirely subjective and prone to variability according to the personal biases of the assessor. As well, this project was highly context specific, warranting further investigation to determine if this representation of change attributes is valid in other organizational change contexts.

Finally, the laboratory medicine service stream is at the forefront of organizational change of 16 service areas identified to become provincial service delivery streams under the PHSA foundational mandate. This work could be a springboard for determining if these conclusions and recommendations would be generalizable to other PHSA service streams as they begin their own process of creating change readiness within their organization.

Thesis Summary

This study investigated the state of change readiness of a cohort of laboratory leaders who are undergoing a significant change in how they will operate within their regional health authority as they become key members of a new system-wide organization. The learnings discovered in collaboration with HALLs during this change could be instructional for others as they embark on similar seismic organizational changes. Together we learned that most leaders are inherently optimistic about change, knowing that change is a mechanism for constant improvement. It also serves as a cautionary tale that known barriers must still be addressed in order for the change recipients to have faith that the change effort can ultimately be successful. To further shift the change recipients toward engagement with the change effort, HALLs identified a need for regular inputs of information. In the event there are no details to share, all they ask is that the change agents are honest and transparent. Finally, when the change requires a new organization to form, efforts to build trust among all stakeholders helps them to work collectively to form a new organizational identity and discover new ways of working together toward achieving a purpose larger than they could achieve on their own.

With the people of the organization being a tipping point for success (Oreg et al., 2011), building change readiness among these key individuals could make all the difference. As this study has shown, change readiness is truly an indicator of the level of trust found within the entire organization. Change readiness begins when the individuals trust that the plan and the process are something they can endorse. It grows as trust forms in the personal relationships between SLs and HALLs. It builds when those responsible for developing solutions (both SLs and HALLs) are able to work effectively on complex, challenging, and contentious issues in a

way that can make real progress. It spreads as the organizational members sense the opportunities that their collective efforts can achieve when they work toward one common purpose of doing what is best for the people of BC.

There are many factors that contribute to achieving all the objectives of a change initiative. This study provides insight into the human side of the change management process. By building commitment of the key leaders to the change plan, SLs can be confident that this human component is on a trajectory toward successfully achieving all the change objectives for forming a single, consolidated, provincially coordinated service delivery stream.

Time is running out for continuing on our current course of action. The infrastructures supporting the existing system are starting to give way. Quality is being impacted while laboratory leaders tread water trying to do more with less. We cannot sustain this much longer without failing the people of BC. P16 wondered aloud about how we could design a new way of working together when he said,

> What is the dialogue that allows people to say, "Okay, this is the way things exist. These are the things that make logical sense from a go forward perspective." And then what is that iterative process that we share together in moving towards that vision of basically servicing the population effectively, no matter where they live?

As public sector organizations, the finite resources—budgetary, supplier, and human—shared among all the LSP stakeholders must be managed efficiently and effectively, while at the same time incorporating innovation and nimbleness. The status quo is not an option. The laboratory service delivery as a whole must do things differently. It will require system-level

thinking and high-functioning relationships to respond to emergent needs with innovative solutions.

Healthcare is a complex-adaptive system. Transformational change to laboratory service delivery requires simultaneous changes at the individual, collective, organizational, and system levels of the organization. Managing change is a complex process undertaken by both the change agents and the change recipients. Although the attributes of change readiness are dynamic throughout the change process, the presence of high levels of trust build and reinforce change readiness at every level. An organizational culture based on trust enables the individual to be willing to take the risk of endorsing change even while managing ambiguity. A trust-based culture facilitates the formation of healthy relationships committed to the collective, empowers the organization to accomplish shared goals, and provides a foundation to enable the system to respond nimbly to complex-adaptive challenges. It is my hope that by encouraging trust building throughout the PLMS, the outcomes of this project will contribute to the successful, sustainable future for laboratory medicine in BC.

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Appendix A: Inquiry Team Letter of Agreement

In partial fulfillment of the requirement for a Master of Arts in Leadership—Health (MALH) at Royal Roads University (RRU), Sheryl Thiessen (the Student) will be conducting an inquiry study at BC's Agency for Pathology and Laboratory Medicine (Agency) to discover the change readiness of public health authority laboratory leaders as the form a single consolidated laboratory service stream which is being considered by the PHSA Senior Executive team. The Student's credentials with RRU can be established by calling Dr. Catherine Etmanski, Director, School of Leadership Studies, at [telephone number] or email [email address].

Inquiry Team Member Role Description

As a volunteer Inquiry Team member assisting the Student with this project, your role may include one or more of the following: providing advice on the relevance and wording of questions and letters of invitation, supporting the logistics of the data-gathering methods, including observing, assisting, or facilitating an interview or small group, taking notes, transcribing, reviewing and analyzing data, and/or reviewing associated knowledge products to assist the Student and the Agency's change process. In the course of this activity, you may be privy to confidential inquiry data.

Confidentiality of Inquiry Data

In compliance with the RRU Research Ethics Policy, under which this inquiry project is being conducted, all personal identifiers and any other confidential information generated or accessed by the inquiry team member will only be used in the performance of the functions of this project, and must not be disclosed to anyone other than persons authorized to receive it, both during the inquiry period and beyond it. Recorded information in all formats is covered by this agreement. Personal identifiers include participant names, contact information, personally identifying turns of phrase or comments, and any other personally identifying information.

Bridging Student's Potential or Actual Ethical Conflict

In situations where potential participants previously held a position of authority over the Student, you, as a neutral third party with no previous working relationship within the potential participant's organization, may be asked to work closely with the Student to bridge this potential or actual conflict of interest in this study.

Such requests may include asking the Inquiry Team member to:

- send out the letter of invitation to potential participants
- receive letters/emails of interest in participation from potential participants
- independently make a selection of received participant requests based on criteria you and the Student will have worked out previously
- formalize the logistics for the data-gathering method, including contacting the participants about the time and location of the interview

- conduct the interviews (usually a maximum of 3-5 separate interviews) with the selected participants (without the Student's presence or knowledge of which participants were chosen) using the protocol and questions worked out previously with the Student and
- produce written transcripts of the interviews with all personal identifiers removed before the transcripts are brought back to the Student for the data analysis phase of the study.

This strategy means that potential participants with a prior direct working relationship will be assured they can confidentially turn down the participation request from the Student, as this process conceals from the Student which potential participants chose not to participate. Inquiry Team members asked to take on such 3rd party duties in this study will be under the direction of the Student and will be fully briefed by the Student as to how this process will work, including specific expectations, and the methods to be employed in conducting the elements of the inquiry with the participants, and will be given every support possible by the Student, except where such support would reveal the identities of the actual participants.

Personal information will be collected, recorded, corrected, accessed, altered, used, disclosed, retained, secured and destroyed as directed by the Student under direction of the RRU Academic Supervisor.

Inquiry Team Members who are uncertain whether any information they may wish to share about the project is personal or confidential will verify this with the Student.

Statement of Informed Consent:

I have read and understand this agreement.

Name (Please Print)	Signature	Date

Please return the signed copy to Sheryl Thiessen and keep a copy of this consent form for your records.
If returning this document by email, you may type your name in the line above, then send the document from your personal email account directly to the email below to indicate acceptance of this agreement.

Email: [email address]

Appendix B: Letter of Invitation for Individual Interview

Dear [Prospective Participant],

My name is Sheryl Thiessen, Director of Quality and Patient Safety at BC's Agency for Pathology and Laboratory Medicine (the Agency). I am conducting a research project in partnership with PHSA, and to partially fulfill the requirements for a Master of Arts in Health Leadership (MALH) from Royal Roads University (RRU). This project has been approved by Jim Slater, PHSA's Chief Provincial Diagnostics Officer who has given me permission to contact you for this purpose.

The purpose of my research is to discover how we might successfully transform from separate BC public health authority laboratory service provider organizations to working within a single, provincially-coordinated service delivery system as we move forward with achieving the PHSA vision of "one system of care." It is my intent that the findings from this research inform the development of strategies to support successful transition to the new model. A compilation of themes resulting from the input from all interviews may be shared with PHSA executive leaders to help shape the action plan for effective change management.

PHSA is responsible for determining the context—the what, when, how, and why—of the change in laboratory service management throughout the province to a consolidated service delivery model. This project is focused specifically on the personal preparedness of the individuals who will be most affected by this change. I am inviting you, as a leader of one of the public health authority laboratories in BC, to participate in this research project to give you an opportunity to voice your opinion regarding the change, in a way that can inform PHSA. I want to engage you in the process to give you an opportunity to provide input into your future.

This letter is specifically inviting you to participate in a personal interview to provide insight into your thoughts, attitudes, beliefs, and feelings about the proposed changes, how the proposed changes may impact you personally, your perceptions about the ability of PHSA to accomplish the goals set out by the Laboratory Services Act, and many other aspects related to this organizational change. The interview will be arranged at a time and location of your convenience and is estimated to last approximately 30 minutes, to a maximum of one hour. Upon transcription of your information, you will be given an opportunity to verify that your information has been accurately captured.

As a laboratory leader, you may feel required to participate in this research project. Please be aware that your participation is completely voluntary. Your decision to participate or not participate will be maintained in confidence and will not become known to anyone outside the Research Inquiry Team.

The attached Research Information Letter contains further information about how the study will be conducted and should enable you to make a fully informed decision regarding your participation. Please review this information before signing the consent form.

If you feel you are sufficiently informed of all aspects of this research project, please provide your informed consent by completing the attached consent form and returning it to me via email. Once I receive your consent, I will contact you to arrange a suitable time and place to conduct the interview.

If you do agree to participate, you can still change your mind at any time before or during the interview by letting me know of your decision. Should you decide to withdraw from the project after the interview has taken place, please notify me by email within two weeks so that your data can be removed from the dataset.

If you would like more information or have additional questions regarding the project and its outcomes, simply reply to this email or contact me at:

Name: Sheryl Thiessen
Email: [email address]
Telephone: [telephone number]

Sincerely,

Sheryl Thiessen

Appendix C: Research Consent Form – Individual Interview

My name is Sheryl Thiessen and I am conducting a research project as part of the requirement for completion of a Master of Arts in Health Leadership (MALH) at Royal Roads University (RRU). As a potential participant in this study, this letter is intended to contain all the necessary information you will need to make an informed decision. Please read it carefully and contact me if you have further questions. My credentials with RRU can be established by contacting:

> Dr. Catherine Etmanski, Director, School of Leadership Studies
> [telephone number]
> [email address]

Purpose of the study and sponsoring organization

The purpose of my research is to understand how we might prepare laboratory leaders to successfully adapt to a consolidated service delivery model for laboratory services in BC as a result of the Laboratory Services Act enacted in 2015, and PHSA's expanded mandate. As the sponsor of this project, PHSA is interested in working collaboratively with the laboratory leaders from each of the public health authorities to fully understand how the transition to a provincial service delivery model can lead to improved patient care. The project objective is to fully understand how the organizational change might affect you, and discover active steps to ensure that, together, we create mutually beneficial relationships as we work toward a single, coordinated laboratory service delivery model within the Province.

Your participation and how information will be collected

The research will consist of two separate data collection phases. The first will consist of an individual interview with each participant. Interview transcripts and field notes from all interviews will be collectively analyzed to identify common themes. The themes will form the basis for the initial discussions at a group meeting or meetings with all participants to determine actionable interventions designed to meet the project goals and objectives. Each personal interview is likely to last approximately 30 minutes to an anticipated maximum of one hour. The anticipated questions will cover:

- your perceptions of previous laboratory change initiatives
- your thoughts, feelings and perceptions regarding the anticipated new service delivery model
- what supports you feel are necessary for you to be successful

The second data collection will happen during a group session in which the group will review the themes identified from the interview data, discuss possibilities to address concerns, and collectively describe the opportunities presented by this change.

All interviews and group discussions will be audio recorded from which a written transcript will be confidentially prepared. In the case of videoconference interviews, the video will also be

recorded. Additionally, any field notes, flipchart records, photographic images taken of whiteboard notes, or other written records will be added to the total body of raw data.

Time commitment and meeting location

Individual interviews are expected to last from 30 minutes up to one hour. Individual interviews may be conducted in-person at a time and location convenient to you or via an electronic teleconference method using zoom.us/, a US based website. The teleconference sessions will be captured as a video recording. These recordings are not stored outside of Canada. Go to https://zoom.us/ for more information.

The group session is anticipated to take approximately two hours and will likely be arranged to take place on or around a regularly scheduled Regional Leadership Committee meeting in order to make it convenient for members to attend in person.

Benefits and risks to participation

This project is intended to benefit the public health authority laboratory leaders by identifying the pre-existing understandings or perceptions related to the potential organizational change, anticipate expectations of how the changes will personally affect you, and identify strategies that might be put into play that could enable a successful transition to a new consolidated service delivery model.
Identifying possible barriers as well as opportunities for success will inform the PHSA leaders of ways to make the change a mutually beneficial experience.

You have the option to choose not to participate in either the individual interview or in the small group session. By choosing not to participate, you risk not having your concerns addressed and not adding your input into how the new model will function.
As each organization has unique needs and characteristics, it is important to hear from all perspectives prior to implementation of the new model to make sure roles and relationships are clear.

There should be no personal risk for choosing not to participate in the individual interview as all data will be anonymized and presented as a themed summary. However, as all participants are well-known to each other and the group session is scheduled to take place around the time of a regularly scheduled face-to-face Regional Leadership Committee meeting, there may be undue pressure to participate in the small group discussion as your absence will be readily apparent. As the primary researcher, I will inform the group at the start of the in-person session that all participation is voluntary and that any individual absence should not be interpreted as unwillingness to contribute to the eventual outcomes.

Inquiry team

Three members of the Agency have been invited to assist me as part of an inquiry team. These individuals will be assisting in the interview process after having received guidance to ensure data is collected in a consistent and impartial manner. A member of the MALH Cohort 2017 is

also on the Inquiry team to assist with operational or technical issues related to the project, as well as review of reports for quality and content. All inquiry team members will have access only to that portion of the raw data that is necessary.

Real or perceived conflict of interest

As this project is being conducted in partial fulfillment of the requirements an RRU MALH program, I stand to benefit from your participation in this project. I disclose this information here so that you can make a fully informed decision on whether or not to participate in this study.

Confidentiality

The privacy of your information is important to me. All personally identifiable information and documentation will be kept strictly confidential. Each individual interview and the group session will be audio-recorded with only Inquiry Team members having access. Videoconferencing will be conducted and recorded using the on-line program available at https://zoom.us/.

Data from individual interviews will be anonymized by use of an alpha-numerical code assigned to each individual. This code will not be shared with anyone beyond the Inquiry Team. The interview data will be summarized into themes prior to being shared for discussion in the group session. At no time will specific comments be attributed to any individual unless specific agreement has been obtained beforehand. Due to the nature of the group method, it is not possible to keep identities of the participants anonymous from the researcher, facilitator, or other participants. Although all participants are asked to respect the confidential nature of the research by not sharing names, discussions or identifying comments outside of the group, strict confidentiality cannot be guaranteed as I am unable to control what others will do with the information.

Only anonymized data or summaries will be included in the final report.

Data security, storage and retention

Hard copy documents, such as signed consent forms and written notes, will be stored in a locked desk drawer within a locked office at the Agency. Electronic data (such as transcripts, audio or video files, or emailed consent forms) will be stored on a password protected USB drive to which only I have access. No data will be stored outside of Canada. See https://zoom.us/ for more information.

Raw data will be retained until the successful completion of my RRU MALH program. Upon graduation, all electronically stored data (USB drive and any back-up storage locations) will be deleted. Paper documents will be discarded for shredding in a confidential disposal receptacle.

Consent to participate and withdrawal of consent

It is your choice to voluntarily participate in any or all portions of this research project. Your consent to participate in the interview will be indicated by completing and returning the consent form attached to this email invitation. Please note that declining to participate in an individual

interview does not prevent you from participating in the group session. You are also free to withdraw during the individual interview by indicating your desire to the interviewer, or within two weeks following the individual interview. However, after that time, your data will be incorporated into the aggregate data in preparation for the group session and will no longer be able to be removed.

As separate email invitation to participate in the group session will be emailed to all prospective participants after the individual interviews are completed. You may indicate your desire not to participate in the group session by not attending or you may leave at any point during the session. If you do choose to participate in any part of the group session, it will not be possible to separate your individual data from the discussions.

Prior to agreeing to participate, it is advisable that you obtain permission from your organization since the health authority organizations would be identifiable within the final report and your identity could be inferred. As well, there could be other organizational impacts that may need consideration.

Procedure for withdrawing data from the study

If you choose to withdraw from the study within two weeks following the interview, please notify Sheryl Thiessen by email at [email address]. Upon notification, your uniquely identified data will be removed from the data set by deleting those records from all locations on the password protected USB storage device. Written notes from your interview will be confidentially shredded and disposed.

Sharing results

In addition to submitting my final report to RRU in partial fulfillment of a MALH program, I will also be sharing my research findings with the PHSA Executive team in the form of a written report. All participants will receive an emailed copy of the executive summary. Additionally, findings from the research may be presented externally in the form of a poster or conference presentation. The final thesis will be published through the Theses Canada Portal, catalogued in UMI/ProQuest database, and posted in the RRU Library D-Space.

By replying directly to the e-mail request for participation you are indicating that you have read and understand the information above and give your free and informed consent to participate in this project.

Please keep a copy of this information letter for your records.

If you would like more information or have additional questions regarding the project and its outcomes, contact Sheryl Thiessen:

Email: [email address]

Telephone: [telephone number]

I thank you in advance for your consideration in participating in this research project.

Respectfully,

Sheryl Thiessen

Appendix D: Research Consent Form – Individual Interview

By signing this form, you agree that you are over the age of 19 and have read the information letter for this study. Your signature states that you are giving your voluntary and informed consent to participate in this project, and that the data you contribute can be used in the final report and any other knowledge outputs (articles, conference presentations, newsletters, etc.).

☐	I consent to the audio recording of the interview (in-person) or video recording (by teleconference).
☐	I consent to the use of zoom.us, a non-Canadian internet program, for conducting the interview by teleconference (if necessary).
☐	I consent to the use of quotations and excerpts expressed by me during the interview in this study, provided that my identity is not disclosed.
☐	I consent to the use of any notes made during the interview be used in this study.

Interviews will be scheduled upon receipt of this consent form. Ideally, all interviews will be conducted by May 25, 2019. If you still desire to participate but cannot by that date, please contact me to arrange another option.

Interviews can be scheduled anytime between 7 am and 10 pm for your convenience.

Please propose some dates and times that will work for you:

Interview Date(s) and Time(s):

Name: _____

Date: _____

Return by email:
You may type your name in the line above, then send the document from your personal email account directly to the email below to indicate your consent. This will eliminate the need to print, sign, and email a copy of the document.
Please retain a copy of your completed consent form for your records.

Name: Sheryl Thiessen
Email: [email address]

Appendix E: Individual Interviews Question Table

Individual Interview Questions	Participant ID Code:
Interviewee:	Interviewer:
Date:	Time:
Preamble: The success of any organizational change rests in large part on the attitudes of the people who are on the receiving end of the change. As a Laboratory leader, the new consolidated service delivery stream might have a greater impact on you as it may change some of the existing working relationships—with your health authority, with PHSA leaders, with the Agency, with your staff. Your answers should reflect your attitudes, feelings, and beliefs related to the coming consolidated laboratory service delivery stream.	

Q1: Tell me a little about yourself and your background. What is your current role, how long have you been in this role? What is your history with labs in BC?

Q2: Tell me about your experience with any previous laboratory or health care reform initiatives.

Q3: What was good about how the change process was managed?

Q4: How could the change process have been managed better?

Q5: How would you say you normally respond to change processes?

Q6: The proposed consolidated service delivery stream model for lab services is a significant change to how labs have operated until now. What is your current attitude toward this change?

Q7: Lab reform has been a long time coming. Is this time different? If yes, then in what way?

Q8: For the past 4 years, the Agency was going to be responsible for implementing the new consolidated service model. What are your thoughts about the Agency?

Q9: What are your thoughts now that PHSA is responsible?

Q10: How would you describe your attitude toward PHSA's ability to accomplish its stated objectives of improved laboratory service in the province?

Q11: What impact do you anticipate the new consolidated lab model will have on your relationships?

Q12: Do you have any personal fears about how this change will affect you?

Q13: What is your current level of engagement and endorsement in the new model?

Q14: What other thoughts or concerns do you have that have not yet surfaced but you feel are important related the personal impact the proposed organizational change will have on you?

Appendix F: Letter of Invitation to Participate in Focus Group Discussion

Dear [Prospective Participant],

My name is Sheryl Thiessen, Director of Quality and Patient Safety at BC's Agency for Pathology and Laboratory Medicine (the Agency). I am conducting a research project in partnership with PHSA, and to partially fulfill the requirements for a Master of Arts in Health Leadership (MALH) from Royal Roads University (RRU). This project has been approved by Jim Slater, PHSA's Chief Provincial Diagnostics Officer who has given me permission to contact you for this purpose.

The purpose of my research is to discover how we might successfully transform from separate BC public health authority laboratory service provider organizations to working within a single, provincially-coordinated service delivery system as we move forward with achieving the PHSA vision of "one system of care." It is my intent that the findings from this research inform the development of strategies to support successful transition to the new model.

PHSA is responsible for determining the context—the what, when, how, and why—of the change in laboratory service management throughout the province to a consolidated service delivery model. **This project is focused specifically on understanding the personal change preparedness of the individuals who will be most affected by this change, as well as jointly identifying what you feel is necessary to create a collaborative team mindset that can accomplish coordinated laboratory service delivery in BC.** I am inviting you, as a leader of one of the public health authority laboratories in BC, to participate in this research project to give you an opportunity to voice your opinion regarding the change in a way that can inform PHSA.

You have been identified as a prospective participant because, as a laboratory leader of one of the public health authorities in BC, you will be directly affected by the change. **I am inviting you to participate in a focus group session to discuss the themes identified during the individual interviews, as well as develop strategies you and your colleagues feel would be helpful for all public laboratory service providers to successfully integrate into a highly collaborative team to achieve unified, cohesive service delivery. The resulting recommendations will be presented to the PHSA Laboratory Service leaders for their consideration.**

This discussion will be conducted by teleconference at a date and time convenient to all who are interested in participating. The discussion is expected to last approximately one hour.

The attached Research Information Letter contains further information about how the study will be conducted and should enable you to make a fully informed decision regarding your participation. Please review this information before signing the consent form.

Your participation is completely voluntary. If you do not wish to participate, simply do not reply to this request. Your decision to not participate will be maintained in confidence.

As all public health authority laboratory leaders are receiving an invitation, you may feel compelled to participate. Please be aware that your participation is completely voluntary and will not be shared with PHSA leadership. If you do choose to participate, you are free to withdraw at any time during the discussion. However, it will not be possible to remove individual information provided during the group discussion due to the nature of generative conversations.

If you feel you are sufficiently informed of all aspects of this research project, you are invited to provide your informed consent by signing the attached consent form and returning it to me via email. I will then send out a poll to find a meeting date and time that works for everyone. You will be notified of the date and time of the group discussion once arrangements have been made.

Please respond by June 24, 2019.

If you would like more information or have additional questions regarding the project and its outcomes, simply reply to this email or contact me at:

Name: Sheryl Thiessen
Email: [email address]
Telephone: [telephone number]

Sincerely,

Sheryl Thiessen

Appendix G: Research Consent Form – Focus Group Session

By signing this form, you agree that you are over the age of 19 and have read the information letter for this study. Your signature states that you are giving your voluntary and informed consent to participate in this project, and that the data you contribute can be used in the final report and any other knowledge outputs (articles, conference presentations, newsletters, etc.).

- ☐ I consent to the recording of the small group session.
- ☐ I consent to quotations and excerpts expressed by me during the group session be included in this study, provided that my identity is not disclosed.
- ☐ I consent to the material I have contributed to and/or generated (e.g., whiteboard notes or visuals) through my participation in the group session be used in this study.
- ☐ I commit to respect the confidential nature of the group by not sharing identifying information about the other participants.

Name: (Please Print): _____

Signed: _____

Date: _____

Return by email:

You may type your name in the line above, then send the document from your personal email account directly to the email below to indicate your consent. This will eliminate the need to print, sign, and email a copy of the document.

Please retain a copy of your completed consent form for your records.

Name: Sheryl Thiessen
Email: [email address]

Appendix H: Focus Group Themes

Concerns:

Impact to ability/effectiveness in role:

- Loss of autonomy / ability to make local decisions – increased bureaucracy
- Loss of local nimbleness and responsiveness
- Decreased influence as PHSA/PLMS grows larger

Need to protect and maintain local relationships:

- Organizational identity
- With Health Authority – Medical Advisory Committees / senior leadership
- With site – operational impact
- With site clinicians
- With local foundations
- With local staff

Lack of distinction between many different PHSA identities:

- as Executive Leadership (Senior Executive Leaders)
- as Provincial Laboratory Medicine Services
- as Agency (entity)
- as LM Labs (entity)
- as "Vancouver" / lower mainland labs
- as Provincial labs (BC Cancer, BC C&W, BC CDC)

Engagement:

- Struggle between optimism (confidence that this is the best plan at this point in time – just need to get started) and pessimism (will we ever accomplish our objectives?)
- Engagement deteriorates with long delays in receiving information:
  - Sense-making – individual, and collective (rumours)
  - Doubts, fears, unwillingness to engage all increase during periods of silence
- Many are reserving judgment until there is more information/visible progress

Questions:

- What is the plan?
- Why do it this way? (Rationale)
- What impact will this have with my health authority/local clinical colleagues/staff?
- What will my new role look like?
- What are my responsibilities?
- Will I still be able to make local decisions?
- Will all voices really be equal? (Fear of outside influences /special interests given priority/ large HAs overwhelming small HAs)
- Will the importance of the connection to local clinicians/local site be valued?

Enablers:

Clarity of:

- Plan
- Rationale
- Roles/responsibilities

Communication:

- Share Vision, plan, rationale: passive, one-directional: Leaders to provide
- Collaboration, involvement, inclusion: Bi-directional: Wanting leaders to listen and value input from stakeholders (Regional Ops and Med leaders)

Funding:

- Ownership of the budget
- Funding mechanisms (Global vs MSP)

Leadership

- Ability to make decisions – Authority
- Ability to deliver results based on what's best for patients throughout the province

Tensions to be managed:

How can we move the epicenter to balance both? Where does the epicenter need to be?

SHARED/BALANCED		
Regional/Local	**Culture**	Provincial Lab Medicine Service
Primary: Local "Family" – staff	**Identity**	Provincial Lab Medicine Service
Regional/Local	**Loyalty**	Provincial
Regional autonomy	**Collaboration**	Coordinated provincial plan
Silos	**Compliance**	Collaborative team
Independent regional representative	**Voice**	Equal partnership
On-site colleagues	**Clinical Relationships**	Provincial consultant role
Academic/Research	**Innovation vs implementation**	Operational
Health Authority/local foundations	**Funding**	PHSA/PLMS
Distributed	**Test Menu**	Provincial consolidation
SME input	**Patient-centered Decision-making**	Consistent/transparent Decisive leader
Healthcare	**Political**	Government
Separate Public/Private	**Service Providers**	Incorporation of all LSPs
Laboratory	**Optimized System**	Healthcare
Regional/Geographic HA	**Boundaries**	Discipline streams

Appendix I: Focus Group Purpose Objectives Process

Purpose: To answer the overarching question:

How can we adjust our mindset from individual health authority laboratory leader representatives to becoming partners within a single provincially managed laboratory system?

- How might we be able to create a new provincial laboratory service identity?
- What recommendations and strategies can we suggest in order to facilitate the new province-wide identity of laboratory services?

One of the key enablers to transform from individual to collective mindset will be to develop a culture that will support success.
All affected participants socially construct culture. As leaders, you are key influencers of culture within your area of influence. Starting with you, what strategies will begin development of a Provincial Laboratory Service identity?

Objectives:

- Discuss the themes to identify areas of shared concerns and opportunities
- Discuss the tensions
- Identify strategies to transform the collective mindset to a provincially coordinated, patient-focused system of care mindset

Timeline:

Time	Topic	Process
10 min	Discussion of themes drawn from individual interviews	Participants to develop shared meaning from themes
10 min	Discuss the competing tensions	Separate Tensions into Strategic and Socially-Constructed buckets
20 min	Discuss Socially-Constructed themes for developing a collective mindset	Culture Identity Loyalty
15 min	Develop recommendations for beginning the transition to the collective mindset	2 minutes personal reflection 8 minutes group discussion 5 minutes clarifying recommendations
5 min	Summary	

Appendix J: Focus Group Follow-up Survey

This is a short survey asking you to indicate your agreement or disagreement with the findings from my research project. Please indicate whether you agree with each statement, partially agree, or disagree with the finding. A short explanation of why you answered the way you did would be helpful to understand your thoughts. Thank you for taking the time to provide this last input into the research project intended to discover how we can work together to create a new Provincial Laboratory Service.

Statements about the Focus Group findings	Agree	Partially Agree	Disagree	Why I answered this way
Lack of clarity of the plan and definition of the PLMS identity are barriers for these leaders to begin the process of identifying as members of a single, cooperative, collaborative PLMS team.				
Length of elapsed time between informational inputs, perceived to be long, introduced individual doubt and endangered engagement in the plan.				
Clarity of the plan and the several PHSA identities is necessary for these laboratory leaders to be able to fully participate in creating a new provincial laboratory service identity.				
Statements about the Focus Group meeting				
The themes outlined in the meeting document represented my main concerns about the PLMS.				
I was able to adequately express my feelings, concerns and views about the laboratory consolidation.				
I had an opportunity to contribute to defining some recommendations that will help me further engage in and support this organizational change.				
This process made me feel that my				

perspectives and opinions regarding the proposed change are valued.				
This meeting gave me a sense of belonging and cohesiveness within the group.				