TRANSFORMATIONAL CHANGE AND THE ROLE OF SOCIAL WORK

by

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Transformational Change in Northern Health; the Role of Social Work

In response to a growing prevalence and impact of chronic disease and with the expected exponential increase in the population of older people, the medical system in British Columbia began a shift from an acute response toward a more proactive and 'planned care' orientation (BC Ministry of Health, n.d.).   The Health Authority and the provincial government committed to working together toward changing the face of health care for patients (Northern Health, n.d.). The Health Authority, therefore, has undertaken a system change approach toward the provision of integrated primary health care, where interprofessional teams (IPT) provide holistic care, using a person centered approach. The process of implementing primary care homes and teams had already begun, where integrated health care wraps around the individual and their family to provide more effective and eventually more efficient care to the people living throughout the health authority. An integrated primary health care team approach was introduced throughout the Northern Health Authority to ultimately produce better population health outcomes and improve social and health equity (Canadian Association of Social Workers, n.d.). As they transform to this new way of delivering service, the entire organization must shift how they do their work, accommodating new processes and norms, changing how they think about healthcare. Transformational change is all-encompassing and requires the people involved to actually change both their behavior and their thinking and attitudes (Tafvelin, Hyvönen, & Westerberg, 2014).

Imperative to the successful transformation of the provision of health care is the need for leadership that understands and is competent in human relationship and community building. This practicum experience provided a unique opportunity to glimpse the change process from the perspective of the Executive leadership within Northern Health. Exploring the role of social

work within this corporate setting allowed a better understanding of where and how social

workers fit as professionals in the context of leading and coaching others, especially during a

transformational change process. This report begins by describing the physical, structural and

theoretical setting, including a brief history of Northern Health's transformational process to

date, before reviewing the latest literature and identifying key concepts within transformational

change, leadership and the role of social work.   The learning outcomes are critically explored

using practical examples from the practicum experience, highlighting the role of social work

within leadership and the value the profession has during a transformational change process.

Future considerations and implications for both social work professional practice and social

policy development are discussed in relation to transformational change.

The practicum setting. The practicum placement was held in the executive offices of

the HSBC building downtown, Prince George, from Monday to Friday business hours from April

20th to August 21st, 2015. It involved joining the Northern Health Integrated Health Services

Regional Resource Team (Regional Resource Team), an Interprofessional Team (IPT) created to

provide necessary resources to support the process of integration from a regional level. The

Regional Resource Team, in their task of implementing this change across Northern Health is positioned within the Integrated Health Care Support (IHC) side of Figure 1.   The Resource Team is made of professionals from Human Resources, Communication, Finance, Information Technology and

Figure 1 Integrated Health Care
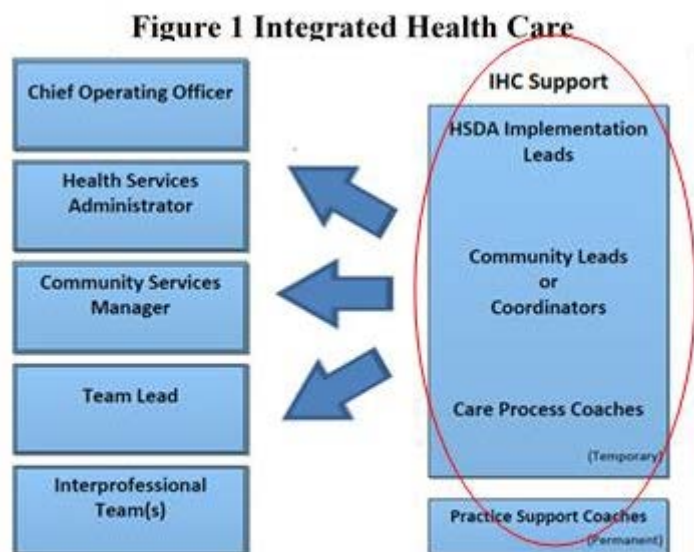
Figure 1. Interprofessional Health care support provided to the various levels within Northern Health (Northern Health, 2015).

the Implementation Leads from Public Health and the North East, North West and Northern Interior Health Areas. The Regional Resource Team worked on cross cutting issues to ensure a consistent approach to change. The practical experience was under the direction of Mike Simpson, Executive Lead Community Services Integration & Implementation Division who, in this corporate environment, provided a unique opportunity to observe change and transformational leadership expressed with a social work perspective and within the macro level of the organization. Figure 2 illustrates the organizational structure of Northern Health as of July, 2016. Care Process Coaches and Practice Support Coaches provided local training and lead local quality improvement initiatives.

Figure 2. Northern Health Structure, Pre Transformation, 2015

Figure 2. The practicum setting was under the direction of Mr. Simpson, Director/Manager of "Specialized" services (Northern Health, 2015).

This was a most opportunistic time to be involved with the organization as they move from the planning stage to an action phase of a system-wide, transformative change process. As a practicum setting, the Northern Health resource team afforded an opportunity to explore and observe the role of social work within leadership positions, having positive influence of people through an enormous system tran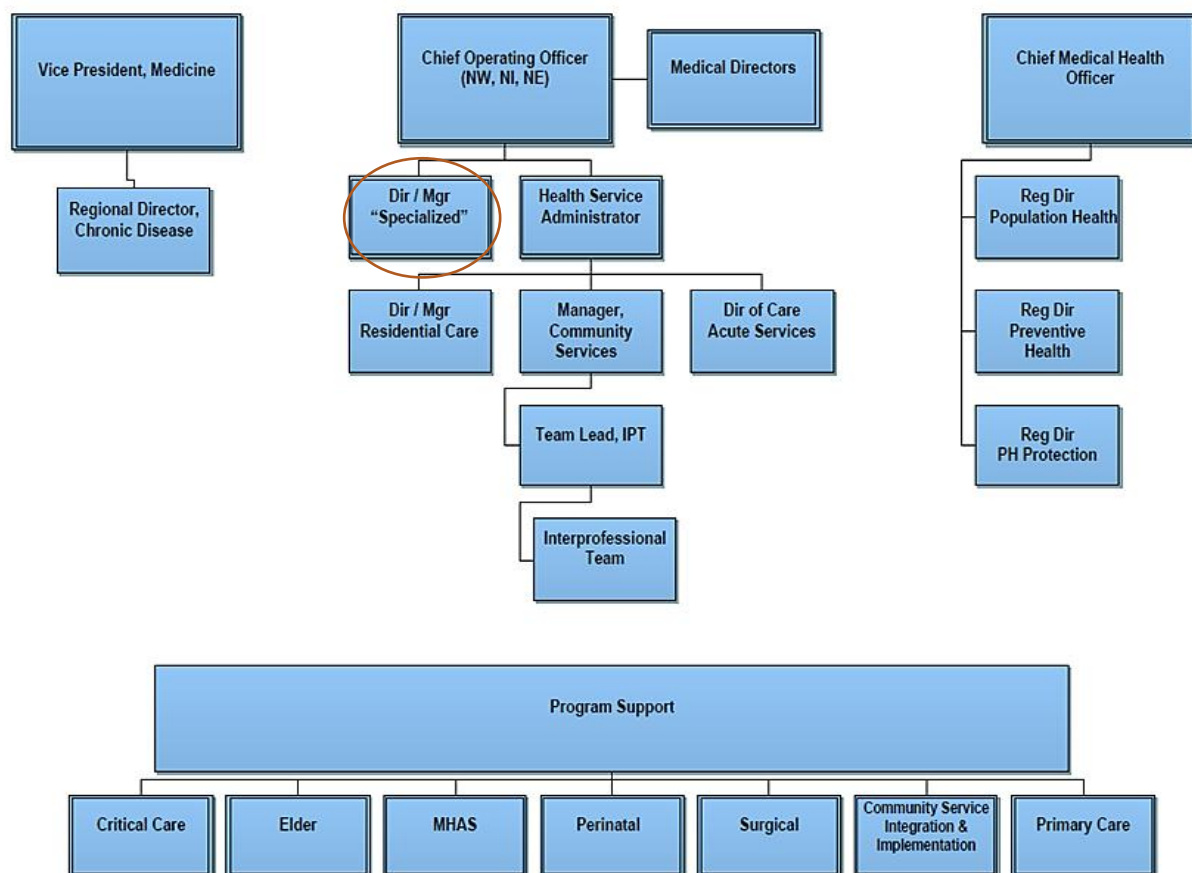sformation. At the same time, observing leadership in action was difficult in that the bulk of the practicum took place during the summer months when many people take vacation. It was also an unfamiliar and difficult work environment to be a practicum student, requiring a period of adjustment to learn the environmental language and norms, the complex history of the change process and details of the planned rollout of integration throughout the region. The Executive members were not used to having outside learners in their midst so norms and practices for the learning environment were not yet established. To facilitate the integration of theory into practice, a daily professional journal was kept to record and reflect upon learning. It was a place to reflect on the learning topics and other ideas or issues to up during a practicum experience. This journal was a helpful tool to process and analyze new information and the daily entries provide concrete examples to illustrate learning and suggest further exploration.

Learning goals. The overall goal of this practicum experience was to better understand the role of social work within Northern Health's transformational change to an integrated primary health model, and evaluate how social work values and ethics influence those being led through the change process. The motivation for seeking this placement included the reputation of Mr. Simpson, the practicum supervisor, for his social work ethics and his leadership ability within Northern Health as well as the opportunity to work in a new environment to explore and apply social work values and skills. Change management, or the people side of change, is where the

role of social work was anticipated to shine. The practicum experience provided an opportunity to evaluate how social work values and ethics influence a more holistic and broad perspective for those being led through the change process. This experience offered new opportunities for positions of leadership, as well as a better understanding of the overall nature of the change and an opportunity to grow, not only as an employee but as a future leader. The learning within the practical placement was guided by the following questions:

1. How do traditional social work values and skills of those in Leadership positions affect their experience leading people through a transformational change process?

2. How do these values and skills compare to those needed to drive transformational change? How do they connect to leadership skills?

Through observation and discussion, I was successful in reaching my overall learning goals:

1. I gained a better understanding of the role of social work throughout Northern Health's integrated primary health care.

2. I determine social work skills and abilities associated with promoting and leading active participation in the change process.

3. I increased my knowledge and understanding of the following:

    a. boundary spanning

    b. person-centeredness

    c. role ambiguity

4. I hope to influence future research into the link between social work values, skills and abilities and successful transformational leadership.

To achieve these objectives I engaged in a variety of activities as outlined below:

1. I read suggested readings from Mr. Mike Simpson, Practicum Supervisor, including

    internal documents, both historical and present as well as Kotter's 2014 book

    'Accelerate; building strategic agility for a faster-moving world' and Hiatt and Creasey's

    (2012) 'Change management: the people side of change'.

2. I maintained a daily professional journal about daily events, noting learning topics to

    bring up for further discussion with practicum supervisor. I will include this journal in

    the submission of my final report and presentation.

3. I observed social workers operating within this change process, noting how their skills

    and social work value system promote the change process. I also shadowed a social

    worker on the Prince George Team 1.

4. I discussed the contributions of social workers to the systematic change process.

    a. I met with Mike Simpson on a weekly basis (or more, as available) to broaden my

        perspective and discuss current events of the change process.

    b. I completed interviews with social workers in executive positions, leadership

        positions, as members of an Interprofessional Team (IPT) and the Executive

        Director of the Prince George Division of Family Practice.

5. I joined in the everyday work carried out by the teams within their work setting.

    a. I attended IPT planning and coordination meetings and discussions with a variety

        of professionals, departments and teams including physicians.

    b. I took part in integrated health care training, involving forums for IPTs as well as

        a forum with Psychiatrists and physicians.

    c. I joined the Regional Resource Team to experience the regional scope of the work.

    d. I travelled to Vanderhoof, an hour west of Prince George, to meet with members of their IPT to discuss current communication issues.

6. I completed specific work tasks to be determined by practicum supervisor.

    a. Answering questions generated by the Public Health Nurses and the Primary Care Nurses forums.

    b. Updating various job descriptions to reflect IPTs and the person centered Primary Care Model (Northern Health, 2012).

Theoretical Frameworks

This practicum experience was influenced by my past experience as a social worker in the North, my social work perspective, approaches and philosophies involved in working within the helping profession. As a lifelong resident of Prince George, BC and a current employee of the University Hospital of Northern BC, I understand the challenges faced by northern workers and residents receiving services from our medical system and value the generalist approach needed in my helping practice. As a generalist practitioner, working within a large institution such as the Northern Health Authority, I work from a structural social work perspective (King, 2008) and approach people from a person centered, strength based perspective (Rice & Girvin, 2010). As a practicum student on the Regional Resource Team, I was introduced to a regional perspective of an IPT whose role it was to help guide and transform the entire system to a Primary Care Model (Northern Health, 2012). This regional perspective was emphasized and my previous helping experiences became interconnected with those of the practicum, influencing my understanding of what was involved in a structural change of this magnitude. The practicum

experience in turn, influenced my work with clients and IPT members, providing a more holistic approach to both experiences.

The structural perspective of social work, a social change or conflict theory of oppression, states that societal and structural influences shape the context of our practice (King, 2008). Social problems are understood as an effect of oppressive social constructions, and as barriers to service, they must be removed (King, 2008). This practicum was approached from within a structural social work framework (Rice & Girvin, 2010), and was enhanced by working within the very structure responsible for shaping and directing the systemic change process. Operating from a Strengths Based perspective (Rice & Girvin, 2010) facilitates people to become more resourceful, capable and resilient to manage their challenges, accepting that every person, family, group and community holds the key to their own meaningful change process (Hammond, 2010). The Strengths Based paradigm (Hammond, 2010) also works well with transformational leadership driving the transformational change process to an integrated primary care approach. While it may be a struggle to practice from the underlying values, principles and philosophy of the approach as a starting point of change, it is empowering to actively engage others into the process while valuing the experience and abilities of the people at the center of it (Rice & Girvin, 2010).

Northern Health Authority. The Health Authority is divided into three Health Service Delivery Areas: the Northeast, the Northern Interior and the Northwest (see Figure 3). Together, they are responsible for delivering health care to a population of 350,000 residents, spread throughout nearly two-thirds of the province of BC, from Haida Gwaii to the eastern BC border, from the northern BC border and as far south as Quesnel and Valemount. This is an area of

nearly 600,000 square kilometers, offering health services in over two dozen communities

through 50 health facilities, with populations ranging from a few hundred people to over 80,000.

Figure 3. Northern Health Authority by Region
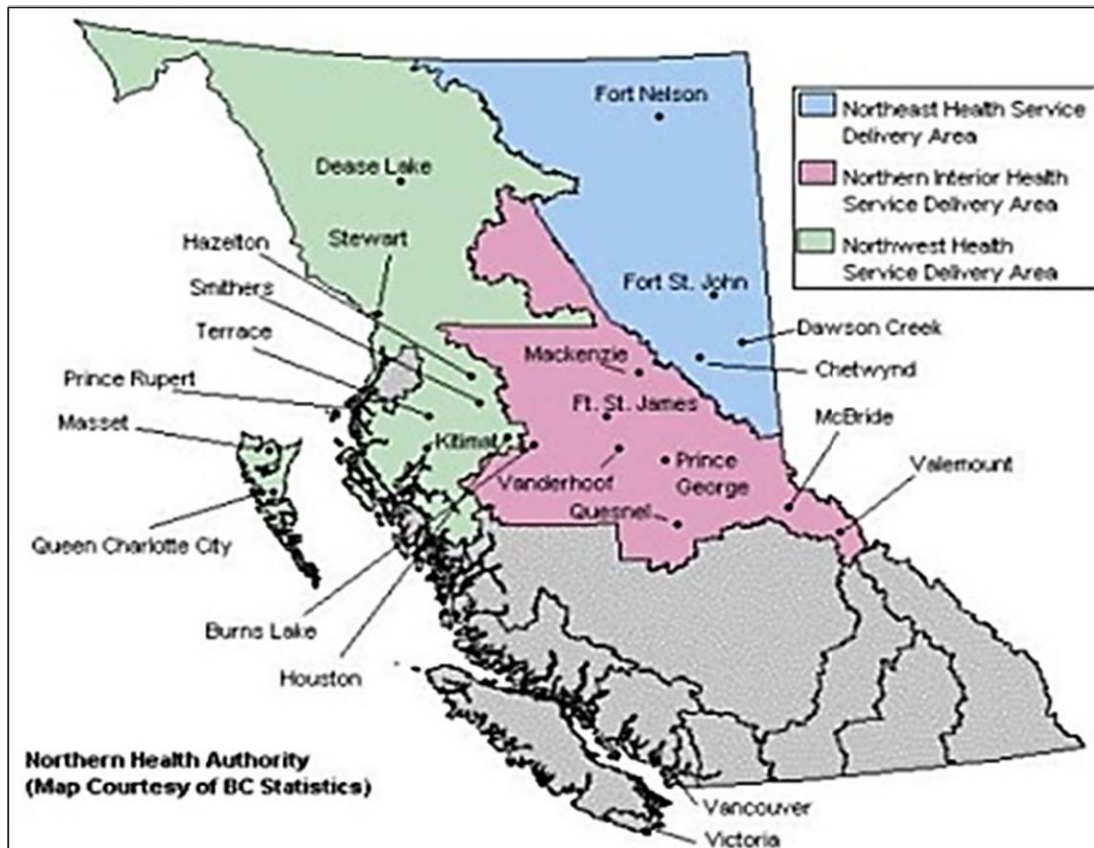
Figure 3. Northern Health Authority consists of over half of the geographical province of BC
(Northern Health, (2015)

Northern BC communities, while unique in many ways, all share similarities, such as

limited infrastructure and access to services due to their geographical distance from urban

centers (Peters et al., 2010). The central hub of Northern Health is the City of Prince George,

offering many specialized health services and amenities. When specialized services are not

available in Prince George however, people living within the Northern Health Authority travel to

larger city centers such as Vancouver or Calgary, approximately 800 km further away from

Prince George. Travel is often further hampered by poor transportation options, harsh winter

weather and high travel costs, resulting in physical and social isolation (Peters et al., 2010). The challenges of British Columbia's demographic and disease trends lead to population health inequities, requiring a collaborative, Population Health approach (Northern Health, n.d.). The goal of such an approach is to improve the health of the entire population while reducing health inequities among specific population groups (Northern Health, n.d.). This approach is also one of Northern Health's four pillars of their 2009-2015 strategic plans, concerned with the determinants of health and integrating accessible, high quality health services for Northerners (Northern Health, 2014).

Northern Health remains steeped within the medical model of care and the traditional methods of physician compensation. Yet the Health Authority is determined to set a change in motion to improve access to integrated health services and to measurably improve staff and physician engagement (Northern Health, 2009). They have changed systems and processes, continuing to change many historical norms and practices. This affects core guiding principles, ensuring they shift their approach and deliver health care together, as an organization. As part of this reorganization at a systems level, Northern Health has chosen to focus on developmental evaluation based on the innovation driving change (Gamble, 2008). More traditional approaches work to predict outcomes and focus measurement on goals, while developmental evaluation is intended to support innovation within a context of uncertainty (Gamble, 2008). Innovation is necessary with the transformative change underway, as the system is created by the very people providing care. With transformational change the outcome is unknown, the change is all-encompassing (Tafvelin, Hyvönen, & Westerberg, 2014) meaning the outcome is dependent upon the people working within the system.

Moving forward, Northern Health strives to merge the current realities of providing care within a medical model with a future vision of providing person centered care using a Primary Care Model (Northern Health, 2012). To begin transforming to new ways of practicing, Northern Health has taken direction from Kotter's guide 'Accelerate' (2014) a model developed to drive transformational change in a large, multi-silo organization, where there is a need to handle challenges fast enough to take advantage of opportunity while maintaining quality care or 'status quo'. The basic premise of Kotter's model is to have a dual system, one providing the reliability and efficiency of the organization to continue with regular operation and the other, with agility and speed; "Action is opportunity seeking and risk taking, all guided by a vision that people buy into" (Kotter, 2014). This dual system requires people to make a shift in the way they do their work, to challenge old systems of operation and look for innovative ways to change. In addition to Kotter's (2014) premise of dual systems, Northern Health has also explored Sharmer & Kaufer's, (2013) model, based on the idea that most learning methodologies rely on the past for information, and learning for the future requires an inner shift to suspend judgment and redirect our attention. Transformational change toward a future change, therefore, requires specialized and skilled leadership, well suited to the values and skills of social work to help teams shift not only their behavior, but also their thinking and attitude to move forward in a different direction.

Literature Review

In preparation for this practicum experience, a literature review was conducted using key terms associated with integrated primary health care, the role of social work, transformational change, transformational leadership, and interdisciplinary teams. Within primary health care, person centeredness, community services and case management were explored and the role of

the social work included topics of social work role ambiguity, conflict, and subjective wellbeing. For the purpose of this report, multidisciplinary, inter-professional, and interdisciplinary teams were also researched. 'Interprofessional' implies an exchange of information and skill across the team over time and Northern Health has changed their language to reflect their future state of being, knowing it will take time and learning before reaching this level of practice. During the practicum experience, the concepts of 'risk tolerance', change management, group facilitation skills, and 'team based care' were added. All of these concepts were then paired with the context of northern and remote British Columbia using the search engines SocINDEX with Full Text, Social Sciences Full Text, PsycINFO, MEDLINE with Full Text, ERIC, and Humanities Full Text. Finally, Mr. Mike Simpson, practicum supervisor, provided directed readings regarding transformative change, transformative leadership, primary health care approaches, change management, and transformational change theory. Often the most recent research was obtained, especially in the area of system change and integrated primary health care.

      Integrated primary health care. Primary health care services begin with the doctor, who becomes the first and most common point of entry into the health care system (Conference Board of Canada, 2013) and the primary care home is a place where the family physician provides patient centered and holistic care through an accessible and coordinated, interprofessional team approach (Zuril, 2014). Primary health care is basic care provided by a variety of health care professionals (Zuril, 2014). It is accessible and integrated, concerned with quality improvement and patient engagement and relies on interdisciplinary care, health promotion and disease prevention to build capacity within the community (Ontario Medical Association, 2013). Primary health care is the accepted best practice of providing quality, person-centered health care in an efficient and accessible manner (Graham & Shier, 2014; World
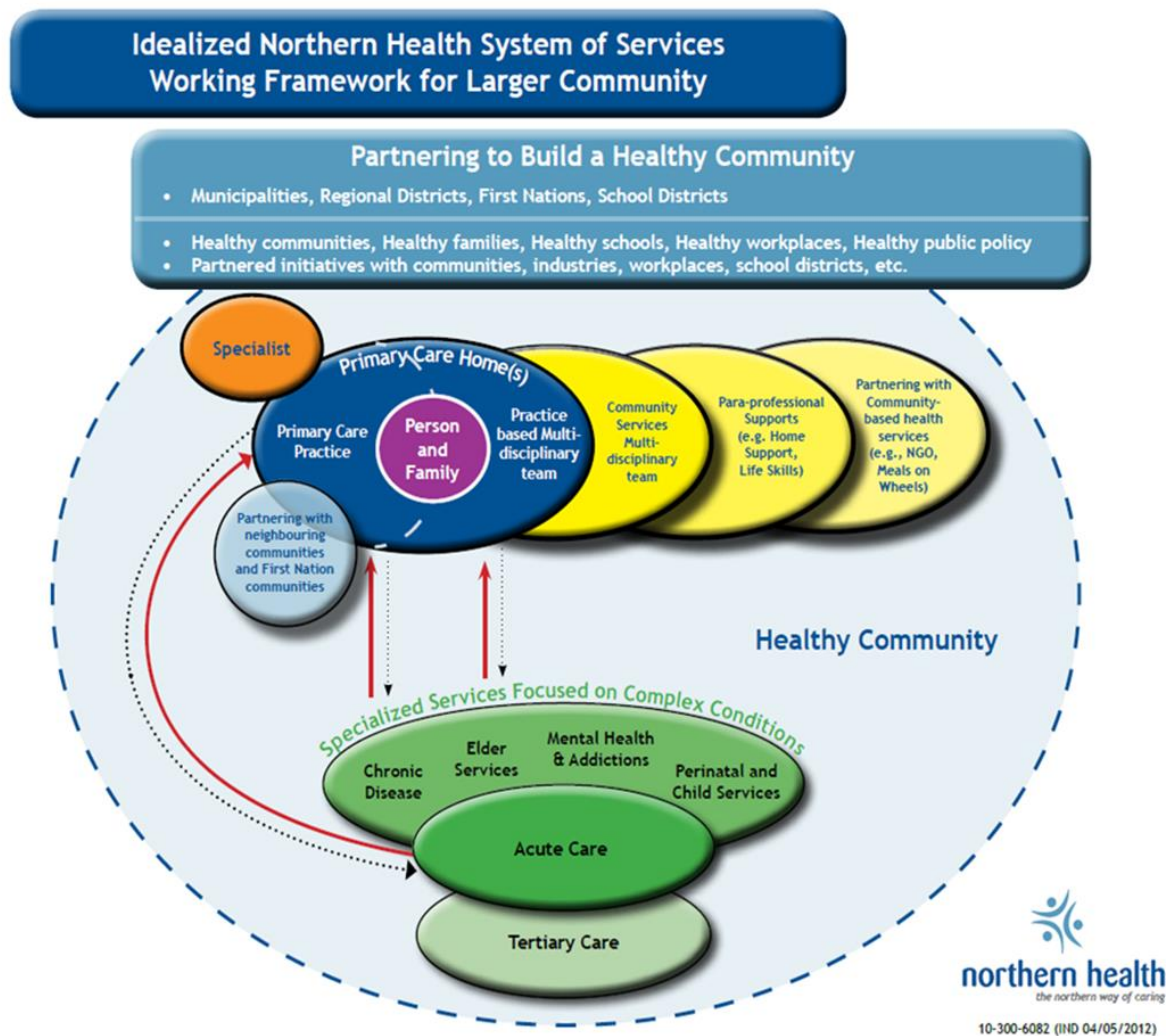
Health Organization, 2008; Zuril, 2014) and, according to Clapton et al. (2008), primary care

services utilizing an IPT and sharing natural geographies can offer patients less fragmented

services between hospital and community.

The importance of person-centeredness, patient involvement, participation and

engagement of the client is agreed upon by those who have adopted an integrated, primary health

care system (see Ontario Medical Association, 2013). People-centered primary care focuses on

health needs and enduring personal relationships and engages people to become partners in

managing their own healthcare (World Health Organization, 2008). As seen in Figure 4, the

person and their family are at the center of care, upheld by the various community and

professional supports, specialty services and acute and tertiary care. This diagram could be

improved by adding standardized communication pathways, showing the need for

communication to travel freely between all parts of this system with from physicians to

community services to acute care.

     Interprofessional teams. According to Northern Health, an IPT consists of a variety of

professionals working together, combining their skills to support the holistic total care of the

patient (Zuril, 2014). An IPT may look differently in each community throughout the various

northern regions, depending on the needs of a population and the availability of qualified

professionals. It could either begin with a physician or Nurse Practitioner, then nursing, social

work, mental health clinician and other therapies as deemed appropriate and where resources

allow. Working within this integrated care team approach may also include specialists within a

specific area of medicine such as psychiatry, neurology, or pediatrics (Zuril, 2014). Team

members eventually learn to draw on knowledge from each other while remaining within their

professional boundaries (Zuril, 2014). This is a long process, but when health professionals with

complementary skills come to understand both their own role and those of other professionals on

the care team, operating from a full scope of practice, they begin to move toward shared goals of

improved care practice.

     Transformational change and leadership. Over the years, the literature continues to

recognize the positive effects of transforming to a Primary Care Model (Northern Health, 2012),

such as improved organizational performance, innovation and job satisfaction (Fuller et al.,

1996; Lowe et al., 1996 as cited in Tafvelin, Hyvönen, & Westerberg, 2014). Given the scope of

the transformation and the importance of successful and seamless transition, there is a need for

this transformational change to have exemplary leadership through the entire process (Bass, 1990, 1997, 1999; Senge et al., 2015; Tafvelin et al., 2014).

The success of transformational change depends, in part, on the ability of the leaders to ensure professionals on the team remain committed to the vision and clear in their assignment (Tafvelin et al., 2014). Transformational leadership, a model based on role clarity and commitment can be applied to systems change where a holistic view combined with the concept of person-centeredness becomes the core of the transformation (Tafvelin et al., 2014). The Conference Board of Canada wrote, "A lack of strong organizational leadership is an underestimated barrier to implementing effective, integrated primary health care teams" (Drummond, Abbott, Williamson, & Somji, 2012 as cited in Conference Board of Canada, 2012). A systems leader is able to see and appreciate the larger system and shift the focus from reacting to problems, to proactively collaborating to create the future. They are introspective, understand resistance, foster reflection and appreciation of the reality of others, all while integrating the information into their managerial practice (Burghardt & Trolliver, 2010 as cited in Ring, 2012). The documented positive benefits of transformational leadership demonstrate the need for specialized and skilled leaders to help people move forward together, creating the process as they go.

The role of social work. Social workers have been immersed in healthcare since the early 1900's responding to the needs created by economic and policy changes, major world events and public health crises (Kerson & McCoyd, 2013). Social work roles in health care today continue to be guided by the values outlined in the Code of Ethics, providing a basis for an identity to the profession (NASW, 2008 as cited in Kerson & McCoyd, 2013). On the integrated primary health care team, the social worker acts as an adjunct to the medical treatment through

care coordination between social and health issues, linking to other disciplines and services, and playing a key role in assessment and ongoing support with psycho-social issues in a proactive manner (Canadian Association of Social Workers, 2005). They bring a broader, more holistic perspective of healthcare and personal wellbeing into the assessment, planning and intervention phases of care, understanding of the complex interconnections between people, time and place which shape and affect their current and future state (Heinonen, MacKay, Metteri, & Pajula, 2001). Consideration of a social context to any given situation allows the health care team to move beyond a biomedical perspective and begin addressing social inequities and structural issues affecting people needing help (Towns & Schwartz, 2012). Social work has historically struggled with role ambiguity however, as inaccurate or unclear role definitions within interprofessional practice leads to significant challenges for both the Social workers and their primary health care team members (O'Brien & Calderwood, 2010). Interprofessional collaboration is imperative to securing role clarity and trust, as unclear professional scope of practice leads to overlapping duties with undervaluing the workers' role and leading to confusion, frustration and chaos (O'Brien & Calderwood, 2010).

While it is now more common to find Social workers within supervisory positions in health care, Executive positions within Northern Health remain more closely related to Nursing. Maintaining competence through adequate supervision, consultation, training, ethical thinking and at this level of the organization remains difficult (Schmidt & Klein, 2004)with so few Executives with a social work perspective. Successful transformational leaders create environments fostering commitment and role clarity to promote a stable organization (Tafvelin et al., 2014). The same ethically based skills and abilities used to help people in need may translate into leadership skills and abilities, especially when the task at hand is moving an organization of

people through transformative change. "The common thread linking the knowledge, skills and values of management practice and direct practice is the significant role played by the emotions that permeate the professional social work domain" (Ruch, 2011, p. 1326).

The Practical Experience; Critical Review

The overall goal of this practicum was to gain an understanding of a transformational system change process and how social work fits into both Regional Leadership and integrated health care teams in Northern Health. While the practicum placement allowed a glimpse into the ideological continuums running throughout the Regional Resource Team, it was also an invaluable opportunity to both experience and envision social work values, ethics and skills at work. The practicum experience was unique in that it occurred during the latter planning phase and early transformation phase of a system wide move to primary care. During this time, the Executive level restructured their communication and decision making processes to better respond to the fast-paced change process. As the momentum increases, the organization not only must adequately respond but also anticipate future organizational needs. The skills and abilities associated with promoting and leading active participation in this process can be compared to traditional social work values and skills, demonstrating the potential influence Social workers have during a transformational change process. The skills involved in group process work can also be applied to IPTs to improve organizational functioning and team cohesion (Guzzo and Dickson (1996, cited in Robotham, 2008, and Trevithick, 2005 and Preston-Shoot, 2007, cited in Pullen-Sansfac on and Ward, 2014).

Further restructuring to include the entire system was yet to come. By the end of the practicum experience, many communities were scheduled to transition in September, 2015 with

the goal to complete initial structural transition throughout the regions by spring, 2016. While the practicum took place on the cusp of the actual transition, there was much planning and anticipation of the movement on the ground and throughout various departments of the organization. Looking back over the four-month placement during the slower summer months, this time was the calm before the storm. Much maneuvering was occurring behind the scenes of the change process, with little movement actually occurring toward primary care practices to clients. For instance, discussions between various unions and Northern Health Human Resources are closed and take time. How to best reorganize the Executive structure and function are also closed conversations.

     Northern Health's transformational change. The transformational change process began long before this practicum experience so it is important to provide a historical context to the current systematic shift and the rationale behind Northern Heath's direction of change. In 2008, the BC Health Officer outlined eight strategic initiatives, including integrated primary health care to respond to the complex issues involved with population health inequities (World Health Organization, 2008). The Northern Health Authority began consultations with northern British Columbians in 2009 to better understand what primary health care meant to individuals, communities and professionals within those communities (Northern Health2, n.d.). They began the implementation of interprofessional primary care teams in three prototype communities and by 2011, Northern Health identified the need to standardize ongoing physician engagement and integrate a clinical information system for sharing client information. In 2012, the model for integrated and accessible primary health care services in Northern Health was developed to be integrated, patient centered and more accessible (Northern Health2, n.d.). As of 2014, Northern Health's 7,000 staff members operated 25 acute-care facilities, 14 long-term-care facilities, and

many public health units and offices providing specialized services (Northern Health, 2014). Six

integrated primary health care teams operate throughout the Northern Health region with

approximately 20 more teams to be implemented by 2016. The first six sites lead tremendous

system changes, from the development of the integrated primary health care teams and

standardized processes, to new documentation processes (Northern Health, n.d.). The

implementation of interprofessional team based care to support primary care will focus on the

following conditions: one or more chronic diseases; mental health and addiction issues; frail

elderly; prenatal and early child health; and child and youth complex care needs (Northern

Health2, n.d.). On average, across the regions, these populations combined make up

approximately 10% of any given physician's panel of patients (Northern Health2, n.d.). Many

forces must come together at all levels of the organization and Government to drive this

transformational change, working together to balance capacity with client need. These efforts

are expected to result in continuous, coordinated and comprehensive care for people and their

families, reduce waiting lists, pressure on emergency rooms and create an overall more

sustainable health care system (Northern Health2, n.d.).

Drivers of change. The direction for change began with the World Health Organization's

(2008) promoting system transformation by directing improvements to the overall accessibility

of services and supporting the need to systematically provide care for people throughout their

lifespan. The drivers of this movement stem from both external and internal forces; from the

current political will of the province, to workers who develop and standardize processes with the

IPTs. Change of this magnitude requires many people in different systems to work together,

reaching beyond their traditional roles and boundaries to create something different. They must

then align and balance unique needs across the Health Authority with their capacity to provide quality service.

Provincial direction. The Primary Health Care Charter directs the health care system through the transition of creating a person centered comprehensive and integrative system to improve the quality of care for lower health status populations and those who experience gaps in care (World Health Organization, 2008). In 2010, British Columbia implemented a sector-wide strategy called the Innovation and Change Agenda. This document provides an overarching framework for coordinated action, laying the foundation for strengthening primary care practices, meant to drive meaningful change across the health system, by setting strategic and operational priorities for the delivery of health services (British Columbia Ministry of Health, 2014). A shared plan of action and a patient-focused vision for the health system are critical to successful change. As the Ministry responds to the health of the Province, Northern Health must be ready to respond to the Ministry and it is therefore essential to maintain a good relationship with the Ministry of Health and respond to requests as needed (M. Simpson, personal communication, June 1, 2015). This need to be responsive was demonstrated in May, 2015, as the opposition party focused on the health care section of the provincial budget in the BC Legislature. The Executive Leadership was formerly requested to make themselves available to respond as quickly as possible to any questions posed by the Opposition. It was considered an urgent matter as the Minister of Health would not answer questions posed to him until receiving a formal response from Northern Health. Despite best efforts to provide pertinent details ahead of time, there is always the possibility of unanticipated questions, taking priority over day to day operations (M. Simpson, personal communication, June 1, 2015).

The BC Ministry of Health declared change management and the implementation of the strategy to be an ongoing challenge as there is still work to do in regard to buy-in from health authorities and other partners (Ministry of Health, 2014). The Ministry (2014) have therefore, set eight priority areas for service delivery action, beginning with a shift from a culture of being disease-centered and provider-focused to a model of patient centered, primary care. This shift will include IPTs working with physicians within the community. Another such priority, discussed during the practicum was to standardize communication pathways between primary and specialist treatment while focusing on IPTs to provide better linkages to community health care (British Columbia Ministry of Health, 2014). All eight priority areas are reflected in Northern Health's vision moving forward into integrated primary health care and will be prioritized and implemented as a part of the transformation.

Northern Health executive and leadership aligns with the Province to promote the change process by providing communication, timelines, direction and mandates to the entire membership, while setting organizational priorities. The current model of information flow begins with implementation, driven by the three regional Chief Operating Officers, who each have an implementation team from their region. This model allows autonomy in different regions but adds complexity to the change process as a whole. Regional leaders must separate their local Health Service Delivery Area's needs from the organization's regional needs, as disconnection from the overall vision of the organization may cause competing priorities within the regions. The role of the Resource Team is to provide resources and support across the regions to have local needs met. They ensure regional considerations are escalated to the regional leaders for consideration. The Workforce Transition Plan describes the process and means by which employees move from the current to future state. Aligning structures to ensure

all pertinent pieces come together and following workforce transition plans will require a cultural

shift from within the organization, including not only how processes occur, but also questioning

why processes are used. The organizational executive must lead by example and reorganize

themselves, changing their own culture to allow more innovation and risk tolerance. Decisions

must be made quickly enough to keep up with the organizational shift.

Boundary spanning, or networking with other organizations or partners, link the

organization with other sources of information within the environment (Mull, 2014). It

encourages innovation by bringing together different perspectives and knowledge, while

remaining within their scope of practice (Mull, 2014). There were many examples of this

practice experienced during this practicum, some of which are identified throughout this report.

The Resource Team was comprised of people from a variety of key disciplines and departments

across the regions, all stepping away from their main work to provide their ideological

perspectives and expertise to help drive the change process forward. Before the move toward

integration, the members of the Resource Team had not worked together across their separate

silos and did not understand each other's roles and responsibilities. They learned from each other

at the table, discovering how their many disciplines align within the larger system, providing

clarity and enabling a collective and unified move forward.

The involvement of the affected unions continues to have an enormous impact on the

change process, as it takes time to ensure fairness and safety for the many workers.

Communication with the entire Northern Health membership are significantly affected during

this time as it is customary to refrain from communicating with workers while negotiating

unionized positions. The multitude of managers must be made aware and understand early on,

the business reasons for change and feel secure about future change to their role to enable them
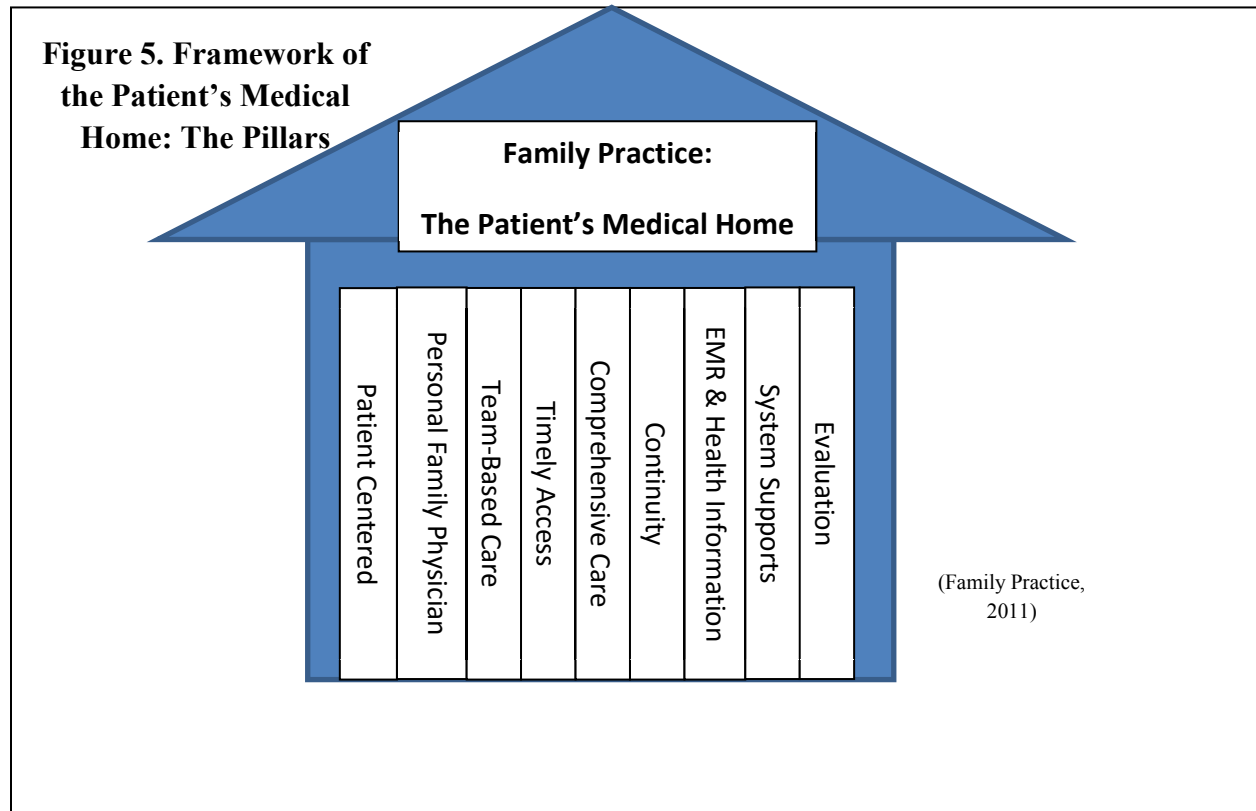
to portray this confidence to the work force. They are the leaders with the most direct and therefore influential effect on the workers providing services. It is imperative the organization develop and maintain trust amongst the employees during this time of change, despite the difficulty with minimal information flow. Once the union talks end, the communication can resume.

Physicians and community partners. Over the last year, Northern Health has been working to advance co-leadership between physician and administrative leaders, recognizing the existence of shared responsibilities. Medical staff and administrative leaders were consulted to endorse the shared functions for their respective roles within the Northern Health Executive & Northern Health Medical Advisory Committee, the Regional Medical Advisory Committees and the Medical & Administrative Leaders. Co-leadership between medical and administrative leaders is an important factor in achieving Northern Health's mission of providing exceptional health services for Northerners. Physicians throughout the organization have been involved in creating this change, including assessing chronic disease management service pathways to and from the primary care homes and restructuring the mental health and addictions process, specifically with psychiatry and primary care physicians. The practicum setting allowed a glimpse into important boundary spanning with physicians and strategic alliances at the organizational level. For example, a physician sits on the ITS steering committee (among others), spending time and energy informing the electronic medical record structure changes across the northern regions. Several doctors demonstrate a stepping away from the traditional roles to drive the change process, encouraging innovation in others by bringing together different perspectives and knowledge; all while remaining within their scope of practice (Mull, 2014). This involvement brings a rich historical perspective as well as a macro lens to the issues and

considerations surrounding implementation of a Primary Care Model (Northern Health, 2012). These physicians take an active hands-on approach, attending meetings, forums and travelling throughout the regions to converse directly with doctors in the area. One Physician has embraced the co-leadership model to focus on physician engagement and orientation to teamwork, touring with the Chief Operating Officer to areas in the regions not yet on board with the change process. This physician has been actively engaged with primary care in his own integrated practice and was a part of the move to primary care from the beginning. He understands the historical discord between physicians in the North and is skilled at talking with doctors in a straight forward manner, cutting through the emotional discord and distrust to get right to the heart of an issue (M. Simpson, personal communication, June 17, 2015). He admits to preferring to be invited to a community to have an honest conversation rather than an informational forum, engaging in two-way dialogue (P. Murray, personal communication, June 17, 2015). He understands the need for physician autonomy, especially in the more remote regions where they have already established ways of carrying out their business (P. Murray, personal communication, June 17, 2015).

This interprofessional team approach to driving change also required the ability to work closely with the physicians within the community and community services. Municipalities and regional districts across the North partnered with Northern Health and Divisions of Family Practice to work on issues important to the community to improve overall health and wellbeing. Divisions of Family Practice began in 2009 with an idea to bring physicians together for a collective voice in healthcare, especially at a local level (Family Practice, 2011). There are currently 34 Non-Profit Divisions of Family Practice agencies in BC, all separate entities, supported by a central office (Family Practice, 2011). In Prince George, every local physician is

now a member of the one local Division (Family Practice, 2011). As depicted in Figure 5, the

pillar of patient-centeredness refers to setting up the system for the convenience and betterment

of the patient.

Figure 5. Framework of the Patient's Medical Home: The Pillars

Family Practice:

The Patient's Medical Home

Patient Centered

Personal Family Physician

Team-Based Care

Timely Access

Comprehensive Care

Continuity

EMR & Health Information

System Supports

Evaluation

(Family Practice, 2011)

For example, having family physician gives people stability over time and together with team

based care is the best system to serve those with complex needs (Family Practice, 2011). When

there is continuity in the system people get to know where to go and system resources are in the

right place and the right time (Family Practice, 2011).

Information management and technology (ITS) plays an essential role in moving toward

integrated clinical systems (British Columbia Ministry of Health, 2015). According to the World

Health Organization (2008), in addition to primary health care, information technology must

ensure both practice and system transformation, allowing information to be shared and accessed

as needed. An Electronic Medical Record (EMR) establishes a common, integrated and

complete clinical information system with standardized administration functions, in which

information and standardized data can be easily shared and collected (British Columbia Ministry

of Health, 2015). The strategic framework illustrated in Figure 6 captures how ITS will support

the transformation of the health system (British Columbia Ministry of Health, 2015). It

highlights the key implications of the three strategic priorities for ITS and the three areas which

must be addressed in order to provide an effective response. A key component to the ability to

provide care in this new way is due, in large part to the ability of team members to access a

common electronic medical record (EMR), including the person's entire care plan. A person's

care plan, an integrated plan addressing a patient's social and health care needs is contributed to

by all disciplines and typically stored, maintained and managed within the primary care home

(Mosby's Medical Dictionary, 2009 as cited in Zirul, 2014). Access extends from physicians and

other specialists in the community as deemed necessary and the IPT. The Province of BC will

focus their ITS efforts on connecting health information systems "across the continuum of care",

including EMR systems, clinical information systems and provincial eHealth systems (BC

Ministry of Health, 2015). It is recommended to expand the use of Telehealth including

videoconferencing to use in recruitment, retention and professional development and to support

regional networks across rural and remote communities to improve quality of health data (British

Columbia Ministry of Health, 2015).

 While ITS does not drive the change process per se, their capacity has a great impact on

when and how health care work is carried out and how data is collected and used. The business

side of the organization drives the transformational change timelines and ITS drives the

alignment and timing of the transformation. For instance, ITS work plans are divided quarterly,

Figure 6. Strategic framework for health information management and technology

Aligning to our policy directions

Policy Directions & IM/IT Implications

Primary and Community Services
- Shared Care Planning
- Improved Data and Analytics
- Telehealth Expansion

Rural Services
- Single Health Record per Patient
- Integrated Clinical Systems
- Telehealth Expansion

Surgical Services
- Single Health Record per Patient
- Improved Data and Analytics
- Surgical Booking and Waitlists
- Telehealth Expansion

Prioritizing our efforts and Investments

IM/IT Strategic Priorities

Health Information Exchange

Data Sharing for Decision Support

Patient-Centred Information and Technology

Enabling and organizing for success

Health Information Standardization

IM/IT Governance and Investment

Shared IM/IT Services

(British Columbia Ministry of Health, 2015).

so they demand the entire system also follow this schedule to some degree. It becomes

imperative to keep ITS up to date with community timelines and service needs during the

transition. Leadership and ITS work together, weighing different perspectives and needs

throughout the system and ITS delivers what is asked of them, basing their priorities on those of

the Executive of Northern Health. Change management support and the overall timelines also

have a significant need to align with ITS for training, to ensure IPT skill competencies and ITS

orientation and training move smoothly. Much pressure is involved in balancing Northern

Health's priorities and timelines with their capacity to respond to and anticipate community

and/or team readiness to move forward. The recent structural changes within the Executive have

left ITS concerned as to how they will continue to receive clear direction and priorities, and how

they would proceed with determining priorities as the rate of change quickens and expands

across the Authority. This exemplifies the extent to which change in one area of the system will have an impact upon other areas of the system and not only needs direction but ongoing change management support.

Interprofessional teams, once developed, situated and trained, have an opportunity to build capacity and skill of their own to provide seamless and quality, person centered care. Although many processes will be provided to them from the prototype communities, there is much room for developing unique/local process to provide more efficient and helpful service to people. A culture of creativity must be developed and then maintained among the workers who are the most affected by the changes; a complicated balance to achieve. People are now expected to take an active role in developing new systems and processes, all focused on the person receiving services. Changing process can be a daunting task for some and values are an essential component of risk management when faced with uncertainty (Chase, 2015). Thinking about building processes in a person centered way can be challenging, especially when it means thinking about healthcare in an entirely new way. For instance, while working together on a future state pathway map, a 'box' was added to the flowchart to accommodate the current reality of waitlists for the IPTs in Prince George. A team member objected to the assumption of waitlists citing this as old system thinking. Instead, she argued, a future state of providing holistic and efficient care in a person-centered way can assume that the current waitlists are a part of the transition process and not a future reality. If people plan for a system with no waitlists, the system will find ways to bring this new perspective to fruition. If they plan for waitlist, they will remain the reality. Other challenges involved shifting focus to place the person's needs before the needs of the organization and truly include the person or client as an active participant in driving their care. These examples all require a shift of culture for both

workers and people receiving service, and require the need for ongoing learning of new roles and new skills. Time and space must be made for people to figure out how they will move forward in their role, and how they will manage their own environments within the IPTs. Beyond the standardized tools and procedures, it is left to the individual teams to evolve to be more efficient and effective. The goal is to encourage workers to remain in their positions long term, thereby stabilizing the entire system. People bonding together through collective problem solving and over time, establish routines, and develop feelings of ownership, pride and a sense of accomplishment. This will help create the change in attitude.

Organizational restructuring. Northern Health's systematic management was traditionally built to minimize risk. People and work streams are in siloes to produce efficiency and reliability. In Northern Health, communication historically travelled from the top of the organization to the bottom and back up again, but rarely across the separate silos. Information was typically provided or reintroduced to the Executive by way of formal process such as briefing notes, meant to inform and open dialogue. Discussion then contributed to either a decision to request further information, undertake or deny the request. The process was repeated until it was successfully resolved or dropped altogether. This structure is slow to move, communicate or make change (Kotter, 2014) and in response, Northern Health is changing their model of care across their three regions. As the move progresses, communication and problem solving will be unique to the regions and often fast paced. The model of person centered care must balance standardization with autonomy, allowing regions and remote areas to be unique in their approach to change.

Restructuring creates a culture of change and growth throughout the organization. In August, 2015, the role and function of the Integrated Health Care Steering Committee and the

Current VS future

(Creating a network)
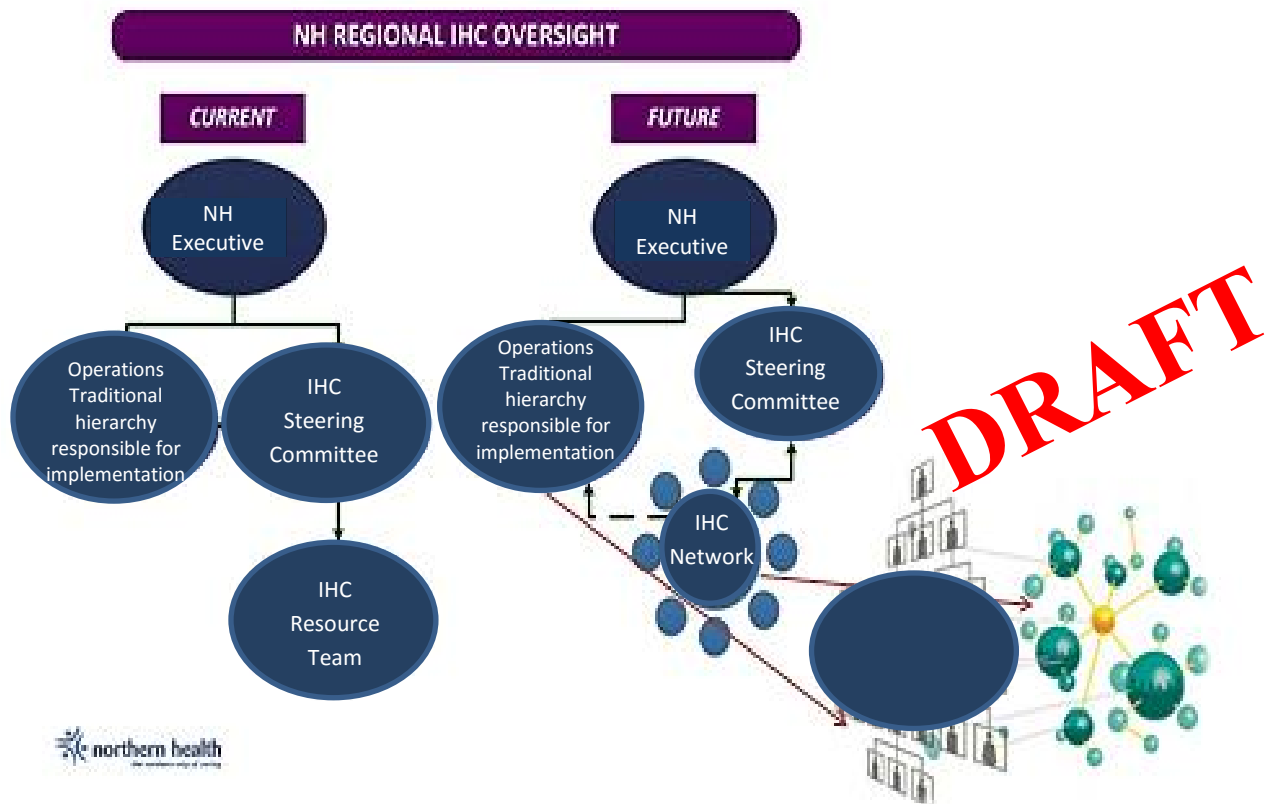
Figure 7. First draft of Integrated Health Care Oversight

Figure 7. (Northern Health, 2015)

Regional Resource Team was reviewed and Northern Health moved toward a structure that

would allow decisions to be made more quickly and more often at the local or HSDA level.

Having three distinct regions within the Northern Health Authority allowed a greater degree of

local operation and decision-making for individual health facilities, however it also left Health

Service Delivery Areas (HSDA) limited autonomy in structure and process. Depending upon the

needs and capacity in their area, this had the potential to create competition and animosity

regarding attention of Regional Leadership. The goal is to create the best balance to allow

autonomy within the regions without compromising person centered care practice. Among the

many examples of successful partnerships, one such model of excellence can be found in the

Southcentral Foundation, an Alaska Native-owned, nonprofit health care organization serving

nearly 65,000 Alaska Native and American Indian people (Southcentral Foundation, n.d.). As a

suggested reading, this website provided a historical overview of how their system came to be

and person centered philosophies worth incorporated in our own experience. In 1999, an

agreement was signed to take over ownership and management of the Alaska Native Medical

Center, instituting a system-wide transformation of care (Southcentral Foundation, n.d.).

Working from the premise that Alaska Native people are in charge of designing and delivering

health care, their vision included a Native Community that enjoys physical, mental, emotional

and spiritual wellness (Southcentral Foundation, n.d.). Their mission is unique in that it

combines the mission and vision of Southcentral Foundation with the Alaska Native Tribal

Health Consortium (Southcentral Foundation, n.d.).

New process and functioning. The structure proposed to and accepted by Northern

Health's Executive in September, 2015 consists of the Executive Committee, Steering

Committee, HDSA Implementation committee and finally HSDDA Networks (see Figure 7).

This working copy, as of July 17th 2015, shows how people within Northern Health have been

organized differently (see Figure 7) with different scopes of practice. For example, the Steering

Committee reduced their core membership and is now the Leadership Rapid Action Team, found

within the IHC Network. Their role is to oversee the strategic implementation plan, addressing

issues related to the implementation, structural changes, interim solutions and change

management, bringing people to their table for discussion and input as needed. The meetings,

chaired to ensure people are working from within the new framework, entail weekly 'huddles' for 30 minutes to help keep pace with the changes to date. Since the Leadership Rapid Action Group is working without agendas or formal minutes, a tried and tested 'standing items' format was applied to enable the priorities of the organization be met. This format allows such items as change management to be addressed on a regular basis. As the team oversees the identification of barriers, it ensures solutions are proposed, tried, monitored and documented. In addition, they oversee decisions regarding standardization and variation, capturing processes to enable comparability and regional resolutions. Plan, Do, Study, Act (PDSA) cycles travel from a Team Lead to their Health Service Administrator, and then to the regional Chief Operating Officer. Any items with a regional impact, such as a mental health service pathway are forwarded to the Leadership Rapid Action Team for removal of barriers and decisions before moving forward with standardization of processes. Transitioning to the new system, this communication pathway will change to pursue PDSA cycles occurring 'as needed', moving through the system, only going as far as necessary to be resolved. Throughout this process, people have also been tasked with asking questions to thoughtfully disrupt old processes and patterns of thinking, and celebrate by communicating successes to the whole of the organization.

The Resource Team stopped their current format and reorganized as a part of the Regional Integration Networks (See Figure 7). The networks (see Figure 7) are a newly developed entity, meant to identify barriers and issues experienced by the IPTs, proposing solutions with a focus on innovation and creativity. They propose change to functions, processes and roles, to redesign services while focusing on the needs of the IPTs and the people receiving services. They then review results of rapid improvement cycles to determine areas to standardize and share regionally. This restructuring is important to support the rate the change will occur

once the entire health authority becomes involved.   Again, it is important for this group to

disrupt old processes while attending to 'work-arounds' and rationales in pursuit of quality

integrated care. Further networks (see Figure 7) will evolve by common topic or locale and

although it has yet to be determined who will make up any given network, one will be created to

ensure the flow of information from the Health Service Delivery Area Integration Networks to

the Rapid Action Team (personal communication, July 17, 2015). In line with this structure

change, there was a recent direction for regional leads to make emergent decisions as needed at

an HSDA level while moving forward with implementing integrated teams. Decisions being

tracked at this level will be assessed for standardization or 'lessons learned' before forwarding to

the Network to determine the impact to the rest of the organization. This new structure differs

from the 'army' Kotter (2014) describes, as there may not be sufficient 'champions' within all

levels of Northern Health with enough power, influence or both to drive the culture to change.

The new system loses much of the flavor of Kotter who sees the networks as having members

from across the levels of the organization and driven by the bottom up (Kotter, 2014). If the

culture does not shift, however and this group does not feel they have the power to make

decisions, the system has the potential of becoming even more bogged down (Kotter, 2014). As

stated by Mr. Simpson (personal communication, July 17, 2015), every organizational structure

can succeed and every structure can fail, depending on the people running it. The players also

have to be inspired to take risk, be innovative and create the

process for themselves (Kotter, 2014). Change is driven by the people embedded in the change

process and will require great support to transition in a positive and helpful manner.

Northern Health's Executive recognized their system of responding was slowing the process down and recreated their communication and decision making process to be more nimble in their ability to react and make key decisions more quickly. The Chief Operating Officers and local Health Service Areas became more empowered to make decisions in order to move the work forward in a community. The project leads were enabled to focus more time, resources and attention on operational implementation at their local level, to be a resource to the networks, pulling new teams together and liaising with the Regional Lead Rapid Action Team for support. One challenge includes to managing, tracking, testing and standardizing processes across the Health Authority. Another challenge involves the necessary culture shift within all levels of the organization. The current shift of structure and processes, in response to their inability to meet the current needs, shows a level of commitment from Northern Health to respond to the ever-changing environment. Once the system has moved to a model of integrated primary care, Northern Health may no longer have the same silos or divisions of care, but precisely how the system will look or operate will be an evolving process, dependent upon the actions and hard work of the people working within the change process.

Information management and technology services and systems within Northern Health have grown and changed over the years, resulting in different and only partially connected systems across the health sector. According to British Columbia Ministry of Health (2015), a strategic challenge affecting transition to integrated care is the multiple, loosely connected clinical information systems and a lack of provincial clinical information standards (British Columbia Ministry of Health, 2015). Recommendations from the Ministry include establishing a sector-wide health information exchange and governance to oversee and guide ITS transformation in all areas of health to prioritize the standardization of clinical processes and

exchanges of health information (British Columbia Ministry of Health, 2015). There is currently little standardization across the Health Authority in regard to the multiple Electronic Medical Records. These EMRs are used by a variety of departments in a variety of communities across Northern Health, all with their own particular systems of providing care, keeping records and sharing information. The information is 'owned' by the electronic medical record, necessitating formal sharing agreements to ensure Northern Health access to share pertinent medical information as needed for continuity of care purposes.

The main ITS concerns moving forward include mandatory reporting requirements and how best to share information, including remote access capabilities, all while ensuring the system is functional and secure throughout the entire Health Authority. All 26 communities throughout Northern Health will be using a clinical documentation exchange system to securely transfer information as necessary. The current care plan within MOIS, the Primary Care EMR, was designed for physician use and is not yet adequate for team use, as it lacks a holistic, team perspective. Northern Health is committed to 'upgrade' to better meet the needs of the IPT, but must first see the entire Health Authority up and running with a basic, yet compatible electronic medical record. Any upgrade to include such items as a better care plan will wait to be addressed after all communities throughout the health authority are transitioned.

The size and complexity of this change process will result in a long transition period. This system will be built over the next 3-5 years, yet the transformative change is occurring now, leaving ITS concerned with both the scope of the work yet to be done. Timing is extremely important as ITS can only focus on one priority at a time, their capacity is limited, and they must be given direction from the organization before they can begin to move. There are limitations to what ITS and their suppliers are capable of delivering and a concern that once communities

begin to transition, they will be inundated with ITS requests without proper direction to prioritize. They also must balance their creativity with the management of priorities, standardizing the use of MOIS across the regions. The drawbacks to this approach is that it is labor intensive and includes risk associated with mandatory reporting requirements, duplication of reporting, and mandatory statistic gathering for the BC Government. For example, Northern Health Mental Health and Addictions have chosen to duplicate their charting in order to maintain their other mandatory reporting requirements built into their current EMR until an alternate system is built to accurately capture the date. This will slow down the entire process of integration but will enable the change process to continue.

Northern Health has long been grappling with standardizing their electronic medical record system throughout the Health Authority at the cost of losing mandatory reporting requirements or creating duplication of charting for workers. By August, 2015, Northern Health remained in conversation with the Ministry of Health and other governing bodies as to how to manage all mandatory reporting requirements. The implications of making choices now that for years to come, will dramatically affect the manner in which information is collected, shared and used can be an overwhelming prospect. Eventually the decisions must be made and the consequences lived with. By the end of the practicum, Northern Health had finalized the decision to transition to Medical Office Information System (MOIS) and/ or Integrated Community Clinical Information System (ICCIS) (now renamed Community MOIS) (See Figure 8). These two electronic medical record systems are already being used by many physicians in the Health Authority and are compatible with each other. Meeting physicians where they are at currently encourages engagement and 'buy-in' to the change process which is integral to facilitate moving forward together as a health authority. The success of this complex transformational change

process relies on the electronic medical record systems being aligned for reporting, information

sharing and privacy needs. The three regions are unique in their approach to the change process

and every community unique in their capacity to provide health care to the local population.

The Role of Social Work within Transformational Change

The Role of social work is at the heart of this report and at the very nature of creating

transformational change relies on the values, skills and abilities, inherent to social work. By

participating in the change management process, I was able to confirm there is a legitimate place

for social work in the executive and leadership environments. My real growth in awareness and

insight however, was how closely aligned our traditional social work values, beliefs and skills

are with those skills and abilities needed to successfully drive transformational change. It is

imperative to understand the change process and the effect a change of this magnitude has on

people, whether within Northern Health, independent physicians and the people they serve.

While cultural values and beliefs have a significant impact on the outcome of transformational

change (Kotter, 1985 as cited in Schein, 1992), the ability to adjust to a cultural change,

including resistance to that change can affect the outcome (Spiker & Lesser, 1995; Waddell &

Sohal, 1998 as cited in Schein, 1992). Relationships between people are an important vehicle for

change (NASW, 2008) and strengthening relationships will promote and restore the wellbeing of

individuals, families, social groups, organizations and communities looking to achieve optimum

psychological and social functioning (Social Workers Act, 1998). There is a distinct need to

bring people together, to create integrated teams with workers who are currently entrenched in

separate silos to promote the person centered perspective (Pullen-Sansfacon and Ward, 2014).

Facilitating change in practice requires an informed, caring, value based social work skills and

cohesive leadership at all levels (Littrell, 2011). Social workers can contribute to the IPT by

drawing upon group work principles, formed by the values and culture of social work and crucial to successful team cohesion (Gray et al., 2008 as cited in Pullen-Sansfacon and Ward, 2014).

      The People Side of Change. According to Hiatt and Casey, (2012), managing the people side of change includes competency in leadership, allowing the organization to respond to changing conditions to enable growth and profit. The structure of the system will be developed by the organization, but how the care is delivered and how workers choose to build their new environments will determine the ultimate outcome of the transformation. In some cases, people will physically move to a new location and begin training to work within their full scope of practice necessitating a need to let go of old process and create new, more person centered approaches. For most people, this will require a mental shift, letting go of traditional ways and embracing a new approach and focus. Learning new interventions will require training or retraining to reach full scope of practice also requires a mental shift. To move the change forward, the culture of the people throughout the organization must first align and then adjust. For those entrenched in their way of practicing the existing medical model this is a difficult endeavor. Change can be difficult to cope with and people often require help and support to manage the necessary shift in thinking and attitude. Helping people to think and act in a person centered manner is a role meant for social work as it is founded on and informed by a specific value base (IFSW, 2000), influencing how people think about providing person centered care is value driven. Restructuring the entire system is imperative to successfully changing how people provide care and approach their work. Changing processes and clarifying new roles allows people to become excited about creating a new and better way of providing services. It is an opportunity to engage people to be an active participant but if this group does not feel they have

the power to make decisions, the culture will not shift, and without a culture shift, the system has the potential of becoming even more bogged down (Kotter, 2014).

Change management requires understanding both internal and external aspects of the change process and must be managed as people are led through a transformational change process. A key point to consider while changing structure is to answer the question "Will this better serve the people?" and according to Simpson, if the answer is 'yes', then the work focusses on resolving barriers by providing testing to move forward toward standardization (personal communication, June 2, 2015). To ensure movement in the right direction, rapid responses is required while shifting concentration to include not only 'what' is done, but also questioning 'how' and 'why' it is important. This takes a person centered approach with openness to applying different processes. Altering how people think about care in a person centered way requires a culture change from the medical model to the Primary Care Model (Northern Health, 2012) and will require strong direction and leadership of the organization.

Just before the practicum placement began, the Resource Team and other leaders attended the ADKAR Change Management Training where they separated change management from project management clearly in their minds. They realized their own 'change management' was not getting enough attention, often left to compete with other projects or priorities. Thinking of the change management side of issues was a different perspective for most people, a 'mechanical' process not yet integrated into practice. Questions generated from the symposiums and forums for Public Health Nurses, Primary Care in the North East, Mental Health and Addictions and Psychiatry exemplify the need for change management with the workers directly impacted by the changes. Issues can be generalized into the following categories; What/how/when will this affect me and my job/role/function, how will we get to the idealized

state, and what exactly will that look like when we get there? People want answers as to how the new system will operate in the future. When reviewing questions generated by the various public forums, there are people working in the system feeling uninspired and powerless to evoke change. While many agree with the need for a primary care model, there is concern about how the change will affect them directly in their future work. Fear and uncertainty can be quelled with reassurance and providing accurate information. The task of providing answers to the questions helped me to understand the nature of people's trepidation for the future. It was challenging to provide an informative answer that fit within the key messages provided by Northern Health Executive. I tried to use positive language that was clear and concise, not easily misunderstood. Reflections on the Public Health Nurse symposium held in April, 2015, was a great example of the type of feedback Nurses were looking for. This response was factual, informational and genuine. Not only did it outline a future plan, but it was acknowledged that people's comfort with the current state and fear of the unknown future may cause "excitement, apprehension or resistance". This identified how everyone will be at different levels of 'readiness' for change, normalizing the issue and empathizing with people's fears, while promoting confidence and commitment to a vision of integrated health care services, where together, everyone will learn as they go. Once the Labor union discussions began however, and despite workers most affected by the change calling for more detailed communications from Northern Health Leadership, the organization, as per protocol, must refrain from direct communication with any staff member about the planned changes until discussions are complete. The representatives agreed to provide this information to staff after all the individual discussions with those affected workers have occurred, leaving the general workforce to speculate. This halt

on open communication causes increased discomfort and fear, and people begin to imagine the worst with limited communication but will improve in time.

Change begins with people and relies on people to be successful. There is a place for traditional social work values and skills to promote people to make positive movement forward through, what often is a difficult time managing change. We can all appreciate having people in our midst who can really listen to us and guide us toward exploring different perspectives and accepting new ways of thinking and doing. This speaks to people working at all levels of the change process, from those providing direct services to people receiving care, and those at the top Executive levels of the organization. The change will forever impact how we do our work within the IPT environments. This is an opportunity to encourage person centered philosophy and practice, throughout all levels of the organization. While assisting with the rewriting of the various IPT job descriptions, I had the opportunity to edit the wording to person centered language, adding strength based statements and ensuring team based care was reflected throughout. The language used in these documents are important, specifically to emphasize a person centered perspective, forever shaping how people approach their work.

Leading People through Change. Leadership and Management, while both essential, are different and the difference not always well understood. Management helps organizations produce reliable, efficient and predictable results and involves planning, budgeting, and providing policies and procedures to guide action, and measure results (Saleeby et al., 2014). On the other hand, leaders create an environment to promote and host conversations, inspiring innovation and solutions to emerge (Saleeby et al., 2014). They can be found throughout many situations and levels of the organization. In Northern Health, transformational leadership begins in the Executive and Leadership levels. This transformation to a new approach to health care

requires strong transformational leadership to help move the entire system though this formidable process. Positive attitudes with a genuine belief in the direction of the organizational change must permeate all teams throughout the regions, further complicated considering the unique geographical and population factors affecting medical service delivery in the northern regions of British Columbia (Peters et al., 2010).

The current confusion and angst amongst Northern Health workers regarding when and how primary care is going to unfold causes stress that can be felt throughout all levels of the Northern Health system. The main challenges of the organizational leaders include guiding workers to shift their thinking, actions and attitude, moving them from "ego-system awareness" or a focus on the individual, to an "eco –system" reality of the organization (Sharmer & Kaufer, 2013). The people within an organization must realize they are a part of a larger system and begin to understand the issues from a broader perspective (Senge et al., 2015). Transformational leadership theory focuses on the collective of the society, where the leader influences the team through the use of charisma, having a vision and inspiring intellectual stimulation regarding the well-being of others, the organization, and society (Bass, 1999). As an example of transformational leadership, Mr. Simpson, Practicum Supervisor, has an ability to set the tone in a room, allowing a safe place for people to bring their perspectives to the table, probe deeper discussion, all while pulling information together to provide a broad, shared vision for all. He used light humor and his interactions have a way of putting people at ease, instilling a sense of humanity and therefore trust to the moment. Ms. Gunn, Vice President, Primary and Community Care and Clinical Programs, admires Mr. Simpson's (practicum supervisor) 'gift' of being able to coach people to move toward innovative new world solutions, allowing them to begin at a novice stage, supporting them to build their competence and confidence (meeting

communication, May 22, 2015). Transformational leadership must also be strong enough to resist people continuing to work in traditional ways. Systems have been there a long time and resistance to changing any process is apt to occur. It demands an open mind and heart to respond to rigid assumptions and agendas (Sharmer & Kaufer, 2013) as well as an ability to create space for people to come together, learn and explore through generative conversation, allowing the collective wisdom to emerge (Senge et al., 2015). While resistance to change is a normal response, successful management of the people side of change enables growth and profit (Pullen-Sansfacon and Ward, 2014). Mr. Simpson's group process skills demonstrated this when he reworked the meeting agenda to maintain control over the direction the discussion went with the Psychiatrist forum.

The Executive Committee of Northern Health strives to use a model of participatory leadership as an organizational change concept (Saleeby et al., 2014). This approach engages key team members to be architects in the process to create the future of the organization (Saleeby et al., 2014). Just as the people receiving care are active members of the team in team based care, so too are Northern Health team members active in their change process. People have to rely on each other to do a good job and allow mistakes to happen, but it is difficult for people to take the risk of losing information or not doing things 'right' the first time. Some professionals are concerned about how information will travel back and forth with the proposed system, others with how the information will be tracked across the region and still others, by the overwhelming volume of workload anticipated. Roles are becoming more unclear and people are looking for direction, unsure of the future. This uncertainty is understood as a by-product of the change process, yet is difficult to manage as people may lose sight of the value in their work. (Senge et al., 2015). Leaders in Northern Health have been formally reassured to encourage innovation

and creativity as they enter into this phase of redesigning how care and services are provided. Giving people direction, but also the permission to do things differently is important in such a traditional setting (Senge et al., 2015). Strong, supportive relationships are of utmost importance to maintaining a profound commitment to a holistic perspective about health and over time, these mentoring relationships will nurture similar thinking and behavior in others (Senge et al., 2015).

Managers are looking for cultural support and development to enable them to create space for everyone to do things differently, to help move their workers through the change process. Two common barriers to team based care, experienced by current interdisciplinary teams include change management and communication, due, in part, to difficulty with the coordination of change throughout the regions and the required shift in cultural norms. Restraints on open communication during union discussions had an immediate impact on those providing services, leaving people unsure of the direction forward.

According to the Guidelines for Ethical Practice (2005), Social workers function to improve policies, procedures and practices, informing administrators of their ethical responsibilities. They encourage employers to remove barriers to ethical practice and strive to promote effective teamwork and communication. Change management and communication are areas where Social workers have training and experience, if not within transformational change, then within helping field. Social work has the fundamental helping skills transferable to assist those workers around them to adapt to change and promote good communication at all levels. There is also a place for Social workers at the head of the table to be reaching beyond those who share social work values and perspectives, to engage those with different values and viewpoints (Elizabeth J. Clark, NASW News, 2007 as cited in Scott and Scott, 2011).

Implications for professional practice. Northern Health Authority is going to be under

tremendous pressure during what could be a very long transition period and the need for Social

work value driven support is vast throughout the organization. The creation of new ways of

working in a generalist manner requires systematic retraining and ongoing support, to both

upgrade skill and to adjust to the changes experienced by teams. Prototype communities continue

to report stress and uncertainty, six years into their process, still grappling with how to form their

team to work in a cohesive and beneficial manner. Working closely with physicians as part of

Figure 8. Northern Health Future Vision of Integration Community Clinical Information Systems
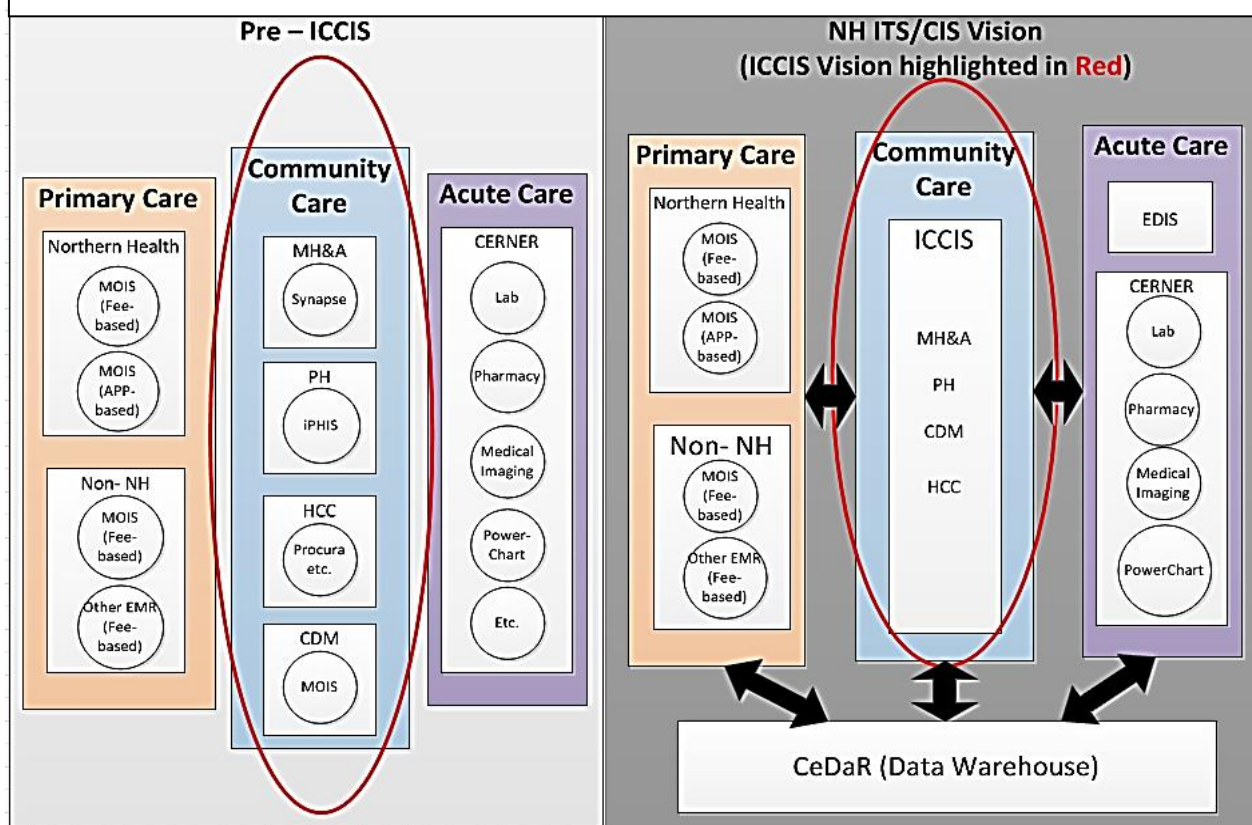
Figure 8. Northern Health Future Vision of Integration Community Clinical Information Systems, comparing past and future structure. The dark arrow depicts how the flow of information has the ability to travel between silos. ICCIS quickly became renamed to "Community MOIS". Northern Health, 2015

the integrated team is new and uncertain for everyone involved. Both team members and

physicians need support to build meaningful relationships and systems of doing business

together. Many details must come together over three vast regions with people working together toward a new way of doing business. Movement forward must be slow and thoughtful, with adequate plans in place to both understand and respond to resistance at all levels, as at no time can care be compromised.

Despite the need for person centered care being integral to the successful health care system, few health providers are properly prepared or trained in this area, leaving a gap between policy and service delivery (World Health Organization, 2008). Doctors and Nurses are trained to respond to medical issues based on a medical model of care, and although they realize the need for this psycho/social piece of treatment, they may not have the skill set to manage these aspects of the holistic approach. They may also be restricted by time and space, or lack a connection to the community resources. The ability to rely on a Social worker to complete this piece of care is ideal, yet access to social work can be problematic, especially within the outer regions, where access to resources and skill capacity vary widely (Schmidt & Klein, 2004). The teams working in the Lakes District, for instance, have had no access to social work for some time, leaving important work to fall to other team members to resolve (Raquel, personal conversation, August 7, 2015). This is an important gap to understand for that region. A social work perspective would help teach and model the values and ethical thinking behind providing value driven person centered care and could assist this region with group cohesion and relationship repair.
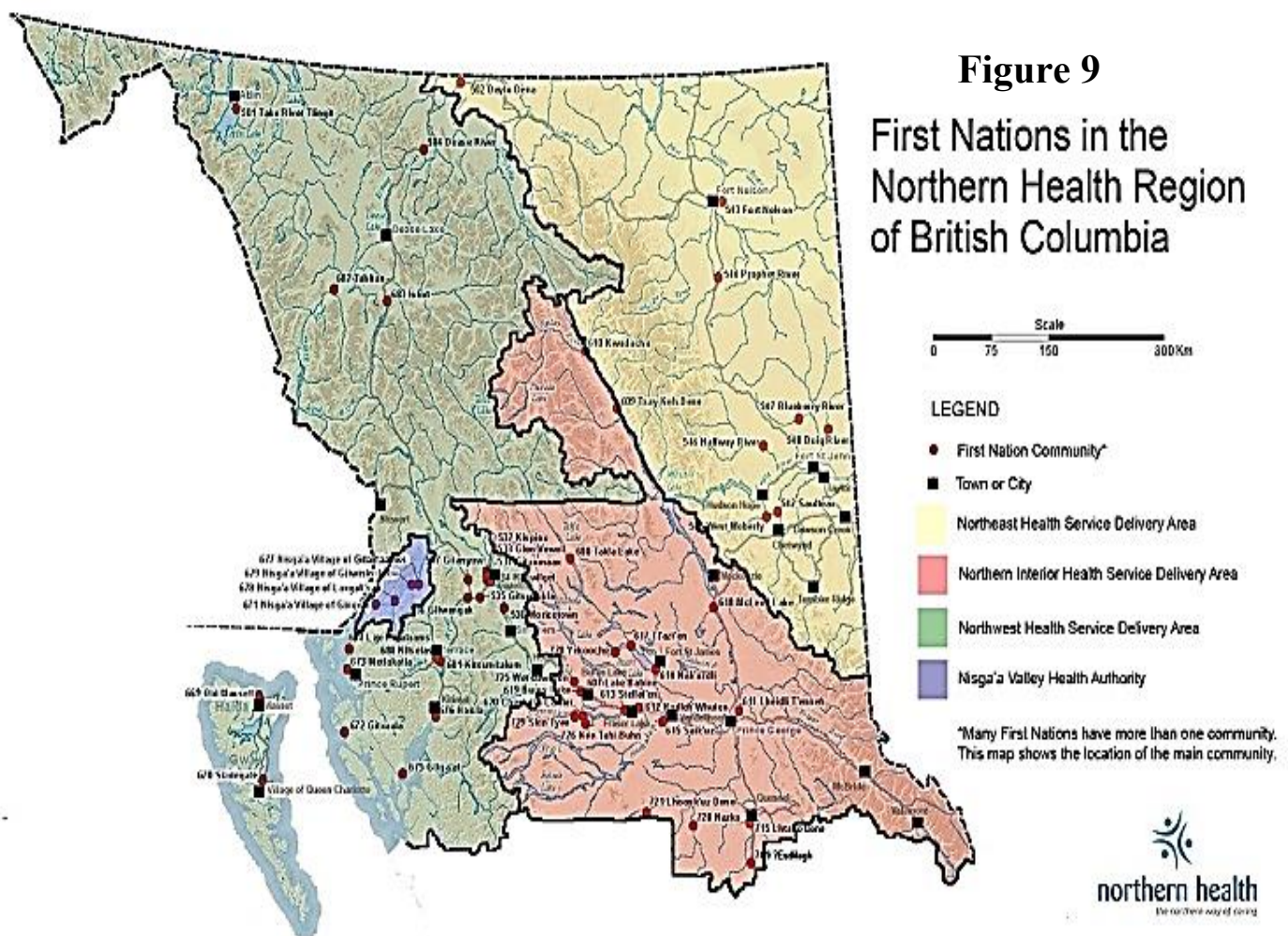
The application of social work skills in group dynamics and communication are useful in dealing with such challenges as resistance and are transferable to apply to team work (Guzzo and Dickson (1996, cited in Robotham, 2008, and Trevithick, 2005 and Preston-Shoot,2007, cited in Pullen-Sansfac on and Ward, 2014). Other skills observed, inherent to social work training

include active listening skills, relationship building and motivation skills and responding to

resistance. Resistance to change impacts the moral climate within the organization and the

values and culture of the organization, impacting the reaction to change (Danisman, 2010).   It is

important to also consider social work skills and values as being connected to information and

technology systems. Social workers can play an integral role in learning how to properly use

information technology accessible to them, not only to provide good data, but as a vehicle to

drive personalized and ethically based care forward. The potential for improved information

technology, according to Simpson (personal communication, August 7, 2015), could begin to

have a diagnostic function, identifying groups of individuals or communities with needs that

require an educational approach to change behavior and improve health. In time, it will be useful

to provide enough clinical information to guide the intervention or treatment of the individual,

addressing health in general, including mental health (M. Simpson, personal communication,

August 7, 2015).

In thinking about the skills needed to respond to the people within the transformational

change process, I am struck by how closely interpersonal skills, inherent to social work, can be

translated throughout the various levels of an entire Health Authority. I have begun looking

differently at any meeting as a 'group' and watching for value driven, interpersonal interventions

working alongside the business style or medical model of running meetings. I have gained more

confidence in asserting my skills within a team or management arena instead of simply in a client

setting. There is a legitimate role for my value driven clinical skills to be used effectively within

any interprofesional team and particularly for leadership positions supporting people through a

major change process. IPTs will be springing up all over Northern Health and social work has a

part to play in supporting people along the way. It is imperative that social work values and

skills are represented at all levels of the organization as social work also has a role to play in

policy and practice development. The policy change to working within a person centered care

model is just one example of where social work values, ethics and skills are invaluable to foster

in those providing direct care.

Social policy development. Northern Health's boundaries encompass a wide variety of cultures

and norms, including the many First Nations territories (See Figure 9) and several remote

Figure 9

First Nations in the
Northern Health Region
of British Columbia

LEGEND

● First Nation Community*

■ Town or City

Northeast Health Service Delivery Area

Northern Interior Health Service Delivery Area

Northwest Health Service Delivery Area

Nisga'a Valley Health Authority

*Many First Nations have more than one community.
This map shows the location of the main community.

northern health

communities with limited access to services. There is continued interest to address the wide variety of challenges and adopt strategies to improve access to health care in rural and remote communities but Northern Health's capacity to respond to the unique needs of these communities is limited. Further research is needed to establish the best paths forward to ensure strong, unique approaches to people living and working in these remote northern regions. The Innovation and Change Agenda provides an overarching framework for coordinated action, laying the foundation for the establishment of a First Nations Health Authority to close health gaps for Aboriginal peoples. Comparing the Northern Health mandate, mission and values with those of First Nations Health Authority, the latter is much more focused on person centered care versus focusing on service/performance. It uses 'us and we' language in context of 'people', measuring outcomes by way of the people's health and satisfaction with services. Northern Health is dedicated to patient centered care and is looking to others who can help lead them in their work with collaborating with aboriginal people within the Health Authority.

Northern Health is actively studying this system for their future plans with partnering more formally with the local First Nations. The current systems, while not yet working formally together, do co-exist and both Northern Health and the Non-profits are learning from each other in hopes of future information sharing and cohesive, team based care. Nak'azdli, a non-treaty First Nation of 700 members on Reserve, next to Fort St. James is a current example of a First Nation working alongside Northern Health. Using a not for profit model, Nak'azdli has created its own Health Centre with a Nurse practitioner, two Nurses and visiting professionals, with many volunteers coming together to help their system work. Another example of a not-for-profit structure is in Hazelton, BC where the United Church owns the patient data of the agency providing the services. To formalize any true partnerships or sharing agreements in these

outlying and remote areas, there must first be a balance agreed upon between autonomy and standardization. With First Nations leading the way, the place for social work will arise again once this journey to partnership is pursued and developed.

Community based services compliment and augment the integrated primary health care approach by providing specialized and targeted services (Clapton et al., 2008), yet community agencies are also not yet a part of Northern Health's transformational change. This is recognized as an important aspect to add on in the future. When information can be more freely shared amongst coordinated and integrated services, people will experience a higher quality of person centered care that is more efficient and easier for the person to navigate (Clapton et al., 2008). Here in northern British Columbia, social workers are often generalists, used to resolving service gaps as they arise and are a natural fit to lead this work as they often already have a connection to resources within their community and have a culture of navigating all systems available to them. As a long-time resident of Prince George, with a strong background in the Non-Profit Sector, it is important for me to provide knowledgeable leadership to the future inclusion of community partners. Information sharing with these agencies would further enhance the quality of care provided and help build our community together

The review of research of an integrated primary health care team approach, conducted by Northern Health, show that IPTs are both effective and cost effective. A deeper review and assessment of the dynamics of dispersed teams and leadership qualities involved in transformational change is necessary for teams to flourish (Allen & Vakalahi, 2013). Little is known still, specific to the role and effect of organizational leadership and managerial decision making within interprofessional practice (Conference Board of Canada, 2012), leaving a need to capture organizational data to assess team functioning at all levels, as well as the impact on

health and economic outcomes. In shifting this culture of the organization, there is a need to

question decisions and rationale along the way, thereby encouraging new ideas and innovative

solutions while creating new processes.   This will require a genuine passion for the work and an

ability to engage people in a manner that instills trust and confidence to try new approaches.

Social work could have a positive effect on policy development, ensuring person centered

practices and the people side of change is prioritized.

Working with Physicians. Physicians are a key component to the success of this

transformative change and moving to a model of patient centered care relies heavily upon the

leadership of physicians. In the letter addressed to Terry Lake, BC's Minister of Health, Premier

Clarke (2015) highlights the mandate of the Ministry of Health 2015-16 and includes the

following direction:

> "Work with the Doctors of BC, College of Physicians and Surgeons, College of
>
> Registered Nurses and the Association of BC Nurse Practitioners, to continue to
>
> strengthen primary care access for British Columbia patients across the province
>
> including the addition of new physicians and Nurse practitioners".

Knowing when and how to engage with physicians is fundamental. Each region is

protective over what they are doing and doctors and others want to be consulted 'with' not

directed 'to' (P. Murray, personal communication, June 7, 2015). The team is reminded to be

aware of 'top down' communication and direction, to listen carefully to the communities and to

be respectful of their current service patterns and trends (P. Murray, personal communication,

June 7, 2015). There is a continued need for Physician 'champions' throughout all levels of the

system, who can help translate information from the Executive, to and from physicians. While

their involvement is integral to changing the system, physicians bring their own level of power,

adding to the complexity of the current changes (L. Holland, personal communication, August

12, 2015). There is a persistent, re-occurring struggle to balance local and professional

autonomy with the need for standardization across the organization. To balance flexibility with

standardization, both within and outside Northern Health, integrated primary health care services

work in partnership with the Divisions of Family Practice, who commit to supporting physicians

until they are ready to join the systematic change to integrated primary care (O. Godwin,

personal communication, August 13, 2015). According to the Executive Director of Divisions,

Ms. Godwin, being a Social worker plays a strong role in the position of leadership within the

Divisions (O. Godwin, personal communication, August 13, 2015). Bringing fundamental social

work values and systems thinking to her present work promotes change to happen more quickly

and efficiently, as she uses her group facilitation and conflict resolution skills to resolve

interpersonal and team tensions. (O. Godwin, personal communication, August 13, 2015). The

Executive Director sees another struggle involving physicians and Nurses, who often find

themselves responding to perceived notions of their power and authority and the cultural norms

within the health care discipline (Conference Board of Canada, 2012). The medical model,

rooted in hierarchy and formal processes, becomes especially problematic with respect to Nurses

and their relationship with doctors (O. Godwin, personal communication, August 13, 2015).

These norms are deeply entrenched and can be detrimental to the working relationship and team

environment, causing tension and animosity (O. Godwin, personal communication, August 13,

2015). This relationship dynamic is in need of healing, or team based care may be in jeopardy

(O. Godwin, personal communication, August 13, 2015). According to Godwin (2015), there is

a role for social workers to help team members to "unpack" their historical issues and explore a

healthier understanding of their roles and expectations, to demystify them and move past these historical issues.

Primary health care services, the first and most common point of entry into the health care system (Conference Board of Canada, 2013), yet physicians are often unprepared and untrained in addressing the wide scope of needs people present with. These might include the psychological and social aspects of care, and the broader health issues such as child welfare, homelessness, and poverty (Canadian Association of Social Workers, n.d.). On the current integrated teams, social workers help physicians take on these 'soft skill' interventions, adding value to the Physician's practice, given their expertise in navigating the financial, social, and mental health and addiction systems, both within the health authority and within the local communities.

Just as physicians are imperative to integrated primary care, Psychiatrists are key members in the redesign of Mental Health & Addictions services. As integrated primary care teams are being asked to take an active role in developing the system as they go, Psychiatrists are being asked to help with the process of determining function of the IPT specialty services. Clinical pathways for people and information to travel from primary care homes to Psychiatry, MH&A specialized services and back again must be defined and processes standardized, including any screening and assessment tools. The Psychiatrists generally see the benefits of primary care, but have grave concerns for their most seriously ill people falling through the cracks of this model. This particular group of Psychiatrists is resistant to the proposed changes and shares a history of protecting specialty services. Providing good leadership to this strong voice is imperative, as the system is already moving forward with change so the time for negotiation is past and time for planning and creating has arrived. The Mental Health and

Addiction open forum held August 6, 2015 was an important first step to begin to engage this

group of professionals and find ways to work together to change the system. The process of

hosting this forum was informed by Mr. Mike Simpson, a social worker with extensive training

in such areas as group dynamics and group facilitation. Such skills in leadership and group

dynamics were invaluable in directing the conversation and understanding the issues from

multiple and differing perspectives to one big picture. For example, in the planning stage the

agenda was reframed to allow speakers to discuss 'how' the system will be built, instead of 'if'

or 'why' the change is occurring (M. Simpson, personal communication, June 2, 2015).

Knowing the historical context of a group provided crucial information to move this group

forward. The forum was chosen to be professionally facilitated to remove Northern Health

Executive from directly telling the Psychiatrists what to do and instead encourage open and

honest dialogue to move forward together (M. Simpson, personal communication, August 6,

2015). In this case, it made better sense to approach this meeting as an informational session,

providing informational updates of how they are moving through changes, rather than trying to

buy the group into a concept which is already adopted (M. Simpson, personal communication,

August 6, 2015). Maintaining a tight agenda, with an unbiased facilitator allowed group

members an opportunity to have their concerns heard, minimize backlash and promote cohesion

with the broader perspective. Generalizing the same particular message as the other specialty

services including chronic disease, reminds the group they are part of the bigger picture of

change occurring across the entire NHA (M. Simpson, personal communication, August 6,

2015). This perspective shift is important as the culture of the system must move to one of

integration, sharing information and becoming truly person centered instead of system centered.

Integrated primary health care teams. Professional team based care works with individuals and their families who are respected as integral to the change process, through partnership and collaboration, improving patient experience, provider satisfaction and long term cost sustainability (Northern Health, 2015). As workers move from the current model of care into interprofessional primary health care teams, they will become a part of a community based team, supporting a physician's practice. One such team in Prince George is situated in an old elementary school, where Northern Health offices provide a home base for the current and future IPTs. As teams form in different locations throughout the health authority, office and primary care home space must be found and secured, before designing systems to accommodate a shared electronic medical record and with remote access. Near the end of the practicum, I had the opportunity to shadow an IPT social worker who is a part of a seasoned interprofessional team, leading the way in the change process. I saw the team in action, joining their morning 'huddle' to review new referrals and discuss any complex issues. I heard the different perspectives and ideas shared amongst the nurses, the occupational therapist, the mental health clinician and the social worker and experienced the value of hearing different views. After a morning huddle, she travelled to a doctor's office downtown and conducted interviews and counseling sessions to their identified panel of people. As I joined her in her work, I observed the generalist nature of her role and was able to think about the language we used in the job descriptions and how it fit well with the expectations and realities of the role. During the one morning, I saw her involved in assisting clients with a variety of social, financial and legal issues while navigating several systems. While this particular team is strong and functional, the social worker admitted that the anticipated organizational shifts are making them nervous about how they will be affected by the system changes.

A challenge of implementation across a vast region is designing a team approach that makes sense for different local communities. IPTs will look vastly different throughout the Northern Health Authority, depending on individual community size, location, capacity and need. Health care workers living in the smaller, more remote communities are applying this integrated primary health care approach to their community within the realities of their resources, assets, skills, cultural norms and geographic location. For an example of complexity and resourcefulness, consider Tumbler Ridge, where Public Health services are now shared with Chetwynd. Remaining true to integration, these two small communities had to find the capacity to fill the public health role in both communities. The team has discovered and is testing unique 'work around' solutions for sharing resources and information. Despite the long distances and limited physician 'buy-in', the role is being shared between the two remote communities.

The pilot communities in Prince George, Fraser Lake and Fort St. John have been working within the new way for six years or more, paving the way for the current transformational shift for the remainder of the Health Authority. The teams are tired and often frustrated with the barriers they face within leadership, and have lost some trust that their work will be meaningful to those changing in the future. They continue to experience times where resolution to their barriers was much too slow, and in response, communication returned to the old systems. The team needs rapid answers to their questions, regular updates and to trust that their hard work will be used to inform future work. They worry that the processes they worked so hard to develop will be changed in the standardization process. During this practicum experience, it was necessary for Executive leadership to respond rapidly to the concerns of the Lakes Region, to build rapport and to actively listen to their concerns. This personal interaction will help resolve issues, demonstrate trust and openness to share. Once the alliances built and

trust developed with those in that region, others will see how the new network system can operate, and begin to trust in the new processes. According to Simpson (personal conversation August 7, 2015), trust is not something to build, but must be earned through action. It is not enough, therefore to change the system. People must also be invited and supported to partake in the new way, so trust can begin to develop and spread.

Given the sometimes vast shift in scope of practice, many staff will experience a completely new way of providing care and will often have to update their competencies in certain areas. Some staff will be affected vastly more than others and despite having to learn new process; the provision of care must remain both seamless and coordinated. This will produce tremendous stress throughout the system that will require ongoing interpersonal management over a long period of time. One pilot team has struggled to work through many challenges and still describe their teams as in the 'storming' stage of development (Tuckman & Jensen. 1997). This team worked very hard to build and reorganize their systems to manage the workload but never did benefit from having a social worker on the team. This means the team and the whole region have been left with inadequate social work perspective and intervention to support the changing medical model of care. Lack of role clarity, trust and overlapping skills can cause chaos within a team and without clear boundaries, people may perceive and project hierarchy of importance and/or power (Conference Board of Canada, 2012). Role ambiguity was certainly prevalent throughout the questions resulting from the public health forums. Most concerns and fear revolved around a lack of understanding their new future role within primary care teams and what they would be expected to do within their scope of practice. The reality is that the system is changing and people will learn and develop new ways as they go, making the end result dependent on the people working within it their ability to manage and shape it. This

prospect is overwhelming for some and exciting for others, so support must be available to those struggling to cope. Understanding the need to be a true stakeholder in the change process is at the core of traditional social work and is person centered. Relationship and team building skills, fundamental to group facilitation and counseling are a part of fundamental social work skills. Building trusting relationships relies heavily upon the skill of active listening, setting aside personal values and concentrating on what must occur to provide better care to the people receiving services.

Social work has much to offer both the integrated primary health care teams as well as the transformational change process to shift the way healthcare is both viewed and delivered within the Northern Health Authority. Their experience and expertise benefit, not only their immediate teams, but the transformational change process as a whole, influencing the next generation of leaders to come. Truly changing how care is provided, allowing the person to be the leader in their own care will take strong leadership and role modelling. As a social worker, the challenge of leading people through a cognitive and behavior shift sounds exciting but managing the push back and resistance to change will be a daunting task. As a leader, it will be important to encourage teams to shift their thinking, culture and behavior to provide integrated, person centered care. Without these shifts, people will quickly revert to practicing in old ways. According to Mitchell et al. (2013), the skill and reliability with which team members work together is fundamental to the success of team-based care. Mitchell et al. (2013) describes honesty, discipline, creativity, humility and curiosity as the personal values, necessary for individuals to function effectively within the team. Kotter (2014) discusses the importance of deep listening, trust and collaboration throughout the relationships within the team. According to Tafvelin et al., successful transformational leaders create environments fostering commitment

and role clarity to promote a stable organization, while support among co-workers enhances the effects of transformational leadership (2014). The role for social work speaks for itself. Strong fundamental social work skill such as group facilitation, understanding group dynamics, conflict resolution and communication promote change at both a transformative level as well as within the very team surrounding the person receiving services.

Summary

The creation and implementation of a transformational change to how healthcare is provided throughout an entire Health Authority is extremely complex and difficult to study in its entirety. Transformational change is slow moving, taking years to fully incorporate throughout the system. This practicum took place on the cusp of full implementation throughout the regions. Northern Health has now embarked on the next steps in their change process, applying an integrated primary health care approach to rural and remote regions of northern BC and expanding all existing primary care systems. The scope of the change process and the individual needs of communities and regions make this a daunting task for any organization, and given this time of initial action, the process began to move more quickly. The higher level systems within the organization, in response, changed their structures and process to accommodate the faster rate of change than they were previously able to manage. This structure may not go far enough however, to facilitate the necessary culture change toward community based and client centered care. There is a need for more of an 'army' of champions throughout the system, with either power or influence (or both) to drive the change forward in a person centered manner (Kotter, 2014). It will be interesting to see if the momentum continues as Kotter (2014) describes and if the current system can be nimble enough to respond to barriers as they arise. The culture must also now shift to allow middle managers to be free to be innovative and creative in their response

to change, refraining from operating in the old silo system. This cultural shift will influence and support the front line where the care is being provided.

There are many intertwined mechanisms that drive change of this nature forward, with different approaches and perspectives regarding how the move should transpire. The people side of change can be affected with organizational priorities overriding change management, yet change doesn't just 'happen', change begins and ends with people. To move an organization forward in a systematic way, new process and function will occur and workers must feel safe enough to take risk and learn to trust one another. Despite having skilled people working on the ground, it will still require time and space for them to adjust to their roles on the IPTs, leaving a variety of opportunities for social work to have influence over how the medical model transforms into a more client centered, helpful and efficient system. Employee resistance to change is directly tied to organizational norms and culture, trying to preserve how things are and have always been inpacting the success or failure of change efforts. (Duff and Hurtley, 2012). It is a difficult task to engage individual people to commit to systematic change; to shift their thinking from being about them personally, widening their perspective to empathize with others. It will take strong, supervisory role models throughout the system, brave enough to risk better systems with innovative solutions. Team dynamics will play a big role in how integration moves forward.

Social work has an integral role in helping the people. Pullen-Sansfaçon and Ward (2014) contend that social work in general is well suited to the task of transforming culture. They can assist people to embrace change and to take an active role in improving the level of care provided to the population. Applying social work principles to change management will support the workers as they shift their entire culture, questioning why systems are in place and

finding new processes to create more client centered systems. Client centered values drive the

guiding questions about how transformational leadership skills and attributes compare to

traditional social work values and skills. Social work values and insights are an asset to any

change process, and can be especially effective when applied to transformational leadership

roles. Social work has a significant role to play in all levels of the organization and in many

capacities during a transformational change. The implications for professional practice are far

reaching, throughout all levels of the organization. The skills applied to support necessary

culture shifts to create person centered care can be positively influenced by social work values

and ethics. This practicum experience allowed but a glimpse into an enormous system change yet

clearly demonstrated the unique and integral position social workers must contribute to the

success of an endeavor of this magnitude.

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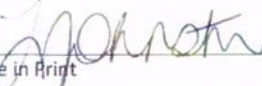   *System of Services: A common understanding* (pp. 20-28).

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