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Closing the Culture Gap: Student Language Competencies for the Assessment of Patients in a Bilingual Health Care Setting

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Abstract

In a bilingual health care institution, how can specialized practitioners improve students' administration of standardized assessments in neuropsychology to French-speaking patients in the absence of language competencies, in alignment with the cultures of both patient-centered care and efficiency? This OIP was developed for a Canadian bilingual health care institution, operating in alignment with political and legal language service and patient care obligations. However, increasing demand for services and professional language competency coupled with reduced funding has led to efficiency-focused departmental practices. Challenges in balancing a culture of efficacy and efficiency with the culture of patient-centered care and bilingualism have led to a culture gap. In this organization, specialized practitioners train students in a non-standardized manner to assess French-speaking patients, and graduate students without language competency tools or support must use clinical judgment to navigate the assessment process. This culture gap impacts the patient's experience and overall assessment results, as well as the student and specialized practitioners value congruence with the organization.

To implement change in this organization as an informal leader and teacher, I use both linear and cyclical change models that align with Symbolic Interactionism. To lead change, I use adaptive and distributed leadership styles, within an ethics of care framework. Both the implementation and leadership approaches focus on double-loop organizational learning, and participatory, stakeholder-driven change. The chosen solution targets the modification of three current organizational practices: student placement, student on-boarding, and patient assessment.

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The solution is incremental and iterative, promoting stakeholder empowerment and sustainable change, towards an organizational culture that is congruent with organizational and stakeholder values. All elements of the implementation plan, including ethical considerations, are subject to periodic study and revision. The communication strategy is tailored to each stakeholder group, and includes a questioning and appreciative approach, supporting informal leadership and development of a shared vision.

Keywords: bilingual(ism), language competency, patient-centered care, neuropsychology, culture

Executive Summary

In a bilingual health care institution, how can specialized practitioners improve students' administration of standardized assessments in neuropsychology to French-speaking patients in the absence of language competencies, in alignment with the cultures of both patient-centered care and efficiency? This OIP was developed for a Canadian bilingual health care institution, operating in alignment with political and legal language service and patient care obligations. However, increasing demand for services and professional language competency coupled with reduced funding has led to efficiency-focused departmental practices and a culture gap with regards to patient-centered care and bilingualism practices. Organization's leadership now prioritizes results greater than performance quality, to meets patient-load demands; legal service delivery requirement; and public expectations.

Within this context, specialized practitioners train graduate students in a non-standardized manner to assess patients French-speaking patients, and students without language competency tools or support (APA, 1993; APA, 2002a; APA, 2002b; Valencia-Garcia & Montoya, 2018) must use clinical judgment to navigate the assessment process. This problem of practice impacts the patients' ability to communicate and interact with students in their preferred language, with resulting impacts on the overall assessment experience and results (Altarriba & Santiago-Rivera, 1994; Gutfreund, 1990; Heredia & Altarriba, 2001; Perez-Foster, 1998; Santiago-Rivera & Altarriba, 2002; Silva, 2000).

The requirement of students to participate in these assessments without language competency tools or support may have personal and organizational negative effects (Bao, Vedina, Moodie, & Dolan, 2013; Edwards & Cable, 2009). Specialized practitioners who are

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responsible for training students in assessments may also experience the negative effects of value incongruence (Kristof, 1996) with the organizational culture.

My position of specialized practitioner holds an informal leadership position within this organization, with teaching responsibilities and specialized knowledge to support student skill development (Cawsey, Deszca, & Ingols, 2016). The OIP is written from a Complexity Theory lens, wherein leadership “does not lie in a person but rather in an interactive dynamic, within which any particular person will participate as leader or a follower at different times and for different purposes” (Lichtenstein et al., 2006, p. 3). As framed by the Interpretive paradigm and Symbolic Interactionism, leaders and followers’ interactions create meaning and influence organizational culture. Depending on the networks of created meanings between and among individuals, as well as the complex adaptation process to other influences, informal leaders may rise to formal positions as required.

To lead change in this organization, I will use adaptive and distributed leadership, following the Reflexive Adaptive Process (Stroebe et al., 2005) combined with Kotter’s (1996) 8-Step Model. Elements of the transactional leadership will be used at first (Vera & Crossan, 2004) to garner small wins (Kotter, 1996), in alignment with the current leadership culture in this organization and in field of neuropsychology. As the change process develops and evolves, elements of transformational leadership will be used to provide stakeholders with long term objectives and vision for change. Adaptive leadership will provide flexibility and balance during periods of change (Heifetz & Laurie, 2001), and is a recognized element for patient centered care, as complex situations arise and care-staff are required to quickly learn and adapt (Corazzini & Anderson, 2014). Distributed leadership is a best-practice approach to change in the Canadian health care context (Dickson, Lindstrom, Black, & Van der Gucht, 2012, p. 14), works alongside

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stakeholder needs (Precey, Entrena, & Jackson, 2013), and incorporates elements of “inclusivity, collectiveness and collaboration” (McDonald, 2014, p. 228).

The chosen solution is a cyclical approach for the modification of three current organizational practices: student placement, student on-boarding, and patient assessment. The change plan mirrors elements of the PDSA cycle (Moen & Norman, 2009) methodology with regards to built-in “study” or “check” points promoting learning and opportunities for modifications. The change plan timeline is three years, and focuses on bridging the culture gap of performance efficacy and efficiency, and the culture of bilingualism and community leadership. Implementation goals include providing students with language competency tools and support, monitoring student language competency and staff congruence with organizational culture and practices, and modifying student hiring and on-boarding guidelines based on findings.

Stakeholders will have varying reactions to change based on their values, experiences, and motivation (Cawsey et al., 2016). Communication strategies for all stakeholders will include elements of the appreciative inquiry approach (Cooperrider & Srivastva, 1987) and humble inquiry (Schein, 2013), and communication methods and frequency will be tailored to stakeholder groups. The shared vision will be supported by the adaptive and distributed leadership approaches, the advisory committee, and the project team. The advisory committee will be a voluntary committee comprised of members from the main stakeholder groups. The project team will be comprised of students and specialized practitioners, including myself, with a reporting function to the advisory committee.

Acknowledgements

First, thank you to the University of Western Ed.D. faculty and my cohort classmates for guiding me through each step of this OIP journey, gifting me with many wonderful opportunities for learning, self-reflection, and growth. Second, thank you to my friends and colleagues for the unfaltering support, patience, and encouragement. And most importantly, to my family- *merci mille fois merci.*

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Glossary of Terms

Neuropsychological assessment: a battery of standardized tests administered by a neuropsychologist or specialized practitioner to patients over several hours. Assessment results are used in combination with patient interview and medical history to determine diagnosis, treatment, and further recommendations.

Neuropsychologist: an individual with a PhD in the field of neuropsychology specializing in brain function and its impact on behaviour.

Neuropsychology: a branch of psychology that focuses on brain function and human behaviour, often in the context of injury or illness.

Patient contact time: a mandated number of hours spent interviewing or assessing a patient that a neuropsychology graduate students must fulfill in order to complete their practicum.

Specialized practitioner: a psychometrist supervised by a neuropsychologist, whose primary role is the administration and scoring of neuropsychological assessments.

Student practicum: a work-placement designed to develop competencies such as interviews, report writing, diagnosis, and neuropsychological assessments for graduate students completing their PhD in the neuropsychology department.

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Acronyms

ACO (Accountable Care Organization)

APA (American Psychological Association)

CAS (Complex Adaptive Systems)

HMHDB (Hospital Mental Health Database)

MEL (Monitoring, Evaluation, and Learning)

OIP (Organizational Improvement Plan)

ORCA (Organization's Readiness for Change)

OR4KT tool (Organizational Readiness for Knowledge Translation tool)

PDSA (Plan Do Study Act)

P-O fit (Person-Organization fit)

PoP (Problem of Practice)

QVC (Quinn's Competing Values model)

RAP (Reflexive Adaptive Process)

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Chapter 1: Introduction and Problem

Organizations are dynamic, with unique histories, foundational values, and internal and external influences that continue to shape the organizations' culture, structure and behaviours. People within the organization are equally dynamic –leaders, followers, stakeholders- playing key roles in organizational change. Chapter 1 provides an overview of the above dynamics, including the organizational context and change readiness, the diagnosis of the Problem of Practice (PoP), and a vision for leadership and approaches for organizational change, essential for the successful implementation of an Organizational Improvement Plan (OIP).

Organizational Context

The following OIP was developed for a Canadian bilingual health care organization, with high priorities placed on graduate student training, cultural competency, and patient centered care. The following section describes the organization, its history, goals and structure. It will also discuss leadership and the leadership approach in the organization.

Influencing factors. There are several influencing factors to consider for the organizational context: the political and legal requirements for health care organization in regions with a high number of Francophones to offer bilingual services; the professional practice governing bodies that the health care organizations are responsive to; the linguistic demographics of patients; recent reduced funding in health care; and the history of efficiency and effectiveness of specialized practitioners. These factors lead to the organization's leadership prioritizing results greater than performance quality, to meet patient-load demands; legal service delivery requirement; and public expectations.

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As a bilingual health care institution in Canada, the organization operates in alignment with political and legal language service and patient care obligations. At the provincial level, the organization is required to provide bilingual services in most departments. This entails the employment of staff with requisite levels of French-language skills (Official Languages Act, 1985; Province of Eastern Canada, 2018). Accordingly, many positions within the organization, including leadership positions, are classified as ‘bilingual essential’. This means that before an individual can be appointed to a position they must meet specific and measurable second language proficiency.

The organization is also a recognized facility for teaching and training future health care professionals, with strong partnerships with nearby educational institutions. Most health care professionals employed by the organization hold secondary positions as educators and researchers. As such, the organization also operates within the guidelines of health care professional governing bodies and training colleges/associations (American Psychological Association, 2002b; Canadian Psychology Association, 2000; The College of Psychologists of Eastern Canada, 2015).

Patient demographic trends in multilingualism mirror the need for bilingual patient care services. According to Statistics Canada, growth in bilingualism is in large part attributed to increases in French-speaking individuals able to conduct conversation in both official languages (Statistics Canada, 2011). According to the 2016 Census, the rate of bilingualism in Canada is 17.9%, and over half of this bilingual population have French as their mother tongue (Statistics Canada, 2017). The increasing demand for services and professional language competency is reflective of this demographic.

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In addition to the above context, healthcare organizations in Eastern Canada are recovering from past reduction in funding coupled with increased annual operating costs, while adapting to patient volume increases as a result of demographic trends (Statistics Canada 2011; 2017). A 2017 review of health care practices observed that reduced funding and higher patient loads “has resulted in the ‘off-loading’ of routine tasks” from doctors and nurses, to health care associates, which may in-turn be influencing the growth of informal leaders at the outer margins of health care organizations (Fitzgerald & McDermott, p. 109).

The PoP that will be discussed is situated within the organization’s department of neuropsychology; specifically with regards to specialized practitioners and the performance of neuropsychological assessments. Social context within this science-based and statistics focused field provides additional support to the efficiency focus. The roots of this specialized practice are found in the American Navy during World War II to increase the efficiency and speed of assessments, before subsequently moving towards practice in educational institutions and health care organizations (Malek-Ahmadi, Erickson, Puente, Pliskin, & Rock, 2012). Specialized practitioners administer a multitude of standardized assessments to patients with the goal of effectively and efficiently measuring cognitive strengths and weaknesses.

In consideration of the above discussed factors, from the institutional level to the practice of specialized practitioners, reduced funding, multiple legislative stakeholders, population trends, and a long-standing culture of efficiency in neuropsychological assessments have contributed to departmental leadership operating with a performance focus to meet patient-load demands.

Goals. The organization’s vision and values focus on the use of the latest research for optimal patient care, educational and teaching excellence for future health care professionals, and meeting the unique cultural and linguistic needs of its community. The foundational mission is

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compassionate patient centered care, and core values include teamwork, respect, and quality of care. The organization has achieved a good reputation in patient centered and quality care, recognized at the national level as being of 'exceptional standards'. The neuropsychology department has equally been recognized on multiple occasions during accreditation exercises for excellence in care and teaching/training programs. This high standard in care may be partially attributable to mandatory annual training and educational videos, and continuous community collaborations, leading to an organizational culture that champions' cultural competence (Wiseman, 2002). This reputation attracts a significant English-French bilingual population. The organization and department are also known as competitive options for students completing the practicum requirement of their PhD, attracting a highly competent graduate student body.

In line with its reputation and history as a place of learning, the organization continues to integrate and encourage research and innovation in all its departments. In the neuropsychology department, pilot programs are delivered on a rotational basis to determine relevance, efficiency, and efficacy before permanent implementation. For example, a group cognitive therapy was recently piloted, and results were tracked for a year. Based on results, the program delivery was adjusted for the following year to accommodate more group sessions over a shorter timeframe. Although support is not guaranteed, new projects, programs, and innovations are encouraged at all levels, particularly when aligned with organizational values and the efficiency focus.

Organizational history. The organization has roots in both health care and education services, as an institution of both teaching and learning, and medical care for its community. A century after it first opened, the organization became affiliated with a nearby educational institution, and began offering teaching programs in the field of neuropsychology. The neuropsychology department is one of the newer additions to the organization, and off-shoot

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programs and clinics are in continuous development. For example, an expansion of a psychology program for monitoring cognitive decline in Alzheimer patients was recently developed.

The organization has a long history within the community, and its values of cultural competence, patient centered care, and continuous improvement through research and learning continue to influence organizational strategy and mission. The organization continues to develop its relationship with educational institutions, partnering in research opportunities and offering cooperative learning and practicum programs to graduate students in a multiplicity of health care and medical settings. The organization nurtures its community ties and holds monthly interactive open-learning events over weekends and holidays for community members and family of health care personnel. Recently, there was an all-day clinic for interacting with new technology in the field of physiotherapy, open to community members and students. The organization also continues to operate as a bilingual health care center, with a mission statement that places emphasis on ability to provide tailored care for its unique community population.

Structure and leadership. The organization can be characterized as a professional bureaucracy with centralized leadership (Mintzberg, 1979), and with a hierarchical and structuralized governance structure (Vera & Crossan, 2004). The leadership culture tends towards the transactional (Vera & Crossan, 2004), due to the economic context, and results and risk-reduction foci. Decision making is largely top-down, although discussion forums and panels with management are regularly embedded in the processes of large-scale organizational changes. For example, during a 2018 change in organizational systems, management held Q&A feedback meetings twice per months to include personnel in the change process. Constructive feedback and commentary was also encouraged via the weekly newsletter, with the option to submit anonymously.

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At the organizational level, management in this health care organization is constructed based on hierarchies between different levels of health care professionals. For example, doctors often form a departmental management team, and have authority over other health care professionals, such as nurses, nurse practitioners, physiotherapists, and other medical technicians. It has been argued that this form of hybrid leadership is able “to act as boundary spanners interpreting policy requirements and translating them to improve clinical care” (Fitzgerald & McDermott, 2017, p. 111). However, health care professionals also exercise informal authority over administrative and assistive personnel.

Interdepartmentally, a collaborative leadership approach, similar to shared leadership (Pearce & Sims, 2002), is practiced between health care professional groups in order to provide a holistic ‘health care team’ approach for patients. Professional practitioners (e.g., doctors) within departments, including the neuropsychology department, maintain high levels of autonomy (Mintzberg, 1979). As shown in Figure 1, the neuropsychology professional practitioners collaborate with XY professional practitioners, who may be in the field of speech pathology, occupational therapy, or physiotherapy. Within the department, the institutional transactional leadership is mirrored between professional practitioners and support staff, where individuals in non-leadership roles play a more supportive role so that professional practitioners can in turn provide quality patient centered care. Department management provides professional practitioners, specialized practitioners, and all support staff with annual performance reviews, where both parties have the opportunity to provide feedback. For students, specialized practitioners and neuropsychology professional practitioners take on a supportive role reminiscent of the gardener leadership metaphor (Alvesson & Spicer, 2010) to guide them

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through their training curriculum, satisfying competencies and criteria set by both the governing health care bodies/associations and the organization.

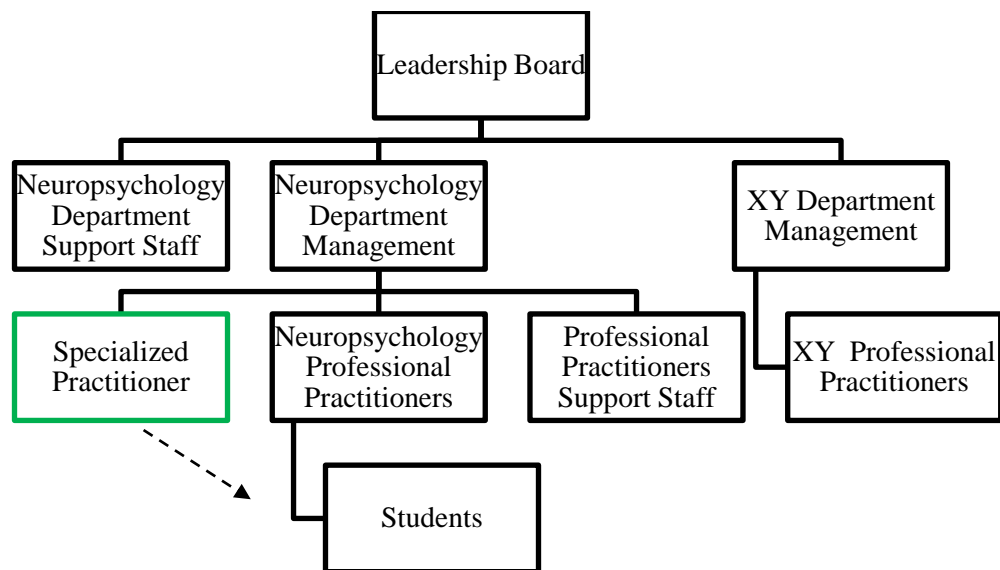


Figure 1. Organizational Chart. This figure illustrates the hierarchical governance structure of the organization, as well as the lateral autonomous practice of the Professional Practitioners.

This environment provides opportunity for informal leaders to advance appropriate and relevant initiatives, when supported by management and formal leaders at the departmental level. The autonomy of professional practitioners and reference to previous cases of pilot programs suggest requirement for higher levels of approval are context and project dependent. The existing culture of interdepartmental collaboration also supports initiatives involving multiple stakeholders and priorities, as well as shared authority with personnel members of various levels. However, potential projects must be aligned with the organization's risk-reduction and efficiency focus, while upholding the reputation for patient centered and quality care, and student teaching/training excellence.

In sum, this organization has a history of bilingualism, innovation and research, and a strong focus on providing patient centered care. A collaborative leadership approach is practiced

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interdepartmentally and transactional leadership is practiced within the department, with organizational processes emphasizing performance to meet patient-load demands.

Leadership Position and Lens Statement

The following section describes my leadership approach; the PoP and OIP theoretical approach; and the organization theoretical lens.

Personal position. My approach to leadership is value-based and founded on the following overlapping moral principles of transparency, equity, and democracy. As a fluently bilingual (French and English) specialized practitioner, with experience in private as well as public institutions, I hold an informal leadership position within this organization. Specialized practitioners have been an established part of the neuropsychology health care team in this health care institution for over twenty years. With minimal direction from the supervising neuropsychologist, they are responsible for the independent assessment of patients, as well as for the teaching and training of PhD students in neuropsychology assessment tools and techniques. The position holds teaching responsibilities and knowledge power (Cawsey et al., 2016) with respect to the students. This power is shared by the supervising neuropsychologists, as shown by the dotted arrow in Figure 1.

As required, the specialized practitioner becomes a consulting source of knowledge and expertise for the neuropsychologists in the administration and scoring of assessment materials. In general, the individual's experience and education are contributing factors in the level of agency retained by the specialized practitioner position. The requirements for the position are a Masters level degree in a relevant area, and at least one year of supervised practical experience. Consultations with the specialized practitioner are often requested by staff neuropsychologists regarding the strengths and limitations of specific assessment materials, based on observed and

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reported patient abilities. When I have provided feedback regarding position and department operations in the past, it has been well-received and acted upon by leadership. In the organization, my position of specialized practitioner has some legitimate, expert and referent power (Yukl, 1989).

There are several benefits to informal leadership in health care. Informal leaders often have established credibility within the organization, or increased stakeholder buy-in, which has been shown to influence change management efforts (Peters & O'Connor, 2001). Informal leadership has also been shown to improve patient quality of care and staff work satisfaction (Boamah, 2019). In order to further leverage the benefits of informal leadership, the following leadership approaches focus on increasing the number of informal leaders with a shared vision.

Leadership approach. My leadership approach is informed by the Complexity Theory lens which stems from Systems Theory. Within this lens, leadership “does not lie in a person but rather in an interactive dynamic, within which any particular person will participate as leader or a follower at different times and for different purposes” (Lichtenstein et al., 2006, p. 3). As described by Mary Uhl-Bien, recognized in the field of education for her work on Complexity Leadership Theory, leadership is a process and an “emergent, interactive dynamic that is productive of adaptive outcomes” (Uhl-Bien, Marion, & McKelvey, 2007, p. 299). Within this OIP, multiple people may assume the leadership role, and I view my role as lubricating and directing the creation of meaning to ensure organizational relationships are conducive to forward movement (Schein, 2013).

In a complex, interactive, and dynamic system, where “culture is approached as a pattern of meanings” (Iivari, 2002, p. 60), organizations require the flexibility, balance, and collaborative problem-solving of adaptive leadership (Heifetz & Laurie, 2001). Leaders

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themselves are chosen “through a host of interpretive decisions that are extensions of corporate culture” (Morgan, 2006, p. 143). Adaptive leadership includes the possibility of multi-leader models, which may be more likely to accommodate stakeholder needs (Precey, Entrena, & Jackson, 2013) as more perspectives are represented. Personnel may form into leadership groups as required, subject to internal and external influences (Pearce & Sims, 2000). Depending on the environment, certain group members may be required to take on greater leadership functions (McGrath, 1962, from Northouse, 2016). As framed by the Interpretive paradigm and Symbolic Interactionism, leaders and followers’ interactions create meaning. Depending on the networks of created meanings between and among individuals, as well as the complex adaptation process to other influences, informal leaders may rise to formal positions as required.

Lastly, as an informal leader and health care practitioner, I follow an ethical leadership framework, within a relational ontology ethics of care (Nortvedt, Hem, & Skirbekk, 2011). According to care ethics, morality occurs where “persons are motivated and morally addressed by the vulnerability of others”, and involves the balancing of “considerations of care for a particular person in an actual context” (Nortvedt, Hem, & Skirbekk, 2011, p.193). In the health care context, the patient is in a position of vulnerability and need, and health care practitioner has a professional and moral obligation to fulfill. Ethics of care differentiates itself from other theories by “its relational understanding of normative conflict”, and “emphasizes connectedness, dependency and vulnerability” (Nortvedt, Hem, & Skirbekk, 2011, p. 194). Although transformational leadership if more widely viewed as related to ethical behaviours in leadership, “evidence suggests that many ethically worthwhile projects have been completed through the efforts of individuals employing directive or transactional leadership styles” (Aronson, 2001, p. 247), such as participative and consensus approaches.

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PoP and OIP theoretical framework. The overarching theory of the identified practice gap and organization change process is Symbolic Interactionism, the study of how relationships and language influence our perception of the world, and is influenced by the following premises: (1) “human beings act toward things on the basis of the meanings [...]”; (2) “meanings are derived from social interaction and group life”; and (3) “these meanings are handled in, and modified through, an interpretive process [...]” (Blumer, 1969, p. 2). The ontological assumption of these premises is grounded in relativism (Guba & Lincoln, 1994), and denotes that “social reality is seen by multiple people and these multiple people interpret events differently leaving multiple perspectives of an incident” (Mack, 2010, p. 8).

In the context of the PoP, these premises support the significance given to the quality of interactions between patients and students during neuropsychological assessments. In the context of leadership, these premises assume that interactions between individuals and between groups are considerations that affect how leaders and followers act, potentially also in the context of organizational change. In the context of the organization, the interaction and meaning-making between organizational values and mission and personnel may impact actual/seen organizational culture. This culture is subject to continuous reinvention depending on those interactions: “Reality is indirectly constructed based on individual interpretation and is subjective” (Mack, 2010, p. 8).

A limitation to Symbolic Interactionism methodology is the inability to generalize findings to other situations. However, in alignment with Pollock’s (2013) development of solutions to address practice-specific problems, the “goal is the creation of local theories for practice” (Mack, 2010, p. 8). According to Blumer, “[...] human group life should be studied in terms of what the participants do together in units” (Carter, & Fuller, 2015, p. 2), and “[...]”

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human social life must consider the autonomous contributions of each participant” (p. 3). It is in this light that I approach my PoP and OIP.

Organization theoretical framework. Symbolic Interactionism sets the stage for two theoretical frameworks through which I view the organization, incorporating the assumption that organizations, groups, and individuals are interconnected systems that need to be examined holistically.

The first is the culture metaphor used to describe the organization and understand its influencing forces more generally. The metaphor focuses on “the symbolic aspects of organizational life, and the way in which language, rituals, stories, myths, etc., embody networks of subjective meaning which are crucial for understanding how organizational realities are created and sustained” (Morgan, 1980, p. 616). Unlike the Functionalist perspective of culture, “the constructs for describing the culture are suggested by the analysis”, “focus is on the active creation of meanings and on the ways in which meanings are associated in organizations” and “analysis is context-sensitive and concentrates on local, specific meanings” (Iivari, 2002, p. 60). Complexity Theory operates within the context of culture; “the ambiance that spawns a given system’s dynamic persona [...] the nature of interactions and interdependencies among agents (people, ideas, etc.), hierarchical divisions, organizations, and environments” (Uhl-Bien et al., 2007, p. 299). Within this environment, I view organizational change as occurring within a system of continuous monitoring, evaluation, learning and improvement, at all levels of interaction – from individuals, to groups, to departments.

The second approach is Systems Thinking Theory. First developed in 1968 by Bertalanffy, it is an interdisciplinary theory concerned with the relationships between all elements within both natural and unnatural systems (Mele, Pels, & Polese, 2010). Similarly to

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the culture metaphor, the theory maintains a holistic perspective on system functioning (Mele et al., 2010), including the influence of “ideologies, values, beliefs, language, norms, ceremonies, and other social practices that ultimately shape and guide organized action” (Morgan, 2006, p. 142) and human behaviour (Mele et al., 2010). As my position is within the field of health care, more specifically the area of neuropsychology in the subfield of psychology, the incorporation of a familiar theory that accounts for human psychology may increase general understanding and buy-in from stakeholders. This organization framework also ties into the Complexity Theory lens discussed above, which grew out of Systems Theory in the 1960s.

As an informal leader, I approach my PoP and OIP through the framework of Symbolic Interactionism, and I view this organization through Systems Theory and the culture metaphor: culture is our perception of the world created by interactions, relationships, and meaning-making within a complex and adaptive organization. My leadership approach is adaptive and responsive to the organization’s needs, and emphasizes the benefits of multiple informal leaders.

Leadership Problem of Practice

The PoP question is as follows: In a bilingual health care institution, how can specialized practitioners improve students’ administration of standardized assessments in neuropsychology to French-speaking patients in the absence of language competencies, in alignment with the cultures of both patient-centered care and efficiency? The gap identified by this PoP impacts students, specialized practitioners, patients and the wider organization within this bilingual health care organization.

In this PoP and OIP, the author uses the term ‘French-speaking’ to include both Francophone patients whose preferred and primary language, as well as language of highest

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proficiency, is French; and bilingual patients whose primary language, as well as language of highest proficiency, is French. The term does not include bilingual patients with a higher level of language proficiency in English. Additionally, the term language competence refers to socio-linguistic or socio-cultural competence, in addition to language or linguistic performance.

In this department, Francophones who speak some English are assessed in English and are considered bilingual, without testing their actual English comprehension. In contrast, Anglophones who also speak French are consistently assessed in English. This behaviour tendency in health care staff is reflected in the PoP, as it relates to the following organizational practices: the teaching and training responsibilities of the specialized practitioner position, and the requirement of students to administer French-language assessments.

Are specialized practitioners responsible for supporting students in French-language assessments? In this organization, the designated bilingual position of specialized practitioner is responsible for training students in the administration of neuropsychology assessments. However, the majority of students do not have the requisite French-speaking proficiency, and there is a dearth of Canadian-standardized French-language assessment materials. French materials developed in France are not transferable for North American and Canadian Francophones, due to differences in linguistic norms and vocabulary, and resulting incompatibility of population assessment norms used to score the results. As a result, specialized practitioners train students in a non-standardized or non-regulated manner to assess patients using non-validated French-language materials and speaking instructions, which jeopardize the validity of the assessment itself and disrupts the ethics of care (Nortvedt, Hem, & Skirbekk, 2011).

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Another organizational practice as it relates to the PoP is the requirement that students without the requisite French-speaking proficiency assess French-speaking patients. Due to the ‘patient contact time’ allotment required by their practicum, students must assess a large number of patients. Students’ patient contact time is also prioritized over bilingual specialized practitioner-led assessments. In these instances, and when the specialized practitioner is unavailable to conduct French-language assessments, students must use clinical judgment and French-language speaking notes in order to navigate the assessment of patients.

As a consequence of these assessment requirements, students do not feel linguistically competent, and are not acting in accordance with the ethical guidelines set out by the governing bodies and associations, and further they are not acting in congruence with the organizational culture of bilingual competence and patient centered care. The resulting patient care and assessment report is suboptimal, and there are important validity implications for non-standardized assessment materials and administrations, and linguistic and cognitive implications for patients who are not being tested in their preferred/dominant language. Additionally, these organizational practices run counter to the organizations’ mission, values, and reputation of cultural and linguistic sensitivity within the community.

Should the focus be kept on the student experience? The PoP describes a problem of practice within the profession of specialized practitioners that affects both the student experience and the patient experience. By identifying both experiences, the PoP provides a holistic view of the problem’s complexity. However, determining a solution that addresses both the student and the patient experience may be challenging due to the scope of my influence as an informal leader, and the ethic regulations surrounding patient assessments. The purpose of my OIP is to find solutions for both specialized practitioners and the students they train that align with the

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organization's mission and values, to close the culture gap in the assessment of French-speaking patients at this bilingual health care organization.

Framing the Problem of Practice

There are three points of entry for the contextual forces that influence the PoP: factors within the PoP, factors internal to the organization, and factors external to the organization. Relevant literature, including foundational theorists and more recent research, was sourced using the Western University Libraries search engine using key words, and a backwards or reverse citation tracing approach was used to source additional articles.

Factors within the PoP. The main factors underlying the PoP are: language and communication, person-organization fit, and teaching and evaluation. First, viewed through a Symbolic Interactionism perspective, the problem can be understood as a challenge in patient-student communication. Research indicates that language influences worldview and cognitive processes (Blumer, 1969; Hussein, 2012; Sapir, 1921; Whorf, 2012; Yule, 2010). With regards to bilingualism, there has been a clear theoretical framework around bilingualism as a language expression with unique cognitive components that may affect interactions (Altarriba & Santiago-Rivera, 1994; Gutfreund, 1990; Heredia & Altarriba, 2001; Perez-Foster, 1998; Santiago-Rivera & Altarriba, 2002; Silva, 2000). As noted earlier, more than half of the bilingual population has French as their mother tongue (Statistics Canada, 2017), and this is reflected in the patient population. Most bilingual patients are primarily French-speaking, and although are able to converse in English, an assessment administered in English cannot capture a valid representation of the patient's cognitive status. In an assessment setting, if the student is unable to communicate in the patient's preferred language of choice, their interaction suffers as there is no creation of

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logos, or meaning, between the two individuals (Frankl, 1967). Although presented as an alternative, there are challenges in using interpreters in neuropsychology due to the difficulty in translating a standardized test and subsequent violation of administration procedures (Bainter & Tollefson, 2003; Vega, Lasser, & Afifi, 2016).

Second, viewed through organizational psychology and the Interactionism perspective, the problem can be understood as a challenge between the organizations' and personnel's lived values. Also known as the theory of Person-Organization (P-O) fit, or person-culture fit, compatibility between people and organizations increases with their shared value and fundamental characteristics (Kristof, 1996). Ethical incongruence in the assessment of French-speaking patients by students without developed language competencies is established in research as an existing gap of regulations in neuropsychology language competencies (APA, 1993; APA, 2002a; APA, 2002b; Valencia-Garcia & Montoya, 2018). This incongruence between the organizations' stated and lived values, and staff personal values, may cause negative affect in students and specialized practitioners, with subsequent negative organizational effects (Bao et al., 2013; Edwards & Cable, 2009).

Lastly, viewed through a program evaluation and social cognitive perspective, the problem can be understood as a lack of language competencies tools developed and available for students. Student behaviours and actions during patient assessments are a reciprocal model of interaction between personal factors such as individual experiences, environmental influences and the actions of others, and behaviour (Bandura & Walters, 1963; Bandura, 1977; Rotter, 1954; RHIhub, 2019a; RHIhub, 2019b). Currently, activities such as teaching, learning, and evaluation of student's language competencies are largely absent. Research on bilingual assessment and training, applicable to French-speaking patients, acknowledges the uniqueness of

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bilingual assessments, the necessity of bilingual therapists, and the current gaps in training bilingual students (Biever et al., 2002; Biever, Gomez, Gonzalez, & Patrizio, 2011; Castano, Biever, Gonzalez, & Anderson, 2007; Ochoa, Rivera, & Ford, 1997; Olvera & Olvera, 2015; Rhodes, Ochoa & Ortiz, 2005; Valencia-Garcia & Montoya, 2018; Verdinelli & Biever, 2009).

Internal factors: value model. Personnel act based on iterative constructed meanings (Blumer, 1969), which in turn effect how the organization adapts and changes over time (Morgan, 2006; Mele, Pels, & Polese, 2010). Quinn's Competing Values (QCV) model (Cawsey et al., 2016) observes these meanings using four organizational culture categories: Open Systems View, Rational Economic View, Internal Process View, and Human Resources View. The categories situate relevant political, economic and social contexts within the organization at different levels of discourse, and are based solely on the author's professional experience working within this organization. The QCV model combined with the positional and knowledge forms of power account for varying values and assumptions within the organization (Cawsey et al., 2016), situating different stakeholder perspectives and Person-Organization (P-O) fit within the organizational culture.

Students and personnel entering the organization, including specialized practitioners, often have no positional power; however, they bring with them new observations, ideas, approaches and solutions (Cawsey et al., 2016). For example, new personnel may notice that the minimum level of cognitive abilities required of patients is surmised during the interview phase at the discretion of the student or supervising neuropsychologist. New personnel may also observe that students are not required to declare language competency or training to patient with regards to second-language at the time of the patient's assessment. These observations may lead to challenges with P-O fit.

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In contrast, management, department leads, and other positional forms of power may view the above methods as a bi-product of a need to streamline procedures to increase patient assessment efficiency, keep costs down, and therefore will not feel value incongruence.

Generally, these stakeholders are oriented to attract funding and students for research and publications. This view encourages competition and input from external stakeholders such as universities, other health care institutions, and industry to gain collective achievement and advancement (Cawsey et al., 2016).

Upper-management is equally concerned with consistency, efficiency, structure, and accountability for funding and capacity. Student training placements emphasize fairness of selection, despite the need for French-speaking and bilingual students and changing trends in patient populations. There is also a continuing assumption that French-speaking or bilingual professional staff such as specialized practitioners will be available as the need for these language services arise, indicating a lack of succession planning or ‘back-up’ bilingual professional staff (Cawsey et al., 2016).

At times, flexibility, internal factors, collaboration and organizational engagement is promoted (Cawsey et al., 2016) specifically to support the rational economic view- for example, before an audit. New training initiatives and activities to increase personnel cohesion are promoted, and during which time gaps and challenges in practice are more readily brought to the attention of management.

External factors: PESTEL analysis. The PESTEL analysis (Cawsey et al., 2016) is a tool that contextualizes external factors affecting the organization and the PoP – the following discussion focuses on political, legal, and social factors in the field of neuropsychology. The

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environmental, technological and economic aspects of this model are not within the scope of this OIP, and will therefore not be addressed.

There are several policies related to language and professional practice in the field of psychology, which both neuropsychologists and students must comply with. In 1991, the Eastern Canada Regulation for Registration in the Psychology Act stated that the certificate of practice for psychologists and neuropsychologists would include the language(s) of proficiency, and would determine the language(s) that could be legally used in practice. In 2000, the Regulatory Requirements for Registration in Psychology Across Canada was created by the Canadian Psychology Association, stating that there were various language competency requirements that differed according to the province. In Eastern Canada, as stated in the 2015 Guidelines for Interim Autonomous Practice Members by the College of Psychologists of Eastern Canada, the language of instruction, supervision, and practice for students needed to be completed in French or in English. Additional language testing could subsequently occur, and if a student wanted to add a language of practice, they were required to complete another two full years of supervised practice in that language in order to claim proficiency and competency (College of Psychologists of Eastern Canada, 2015). Consequently, many students opt out of the bilingual neuropsychology degree.

Neuropsychologists and students must also comply with several federal and provincial language legislations. The Official Languages Act of 1985 cites “equality of status and rights and privileges [...] in communication with or providing services to the public”. In the Province of Eastern Canada (2018), bilingual organizations must offer French-language services, employ people with requisite levels of French-language skill, and guarantee French-language service for

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most services; however, there is a grey area for legislation application with regards to students proving services through their requisite practicum.

Socio-political and educational factors in the field of neuropsychology relevant to this PoP include the culture of the profession of specialized practitioners. When compared to other assistive professions in the field of health care such as physiotherapy assistants or communicative health assistants, there currently is no profession-specific post-secondary program in North America for specialized practitioners, and the existence of the profession is not acknowledged on the Canadian Psychological Association website at the time of this OIP. Additionally, the field of neuropsychology itself is largely unknown as a subset of psychology and does not have its own webpage on this bilingual healthcare organization's website. Due to these factors and the identified gap in French-language assessments, the specialized practitioners' role cannot be compared to other similar profession in health care. Additionally, there are important gaps in regulations surrounding the use of specialized practitioners by neuropsychologists and health care organizations (Camara, 1997; DeLuca & Putnam, 1993; Ferraro, 2016; Hall, Howerton, & Bolin, 2005; Malek-Ahmadi et al., 2012). This is a factor to consider in the PoP, with regards to specialized practitioner leadership approaches and analysis of stakeholder reactions.

Within this policy context, students are governed by both the organization's and neuropsychology policies, and the psychology training college and association legislations. Both the organization and training associations must comply with the regulations of the psychology governing bodies. The organization's regulations as well as the psychology governing bodies also follow federal and provincial legislations. Specialized practitioners fall under the neuropsychology policies and the organizations' legislations. Current policies center on the

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necessity for the supervision of specialized practitioners by neuropsychologists, due to the lack of clarity with regards to ethical and professional accountability for specialized practitioners. This situation neglects alternative solutions, such as the creation of new policies and programs for the standardization and accreditation of the profession as is seen in many other health care professions, or the creation of an interdisciplinary model.

In sum, several factors frame the PoP: patients' language of assessment can significantly impact assessment results and quality of care, the current environment creates misalignment with staff P-O fit, and there is a lack of language competency tools for students. According to the PESTEL analysis, policies related to language of professional practice, the culture of the profession of specialized practitioners, and stakeholders accountability to the organization versus psychology governing bodies also impact the PoP. Additionally, in accordance with the QVC model, stakeholders have difference perceptions of the problem and their role.

Guiding Questions Emerging from the Problem of Practice

'Factors within the PoP' noted three factors underlying the PoP, and provided evidence for the need for change: language and communication, person-organization fit, and teaching, learning, and program evaluation. These three elements form distinct lines of inquiry.

1. How do organizational hiring and student selection practices affect the problem of practice?

The first line of inquiry is the role of language in the formation of meaning making, and subsequent influence on quality of interactions (Blumer, 1969; Gutfreund, 1990; Hussein, 2012; Perez-Foster, 1998; Santiago-Rivera & Altarriba, 2002; Sapir, 1921; Silva, 2000; Whorf, 2012; Yule, 2010). If the language of assessment is critical to the validity of the assessment, the focus should be on providing patients with French-speaking or bilingual assessors. Further

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considerations include the challenges in using interpreters in neuropsychology due to the difficulty in translating a standardized test and subsequent violation of administration procedures (Bainter & Tollefson, 2003; Vega et al., 2016).

2. Could the organization's values be used in lieu of professional ethical guidelines to guide the alignment between person-organization fit?

The second line of inquiry is the consequence of value incongruence (Bao et al., 2013; Edwards & Cable, 2009; Kristof, 1996) and the existing gap of regulations in neuropsychology language competencies (APA, 1993; APA, 2002a; APA, 2002b; Valencia-Garcia & Montoya, 2018). Within this context, the main issue is the lack of transparency with regards to language competency when assessing patients. The establishment of language competency guidelines and ethics by the national and provincial governing psychology boards is beyond the scope of this OIP; however, the organization values of patient care and excellence support high ethical standards with regards to disclaimer of language proficiency.

3. Should students be provided with language competency tools and language competency development opportunities?

The third is the gap in bilingual learning and training activities to which students are exposed (Biever et al., 2002; Biever et al., 2011; Castano et al., 2007; Ochoa et al., 1997; Olvera & Olvera, 2015; Rhodes et al., 2005; Valencia-Garcia & Montoya, 2018; Verdinelli & Biever, 2009), which may in turn influence their own behaviour and interactions during patients assessments (Bandura & Walters, 1963; Bandura, 1977; Rotter, 1954; RHIhub, 2019). Providing students with tools upon hiring that focus language competency development may increase validity of assessments for French-speaking patients.

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These three lines of inquiry will guide my analysis of change drivers and organizational readiness, as well as the development of my solutions.

Leadership-Focused Vision for Change

This section will describe the present and future envisioned state of the organization, the change drivers involved in the PoP, and the use of stakeholder collaboration.

Present state. An organization “needs to be ready for change by being dissatisfied with the present” (Cawsey & Desza, 2007, p. 101). At the present, the organization is a health care institution with legal obligations to provide bilingual language services and care (Official Languages Act, 1985; Province of Eastern Canada, 2018) while complying with the guidelines of professional governing bodies, and training colleges/associations (American Psychological Association, 2002b; Canadian Psychology Association, 2000; The College of Psychologists, 2015).

With healthcare organizations in Eastern Canada recovering from past reduction in funding while adapting to patient volume increases and demographic trends (Statistics Canada 2011; 2017), organizational decision-making and hiring practices are increasingly focused on performance results as opposed to quality, as seen in Figure 2. This is particularly visible in the field of neuropsychology, where historically the use of specialized practitioners enabled the assessment of high volumes of patients (Malek-Ahmadi et al., 2012).

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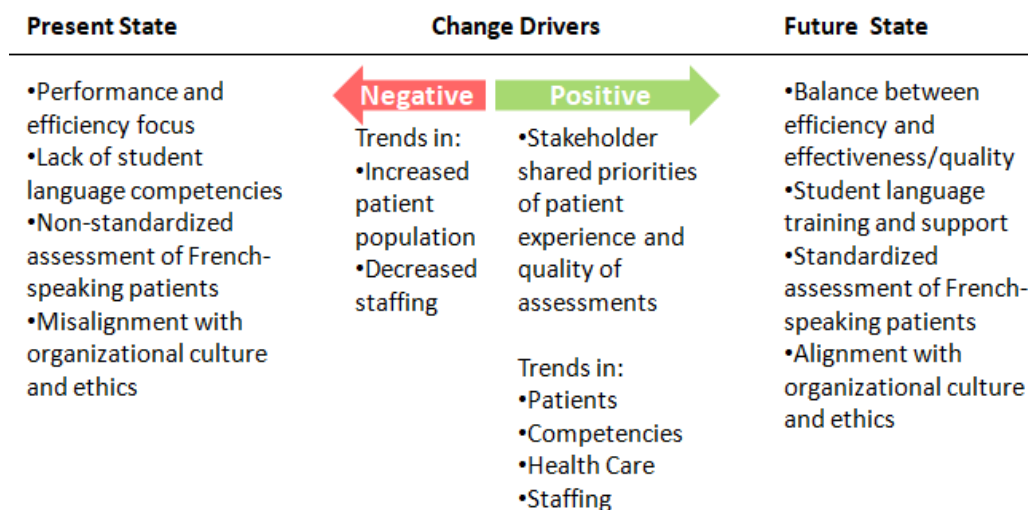


Figure 2. Change Drivers and Organizational Readiness. This figure illustrates the gap between the organizations' present and future state. Adapted from Cawsey et al., 2016.

Within this context, specialized practitioners who train students in a non-standardized or regulated manner to assess patients using non-validated French-language materials and speaking instructions, and students without language competency tools or development (APA, 1993; APA, 2002a; APA, 2002b; Valencia-Garcia & Montoya, 2018) must use clinical judgment and French-language speaking notes in order to navigate the assessment of patients. In the present organizational context, patients' inability to communicate and interact with students in their preferred language may impact the overall subjective assessment experience and the results which then, cannot be objectively valid (Altarriba & Santiago-Rivera, 1994; Gutfreund, 1990; Heredia & Altarriba, 2001; Perez-Foster, 1998; Santiago-Rivera & Altarriba, 2002; Silva, 2000). The requirement of students to participate in these assessments without language competency tools or without having undergone language competency development may have unintended negative personal and organizational effects (Bao et al., 2013; Edwards & Cable, 2009). Specialized practitioners who are responsible for training students in assessments, may also experience the negative effects of value incongruence (Kristof, 1996), and other departmental

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personnel members who are aware of the current gap in training bilingual students (Biever et al., 2002; Biever et al., 2011; Castano et al., 2007; Ochoa et al., 1997; Olvera & Olvera, 2015; Rhodes et al., 2005; Valencia-Garcia & Montoya, 2018; Verdinelli & Biever, 2009), which runs counter to the organization's stated vision and values. In this organization, this gap is acknowledged by students, specialized practitioners, neuropsychologists, and department management as an ongoing challenge.

Future state. The future state envisioned is one where (1) French-speaking patients receive neuropsychological assessments by a French-speaking practitioner; (2) students in health care are provided with language competency tools and opportunities for development; and (3) specialized practitioners are utilized as a primary area of language competency support for students. As seen in Figure 2, patients would receive a higher quality of care, and assessment results would have increased accuracy, leading to increased validity in results, recommendations, potential diagnosis and treatment protocols. Students would feel greater confidence and competence in their roles as test administrators; the affiliated educational institution would be supporting a more effective residency program; and the governing healthcare bodies/associations have support towards rectifying existing ethical inconsistency between vision and practice (Valencia-Garcia & Montoya, 2018). Due to the greater involvement of specialized practitioners, the supervising neuropsychologist would not have to dedicate additional resources towards addressing the dissonance identified above. The organization would also have closer alignment between its patient assessments, student training, and its values of patient centered and high quality care. This organization has deep rooted and mature values with regards to its bilingual health care services and meeting the unique cultural and linguistic needs of its community. Increasing alignment between organizational culture and practice may increase the chances of

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stakeholders, both organizational and community, supporting and participating in the organizational change process (Culture University, 2014).

Change drivers. Stakeholder reactions and support for change stem from their perceived impact of the change on the organization and themselves. Individual reactions depend on cost versus benefit, personal relevance, and consistency of the change with personal attitudes and values (Cawsey et al., 2016). The main change driver and priority for change is understanding stakeholder interests and reactions, in order to provide better support during the change process and avoid stakeholders becoming opposing forces (Cawsey et al., 2016).

Neuropsychologists are internal stakeholders with high decision-maker power and influence (Cawsey et al., 2016). These health care professionals have high levels of autonomy and report directly to departmental management. They are responsible for both students and specialized practitioners, and collaborate extensively with other health care professionals cross-departmentally. According to the QCV model, they may have an Internal Process view, concerned with stability and efficiency (Quinn, 1988). Although the expected impact of the change on the organization is positive, as described in the future state, the perceived impact on the neuropsychologist may be negative due to the potential need for additional resources, perceived loss of authority or influence, lack of experience with change, and/or recent negative experience with change (Cawsey et al., 2016). This could lead to a negative reaction, which could in turn impact coworkers and other stakeholders' views (Cawsey et al., 2016). With a high potential for both "threat" and "cooperation", a collaborative approach should be employed with these stakeholders (Cawsey et al., 2016). Additionally, the Internal Process view shares similarities with the Human Resources view, with regards to an internal focus (Quinn, 1988).

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Accordingly, these stakeholders may be more open to the inclusion of additional training practices and alignment of processes with organizational values (Quinn, 1988).

Students are internal stakeholders with low decision-making power and influence (Cawsey et al., 2016). While the expected impact of the change on the organization is positive, the perceived impact on the individual is mixed (Cawsey et al., 2016). According to the QVC model, these stakeholders may have an Open Systems view (Quinn, 1988) however, despite the increase in competency and value congruence language competency training would require additional time and resources. This may cause students to have an ambivalent or negative reaction towards the change (Cawsey et al., 2016). Students also have a transient role within the organization, which may impact their vested interest (Cawsey et al., 2016). As stakeholders and Change Recipients, an ambivalent or negative reaction will negatively impact the change process; with a high potential for cooperation and low potential for threat, students would benefit from an involvement strategy (Cawsey et al., 2016). These stakeholders have an Open Systems view, which shares similarities with the Rational Economic View with regards to an external focus (Quinn, 1988). Students may therefore be more open to a change process that focuses on efficiency, goal setting, and maximizing output (Quinn, 1988).

According to Quinn (1988), although the QCV model uses terminology such as ‘competing’, the essence of the model is ‘balance’ of the values. This approach suggests that value extremes are “likely to be dysfunctional” (Lamond, 2002, p. 49). The above stakeholder reaction analysis proposes the use of all four values: Internal and Human Resources for neuropsychologist stakeholders, and Open System and Rational Economic for student stakeholders. Viewed together, these change drivers share elements of control and flexibility, and external and internal focus – a balance of values (Quinn, 1988) which may support

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organizational change. Other stakeholder groups to consider are the management group and patients; however, OIP scope will be limited to key stakeholder within the neuropsychology department and under the scope of the author's influence. Figure 2 notes shared interests of all stakeholders as a positive change driver, demonstrating that all groups prioritize quality of assessments and the patient experience, which includes patient centered care and ethical disclosure.

Stakeholder collaboration. In health care organizations, change is often evidence-based and has a strong behavioural component (Khan et al., 2014). In the above proposed change, the future state involves a potential change in the organizations' training system, and a behavioural change in neuropsychology, specialized practitioners, and students. Management's active engagement with the change process may increase stakeholder's positive appraisal of change (Ferrin & Dirks, 2002). Additionally, as stakeholders with high potential for collaboration, there is potential for the neuropsychologists to become Change Implementers (Cawsey et al., 2016). Neuropsychologists, as clinical practitioners with management responsibilities, hold hybrid leadership roles and may be able "to act as boundary spanners interpreting policy requirements and translating them to improve clinical care" (Fitzgerald & McDermott, 2017, p. 111) in the change implementation process. Their involvement could be accomplished through the development of an OIP advisory committee, which would provide procedural, legislative, and ethical advice with regards to the project's development and implementation. One aspect of organizational change readiness is the "personal needs and abilities of the change leader" (Caswsey & Deszca, 2007, p. 101). As described in the leadership position section, although the PoP is within the scope of the specialized practitioners' position, success in the OIP implementation would be greatly increased with management engagement and stakeholder

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collaboration. The existence of this committee would ensure continued alignment of the project with organizational and community values, ensure the project's continued relevance, and increase the sustainability of the project upon implementation completion.

In sum, the PoP gap and resulting organizational challenges is acknowledged as an ongoing challenge. The envisioned future is one where the organizations' stated values are aligned with actual organizational culture, benefiting department staff and patients. Change drivers include stakeholder interests, which all prioritize quality of assessments and the patient experience, and the creation of an advisory committee would increase management engagement and stakeholder collaboration, thus increasing the chances of a successful OIP implementation.

Organizational Change Readiness

In health care organizations there needs to be an emphasis in planning and change readiness since "as many as 60% to 80% of change strategies are not successfully implemented (Kotter, 1996)" (Khan et al., 2014, p. 2). Organizational change readiness can be defined as "the extent to which organizational members are psychologically and behaviorally prepared to implement change" (Weiner, Amick, & Lee, 2008, p. 55). This psychological and behavioural preparation emerges primarily from "organizational experiences, managerial support, the organization's openness to change, and the systems or elements promoting or blocking change in the organization" (Cawsey & Desza, 2007, p. 101). In addition to the stakeholder change drivers discussed above, additional driving forces that contribute to organizational change readiness as illustrated in Figure 2 include: the increasing patient volumes, current climate and evolution of competencies in psychology, trends in health care organizations, and staffing trends.

Patient trends. Patient volume is increasing, leading to increased organizational forums and meetings to address this change. In 2017-2018 across Canada, there were a total of 224,442

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discharges in general hospitals for mental health disorders (including organic disorders such as traumatic brain injury), and the average length of stay was 16 days (HMHDB, 2019). In this organization's department, due to the type of injury treated, the average length of stay for patients is over a month. For specialized practitioners, the current patient volume already surpasses the position's allocated hours, leading to students taking over more patient-assessment responsibilities. There is organizational awareness of this challenge, and stakeholders are generally open to change. In fact, this challenge has spurred an already-in progress organizational change in the hopes of accommodating a larger patient population in a sustainable manner. These patient trends are considered as both a positive and negative driving force for the proposed change. The increase in patient population will lead to increased need for students to assess French-speaking patients, increasing the PoP gap. However, the continued increase in patient population will also pressure organizational leadership to continue focusing on efficiency.

Competency trends. In 1973, the National Conference on Levels and Patterns of Professional Training in Psychology took place (Newell et al., 2010). Nearly a decade later in 1981, Division 16 of the American Psychological Association (APA) published its first set of psychology training standards which addressed language and cultural differences (Newell et al., 2010). Cultural competency was first written about in the medical field in 1989 (Cross, Bazron, Dennis, & Isaacs, 1989). Subsequently, the APA created other organizations with a special focus on ethnic minority affairs in psychology, publishing additional guidelines (Newell et al., 2010). According to the American Psychological Association Ethics Code (2010) and the Multicultural Guidelines for Assessment (2003), psychologists must practice according to their competencies. In the profession of neuropsychology, this area of multicultural and linguistic competence is acknowledged as 'in need of updating' (Ferraro, 2016), due to the gap in patient care and

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language competency in current ethical guidelines (APA, 1993; APA, 2002a; APA, 2002b; Valencia-Garcia & Montoya, 2018). There is also a dearth of culturally valid assessment instruments leading to denial of services (Brickman, Cabo, & Manly, 2006). Health care research trends in cultural and language competence are however increasing, indicating that the proposed organizational change is aligned with the social and research climate (Ferraro, 2016). In effect, this author looked to the pioneered Spanish-English bilingual competency training in the field of psychology in the United States in the development of this OIP, due to the current dearth in research specific to Canadian French-English bilingualism. Governing health care bodies/associations such as those associated with this organization have strong political, legal, and social incentives to close existing ethical gaps in competency (Valencia-Garcia & Montoya, 2018). These competency trends are considered a positive driving force for the proposed change.

Health care trends. Canadian health care is currently feeling the influence of the Accountable Care Organization (ACO), a group or team focused patient care that is “intended to incentivise value based care” (Peckham et al., 2018, p. 12), of which cultural and language competency is an element. Factors for resistance to the ACO model include the leadership and operational style of the organization, which is centered on the high status and autonomy of health care practitioners and their individual licensure. As Keidel (2005) notes, this type of organization may fall victim to “underdoing control”, where the focus is on individual autonomy, practice, and accountability as opposed to “spontaneous cooperation” (p. 11). ACO’s values of cooperation and collaboration are already element in this organization’s culture, and ACO models share similarities with shared and distributed leadership. ACO values also align with the organization’s mission and vision of patient centered care. Overall, the ACO health care trend is another positive driving force.

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Staffing trends. Internal organizational trends affect organizational change readiness, including staffing turnover and position restructuring. In an effort to reduce costs, the traditionally ‘bilingual essential’ human resource and administrative positions have been significantly reduced over the past decade and been absorbed by the neuropsychologist and psychologist practitioners. Additionally, the department has been challenged in filling existing ‘bilingual essential’ specialized practitioner positions, leading neuropsychologists and students to take on a heavier patient load. These staffing trends, in combination with lack of culturally valid instruments (Brickman et al., 2006) for assessment of French-speaking patients, has increased the potential for high staffing turnover. The resulting environment has positioned most stakeholders as “being dissatisfied with the present” (Cawsey & Desza, 2007, p. 101). In this context, staffing trends may act as the positive driving force for organizational change. However, similarly to patient trends, reductions in staff will continue to pressure organizational leadership to focus on efficiency, shifting focus away from the quality of patient care. Additionally the change implementation process will add to specialized practitioner already-heavy workload, therefore staffing trends are also a negative driving force.

Readiness assessment tools. One method to assess change readiness in organizations, particularly the main change drivers, is through the use of standardized questionnaires. These can provide insights as to where the advisory committee might focus efforts or develop preventative and mitigation strategies. To assess organizational readiness, the Organizational Readiness for Knowledge Translation (OR4KT) tool (Gagnon et al., 2014; Gagnon et al., 2018) developed as an expansion of organizational readiness theories including Weiner’s Organizational Readiness for Change (Puchalski Ritchie & Straus, 2018), was employed. The 59 item tool development was based on a systematic review focused within health care organizations, and “input [...] was

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sought from a range of international OR and KT experts” (Puchalski Ritchie & Straus, 2018, p. 56). The tool is valid in a wide range of higher-income countries including Canada, has been adapted into French and “three diverse healthcare contexts” (Puchalski Ritchie & Straus, 2018, p. 56) including Eastern Canada. The six dimensions measured are organizational climate for change, organizational contextual factors, change content, leadership, organizational support, and motivation (National Collaborating Centre for Methods and Tools, 2017). A similar tool to assess trends in change readiness of key stakeholders is the Rate the Organization’s Readiness for Change (ORCA) questionnaire (Cawsey et al., 2016, p. 108-110), which consists of 77 items grouped according to the Promoting Action on Research Implementation in Health Services framework: “the nature and strength of the evidence and its potential for implementation”, the environment or setting in which the proposed change is to be implemented”, and the “capacity or types of support needed to help people change their attitudes, behaviours, skills and ways of thinking and working” (National Collaborating Centre for Methods and Tools, 2009). However, use of the OR4KT is preferred due to the verified validity with French-speaking and bilingual Canadian population, as well as the instruments development in a health care specific context. In order to assess management’s engagement with change and provide management with a self-reflective piece as part of the advisory committee establishment, the Line Manager Attitudes and Actions scale (Randall et al., 2009) is also recommended for use.

The OR4KT results indicate that the organization has a reasonably high level of readiness for change (63 out of 100). Highest scoring dimensions include organizational climate for change, organizational contextual factors, and organizational support. In accordance with Figure 2, trends in patient linguistic demographic, health care competencies and models, and decreased staffing, the organization is ready for change.

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Summary

Chapter 1 described the PoP within the context of a specific bilingual health care organization, and the dynamics of external (using the PESTEL model) and internal (using the QCV model) factors to consider in understanding the PoP. The author identified the theories and lens used throughout the proposed plan to provide personal and positional transparency and justification of the approaches chosen, and the multiple change drivers and possible stakeholder reactions were discussed in the context of organizational readiness. Next, Chapter 2 will build on this foundation and argue the merits of the leadership framework, as well as four possible solutions to the PoP.

Chapter 2: Planning and Development

Chapter 1 described the PoP and the organizational context, setting out the common and conflicting points of interest among stakeholders; the policy framework in which the stakeholders and the organization operate; and demographic and historical challenges facing the organization. In chapter 2, organizational information and leadership approaches to change are analyzed; a leadership framework and change process are developed and four possible change paths that are both flexible and effective to deal with the PoP are proposed.

Leadership Approaches to Change

This section describes and discusses the adaptive and distributed leadership approaches to change selected for this PoP, in consideration of the author's position within the organization and the organizational context.

Adaptive leadership. Adaptive leadership supports change in many contexts, particularly complex environments such as health care organizations. Change is a process of continuous adaptation to internal and external forces, influenced by decision-making (Tsoukas & Chia, 2002). In health care organizations, change has largely been a result of external pressures (Cawsey et al., 2016). Leaders who practice adaptive leadership provide flexibility and balance during periods of change, encouraging collaborative problem-solving (Heifetz & Laurie, 2001). It is also a recognized element for patient centered care, as complex situations arise and care-staff are required to quickly learn and adapt (Corazzini & Anderson, 2014).

As framed by Symbolic Interactionism, internal organizational change is often caused by interactions and meaning-making between and within individuals or groups (Blumer, 1969), which may impact actual/seen organizational culture (Mack, 2010). Adaptive leadership is

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supported by the stakeholder analysis, the QCV model (Quinn, 1988), and the organizational context. From the Rational Economic and Internal Processes View of this organization (Cawsey et al., 2016), leadership may be more readily accepted as an adaptation to external pressures for procedural improvement and increased efficiency. In this organization, past and current leaders are viewed as managers working towards objectives as opposed to leaders working towards a vision. In this context, the leadership approach that would be best received by the followers is one that supports and is aligned with current policy and process improvements in response to external pressures.

Adaptive leadership would also support the professional practice of specialized practitioners in a time of change. The position of specialized practitioner has been virtually unchanged and uncontested since its inception (Malek-Ahmadi et al., 2012): the proposed organizational change may influence a comparative review and/or increased networking of specialized practitioners, in turn surfacing long-held assumptions about values and norms in the field, and “patterns of meaning” (Iivari, 2002, p. 60). From the specialized practitioners’ social context, an adaptive leadership approach would best support the community of practice in a time of culture change.

Distributed leadership. Distributed leadership works alongside stakeholder needs (Precey et al., 2013) and incorporates elements of “inclusivity, collectiveness and collaboration” (McDonald, 2014, p. 228). A comprehensive review of evidence-informed change management found distributed leadership to be a recurring “operationalization” of popular change models used in Canadian health care organizations (Dickson et al., 2012, p. 14).

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Distributed leadership is supported by the stakeholder analysis and current organizational context. Stakeholders in formal leadership positions at this organization are more likely to accept change if they are highly involved in the implementation process – for example, if they see themselves as ‘leaders’ in the process. This approach fulfills the demonstrated need for a collaborative approach such as an advisory committee, which acknowledges the existing high level of autonomy and specialized knowledge of practitioners within the organization’s governance structure. This leadership approach is also currently practiced in this health care organization.

Distributed leadership permits multiple simultaneous leaders, unlike shared leadership. Shared and distributed leadership- both referenced in Gibb’s 1954 article on leadership where sharing leadership roles was first introduced- share many similarities in the literature and are often used interchangeably. Collaborative approaches promote group learning and adaptability (McGrath, 1962, from Northouse, 2016). They are frequently seen in health care settings (Chreim & MacNaughton, 2016), due to the associated increased involvement, accountability, and cultivation of knowledge influencers (McGrath, 1962, from Northouse, 2016), and increased overall patient care effectiveness (Lemieux-Charles & McGuire, 2006).

Specifically, shared leadership is a “multifaceted, multi-pathed influence process” (Pearce & Sims, 2000, p. 133), associated with increased trust, cohesion, and consensus, reduced conflict, and overall team functioning (Bergman, Rentsch, Small, Davenport, & Bergman, 2012). It is a collective product of individuals and relationships where all stakeholders share leadership behaviours and work together (Harris, 2005; Spillane, 2005). This leadership is likened to “a jazz group led by one of the musicians based on the rhythm of the moment” (Schlechty, 2005, from Goksoy, 2016, p. 297).

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In contrast, distributed leadership refers to distributed leadership practices across stakeholders and collective learning (Halverson, 2007). Distributed leadership has multiple leaders, whereas decisions in shared leadership are made by one individual based on “their knowledge and competencies”, and within a “participative perspective” where all stakeholders share leadership behaviors (Goksoy, 2016, p. 297). In this organization, there are multiple professional health care practitioners with equal authority and formal leadership. Therefore, despite their similarities, the approach taken in the context of this OIP is distributed leadership.

Adaptive leadership aligns with distributed leadership, and followership theory. The Complexity Theory lens suggests “a form of distributed leadership that does not lie in a person but rather in an interactive dynamic, within which any particular person will participate as leader or a follower at different times and for different purposes” (Lichtenstein et al., 2006, p. 3). Both adaptive leadership and distributed leadership are responsive to the cultural context (Uhl-Bien et al., 2007; Uhl-Bien & Marion, 2009). In distributed leadership, an equal focus is placed on followers who may also become leaders as the situation demands it. “Situational Umwelt” in the “followership” theory (Suderman, 2012, p. 14) highlights the importance and contribution of followers in the leader-follower dynamic. In Situational Umwelt, “situations dictate whether followers need leaders to use directive, coaching, supportive or delegating styles” and assumes that “followers’ skills and motivations will vary” (Suderman, 2012, p. 14). This interaction requires both adaptive and distributed leadership. A review of Canadian health care organizations stated that “meaning-making and effective communication approaches emphasize[d] treating each other more as equals [...and] the importance of understanding one’s role and responsibility in the change process” (Dickson et al., 2012, p. 14). As the OIP

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progresses, follower stakeholders such as students or other personnel members may take on different roles, and leaders will likewise need to adapt their approach to followers.

Transactional approach. Along with adaptive and distributed leadership, a transactional approach to leading change will also be used. In the beginning phases of the change process, a transactional approach will increase the formal leadership's comfort, and sense of control regarding the proposed changes. A history of scarcity and focus on rewards for performance dominates the perspective of this stakeholder groups' Rational Economic and Internal Processes View values (Cawsey et al., 2016). Solutions will focus on process improvements, as well as the professional and organizational reward of increased efficiency. Additionally, the current leadership culture in this organization and in the field of neuropsychology already tends towards the transactional (Vera & Crossan, 2004), whereby management, support personnel, specialized practitioners, and students focus on the performance of distinct and delineated roles.

As the change process develops and evolves, there may be elements of transformational leadership associated to the change vision and the personal characteristics and leadership styles of the stakeholders involved. The secondary goal presented in the solutions is a long-term policy change, which requires a vision for increased priorities of, and competencies in, patient health care services, aligned with transformational leadership.

Leadership "includes the interactions of leaders with followers and the context in which those interactions are taking place or are embedded over time" (Avolio & Locke, 2002, p. 174), alluding to the need for adaptability. Although both transactional and transformational leadership approaches have separate objectives, they work along a continuum (Avolio & Locke, 2002). The final goal of this organizational change is for better alignment with organizational culture and stated values as well as future change in the field with regards to language

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competencies- a transformational approach. In order to achieve this goal and build stakeholder buy-in, a more measurable approach to goal-setting and organizational/individual benefits will be taken at first - a transactional approach.

In sum, adaptive leadership supports both distributed leadership and a sliding transactional-transformational leadership approach. Distributed leadership is also the standard in health care organizations, and in alignment with this OIP's theoretical lens.

Framework for Leading the Change Process

The change models reviewed are the Reflexive Adaptive Process framework (Stroebel et al., 2005) and Kotter's (1996) 8-step model. The following section discusses the strengths and limitations of each model in consideration of the PoP.

Reflexive adaptive process (RAP) framework. The RAP (Stroebel et al., 2005) is a change framework used to lead change in health care organizations, using principles of complexity science or complex adaptive systems (CAS). CAS is a "dynamic network of semiautonomous, competing, and collaborating individuals who interact and coevolve in nonlinear ways with their surrounding environment" (Boustani et al. 2010, p. 142), and form the basis of Complexity Theory (Uhl-Bien et al., 2007; Uhl-Bien & Marion, 2009). Under the umbrella of Complexity Theory, leadership "seeks to take advantage of the dynamic capabilities of CAS" (Uhl-Bien et al., 2007, p. 299). The five guiding principles as described by Boustani and colleagues (2010) are as follows:

- (1) Vision, mission, and shared values are fundamental in guiding ongoing change processes;
- (2) creating time and space for learning and reflection is necessary;
- (3) tension and discomfort are essential and normal during change;
- (4) improvement teams should include a variety of systems agents with different perspectives of the system and its

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environment, including patients; and (5) system change requires supportive leadership that is actively involved in the change process, ensuring full participation from all members and protecting time for reflection. (p. 143).

RAP's principles 2 and 3 focus on the 'human aspect' of change, which entails the psychological processes, including tension, that most individuals cycle through before accepting and integrating the change in their daily work life. According to the Kubler-Ross model (1969), individuals cycle through similar and predictable stages when confronted with change, including organizational change. For example, when a change first begins, stakeholders may be surprised or shocked by the change, experience denial and frustration at the need for change, followed by low mood. With time, reflection, and involvement with evidence for change such as a gap analysis, stakeholders may begin to engage once again with the idea of change, learn how to work within the new environment, and integrate the change fully into their practice.

A similar theory is advanced in the field of cognitive and social psychology (Ajzen & Fishbein, 2005; Boston University School of Public Health, 2018; Prochaska, DiClemente, & Norcross, 1992; RHIhub, 2019). The Transtheoretical theory posits that stakeholders accept change at different paces, with some individuals requiring more support than others. The theory also states that for full acceptance to occur, stakeholders will have to change their behaviour to accommodate the change.

In the context of the health care organization, there has been little change to patient assessment procedures in terms of language competency, as well as the specialized practitioner's role. Stakeholders might feel anger or frustration if the proposed change is perceived as a criticism on their field of practice, or their personal practice. They may have change fatigue due to other ongoing change management processes, and disagree with the timing of implementation.

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Stakeholders such as students, neuropsychologists, and specialized practitioner's will need time, reflection, and interaction with evidence in order to accept the change and incorporate it into their workplace behaviours. They also need to be involved in the change process and decision-making. This leads into the next principles.

Principles 4 and 5 focus on stakeholder involvement and leadership, with strong implications for the distributed leadership approach. The RAP model provides stakeholders and the organization the opportunity for increased collaboration and reflection as compared to other models, specifying involvement of diverse stakeholders and the need for supportive leadership. These aspects are key to the success of the OIP implementation, and will be accomplished through the development and guidance of a stakeholder advisory committee. These principles overlap with the shared values discussed in principle 1, as the advisory committee will provide guidance to the change process in the form of a common vision. This vision will be aligned with current organizational values and culture, as well as personal, individual beliefs for ethical patient care.

On a larger scale, RAP is comparable to a Plan Do Study Act model (Moen & Norman, 2009), or PDSA; a cyclical process to lead change. Adjustments or returning to a previous phase may occur at any phase, and reflection on previous practices is used to modify and improve. These models focus on production of new knowledge, and continuous improvement (Kantamara & Ractham, 2014). In the context of the health care organization, a cyclical process with multiple feedback loops provides multiple opportunities for improvement. Although stakeholder reactions can be analysed, they cannot be fully anticipated as the organizations' internal and external environment are in constant flux. For example, resources may become more constrained than before, or new priorities may surface. Just as leadership needs to adapt to the organization

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and stakeholders, the proposed OIP must also have built in flexibility. Additionally, it is anticipated that there will be staff turnover during the change process, which brings with it opportunity for new ideas as well as new approval requirements. The cyclical, PDSA-like features of the RAP model provide space to account for these micro-changes within the change process.

Kotter's 8-step model. Kotter's (1996) 8 steps form a top-down model that provides a detailed checklist of clear steps for leaders to follow for successful change. Multiple steps within this model focus on communication and distributed leadership, acknowledging how interactions and meaning influence stakeholder perceptions and organizational culture in alignment with Symbolic Interactionism. The first two steps, (1) establish a sense of urgency and (2) create a guiding coalition (Kotter, 1996), initiate the change process and align with Cawsey and Deszca's (2007) dissatisfaction with the present as a factor in stakeholder readiness for change. The organizational readiness analysis indicates that stakeholders are aware of the need for change, and it is supported by patient demographic trends, current climate and evolution of competencies in psychology, trends in health care organizations, and staffing trends. The development of an advisory committee was also discussed as part of the leadership-focused vision for change, due to the strong behavioral component in health care organizations (Khan et al., 2014) and the stakeholder analysis that revealed the high potential for neuropsychologist stakeholder collaboration (Cawsey et al., 2016).

The next steps are to (3) develop a vision and strategy, (4) communicate the change vision, (5) empower employees for broad based action, and (6) create short term wins (Kotter, 1996). These elements involve stakeholders with the change process to increase buy-in and continued relevance of the change. They are also described as the 'human aspect' of change in

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terms of the need for clear direction, completion of milestones, and appreciation of intermediate accomplishments. When considering the close involvement of the stakeholders through an advisory committee and the organizational culture, these elements will support ethical considerations and a communication strategy. The final steps are (7) consolidate gains and produce more change, and (8) anchor new approaches into the culture (Kotter, 1996). These steps are aligned with the culture metaphor (Morgan, 1980), touching on the potential for change as an iterative cycle and the modification of the organization's culture through the change implementation. Overall, Kotter's model takes into account the importance of stakeholder interactions and leadership communication within the organizational culture, and provides specific, detailed steps for leadership to consider and support the implementation of the OIP.

Analysis. There is a lack of evidence suggesting that any specific change models “have a clear impact on improving patient outcomes” in a health care organizational context (Dickson et al., 2012, p. 14). However, use of specific change models can “minimize the potential for failure and change fatigue” (Dickson et al., 2012, p. 14). According to a review of change models used in Canadian health care organizations, “top-down models of change are being replaced by models that emphasize multi-stakeholder and multi-level participation, including the active engagement of decision makers, providers, patients, and community members” (Dickson et al., 2012, p. 14).

The proposed change is in reaction to the current political, legal, and social dissonance and the possible ramifications of this dissonance on patient care. This change is thereby reactive as opposed to an anticipatory or incremental change (Cawsey et al., 2016), and is associated with “extrinsic motivation” for change leading to “adaptive learning” (Senge, 1990 from Mento, Jones, & Dirndorfer, 2002, p. 49). However, due to the size of the organization and its culture,

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the implementation model will involve an adaptation style which involves small, incremental changes to achieve movement along a change continuum (Cawsey et al., 2016). It is recommended that the change model will require adaptive learning through an iterative, non-radical approach (Cawsey et al., 2016).

In the context of the PoP, the change model needs to integrate a Complexity Theory lens. “Health care delivery organizations are considered complex adaptive systems” and “assembly line conceptual model[s] do not fit health care systems” (Boustani et al., 2010, p. 141). Additionally the model must accommodate double loop feedback and learning mechanisms or cyclical steps that encourage quality improvement, organizational learning, and stakeholder capacity building. These elements also support sustained organizational change. Based on the stakeholder analysis and organizational readiness, the model would also benefit from a strong communication and stakeholder engagement focus, in order to sustain engagement and build further internal capacity with neuropsychologists and student stakeholders. Due to the author’s informal leadership position and experience, specificity of change steps would increase confidence of senior managers, reduce potential for oversight or interference, and increase chances of success.

Both models align with distributed leadership. Kotter’s (1996) step (5) empower employees for broad based action implies a participative and collaborative approach to lead change, and RAPs (Stroebel et al., 2005) principle 4 describes the need for improvement teams and a diversity of stakeholder perspectives. The RAP model is also highly flexible due to the non-linear application of principles, suggesting alignment with adaptive leadership as well. Both models also align with the author’s value-based leadership approach, demonstrating

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transparency, equity, and democracy through the practices of self-reflection, communication, stakeholder empowerment, and participation.

Limitations of the RAP model include lack of specificity and guidance, whereas Kotter's model includes detailed steps. As well, in the Canadian health care context the PDSA cycle is primarily used to "test ideas in rapid cycles for improving a component of the system, primarily related to quality and safety" (Dickson et al., 2012, p. 20), which may be a limitation in the similar RAP model. Although presented as a transactional model where change will lead to organizational efficiencies, the long term goal is for sustainable organizational change.

Limitations of Kotter's model include the top-down approach which limits stakeholder participation and distributed leadership. The model is also mechanistic and linear, which does not take into account Complexity or Systems Theory on which this OIP's organizational lens is based. Lastly, the model focuses on change initiation as opposed to change sustainment, whereby double-loop learning or cyclical models would provide feedback on change processes and encourage organizational learning (Kantamara & Ractham, 2014; Sterman, 1994). Taken together, these two change models balance each other's potential limitations.

As shown in Table 1, the best change model for the PoP is the Reflexive Adaptive Process model to lead change in this OIP, with elements of Kotter's (1996) 8-step model to account for change steps specificity.

Table 1

Comparison of Change Models

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Criteria	<u>Kotter's 8-Step Model</u>	Reflexive Adaptive Process
Complexity Theory lens		✓
Culture Metaphor lens	✓	
Distributed Leadership	✓	✓
Adaptive Leadership		✓
Acknowledgment of psychological needs	✓	✓
Step Specificity	✓	
Cyclical / Iterative Approach		✓

Critical Organizational Analysis

The following section discusses Stacey's Complexity Theory application to the PoP gap analysis to determine what to change. The organizational change is then reviewed following the Reflexive Adaptive Process change model principles (Stroebe et al., 2005) and Kotter's 8-Step Model (Kotter, 1996).

Stacey's complexity theory. Stacey's Complexity Theory views organizations as "pattern[s] of cooperative interaction" (Stacey, 2002, p. 187) and change as non-linear feedback loops (Cawsey et al., 2016). The perspective falls under the CAS, along with the RAP framework, and can be used to decide what to change and which elements of the change model to emphasize. According to Stacey's Matrix (Cawsey et al., 2016), an organizational change or issue will have a degree of certainty (vertical axis) and a level of agreement between leadership on an issue (horizontal axis). If the PoP is close to certainty, a cause and effect linkage can be determined, and past experiences can be used to plan and predict outcomes of the change. If the PoP is far from certainty, a cause and effect linkage cannot be determined or is unclear.

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RAP principle 3. The RAP principles can begin at any stage. For the purpose of this analysis, the process will begin with Principle 3 “tension and discomfort” (Boustani et al. 2010, p. 143) which shares many similarities to Kotter’s (1996) sense of urgency step. The PoP question is as follows: In a bilingual health care institution, how can specialized practitioners improve students’ administration of standardized assessments in neuropsychology to French-speaking patients in the absence of language competencies, in alignment with the cultures of both patient-centered care and efficiency? The purpose of my OIP is to find solutions for both specialized practitioners and the students they train that align with the organization’s mission and values, to close the gap in the assessment of French-speaking patients at this bilingual health care organization.

The effect of the above problem is two-fold: specialized practitioners must train students in a non-standardized or unregulated manner to assess patients using non-validated French-language materials and speaking instructions; and students must use clinical judgment and French-language speaking notes in order to navigate the assessment of patients. The consequence for both students and specialized practitioners is reduced P-O fit and value incongruence, based on the organization’s vision and culture as well as psychology ethical guidelines and suboptimal patient care and assessment results. At this point, stakeholders may experience the first few stages of the Kubler-Ross model (1969) or the Transtheoretical model (Prochaska, DiClemente, & Norcross, 1992), focused on tension and insecurity. As described by Stacey (2002), an organization is a “continual interaction between humans who are all forming intentions, choosing and acting in relation to each other as they go about their daily work together” (p. 187). The creation of ‘discomfort’ and ensuing discussion between stakeholders is “joint action” (Stacey, 2002, p. 187) which may lead to new cooperative learning. The main focus underscored by this

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phase is the importance of discussing/showcasing the consequences of not addressing the PoP, to build the discomfort and urgency.

RAP principle 2. The second discussed principle of RAP involves “creating time and space for learning and reflection” (Boustani et al. 2010, p. 143), and is a good phase to provide stakeholders with additional evidence of the need for change. This phase includes elements of Kotter’s (1996) stakeholder empowerment and communication steps.

Based on an assessment of external trends, patient volume is increasing at an unsustainable rate for the specialized practitioners allocated hours, leading to students taking over more patient-assessments. In 2017-2018 across Canada, the average length of stay for mental health disorders was 16 days (HMHDB, 2019); in this organization’s department, due to the type of injury treated, the average length of stay for patients is over a month. Concurrently, traditionally ‘bilingual essential’ human resource and administrative positions have been significantly reduced over the past decade and been absorbed by the neuropsychologist and psychologist practitioners in an effort to reduce costs, leading students to take on heavier patient loads. With regards to ethical guidelines in the field, the area of multicultural and linguistic competence is acknowledged as ‘in need of updating’ (Ferraro, 2016) due to the gap in patient care and language competency in current ethical guidelines (APA, 1993; APA, 2002a; APA, 2002b; Valencia-Garcia & Montoya, 2018). Trends in health care are also focused on a group or team patient care (Peckham et al., 2018, p. 12), of which cultural and language competency is an element.

At this intersection, stakeholders will slowly move into the later stages of the Kubler-Ross model (1969) or the Transtheoretical model (Prochaska, DiClemente, & Norcross, 1992) as

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they are presented with evidence supporting the need for organizational change and integrate the change into their work life. Based on the above data and the factors within the PoP discussed in chapter 1, a cause and effect linkage may be determined. However, although similar changes have occurred in other health care fields, the field of neuropsychology does not have a past experience to extrapolate required steps to complete the change. Similarly, the department does not have a pre-existing template for required action in this scenario. Therefore, according to Stacey's Complexity Theory, this PoP lands in middle of the certainty axis as seen in Figure 3.

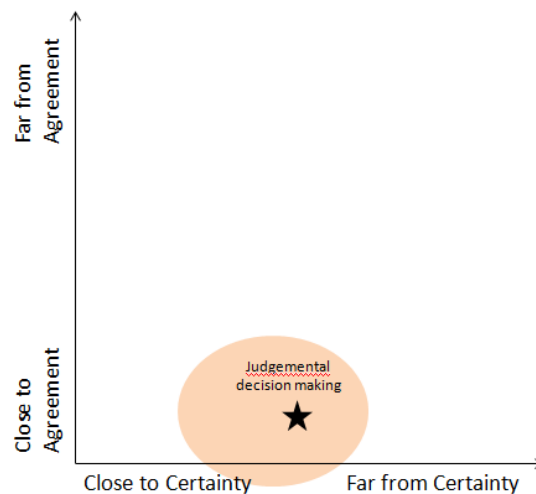


Figure 3. Level of Certainty and Agreement. This figure shows that that organization has mid-levels of certainty and is close to agreement, based on Stacey's Complexity Matrix.

The main focus in this phase is the presentation of evidence to support the need for change, as the discomfort or cognitive dissonance and urgency for the change builds.

RAP principle 1. The next phase discussed is Principle 1 which involves the “vision, mission, and shared values” (Boustani et al. 2010, p. 143), incorporating Kotter's (1996) strategy and communication steps. The purpose of this phase is to focus on stakeholder's reactions and develop their personal stake in the PoP. Based on change readiness findings of the internal environment, stakeholders may be more receptive to change if it resonates with their values. For

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example, students have an Open Systems, and therefore will be more receptive of a Rational Economic View (Quinn, 1988). This requires a greater focus on alignment with organizational efficiency and efficacy. Neuropsychologists who have an Internal Processes view will be more receptive of a Human Resources view (Quinn, 1988). This requires a greater focus on alignment with current organizational mission and values. Taken together, the two stakeholder groups will achieve a balance of QCV values- control and flexibility, and external and internal focus- which may support organizational change. Stakeholders are aware and in agreement for the need for change, however due to the large size of the organization and the fields minimal experience with change, change must be both reactionary and adaptive.

According to Stacey's Complexity Theory, there is high potential for agreement on this issue, placing the PoP on the lower agreement axis as seen in Figure 3. The main focus in this phase is the personalization of the PoP strategy to each stakeholder group: focus on alignment with current organizational culture including values, and underscore the goal of the change process as quality improvement. Additionally, stakeholders in this phase should be given adequate time to understand the importance of their role in the change strategy and vision, and should be encouraged to revisit this phase in combination with principle 2 throughout the change process.

RAP principle 4. The next phase discussed focuses on the inclusion of "improvement teams [...] with different perspectives" (Boustani et al. 2010, p. 143), similar to Kotter's (1996) guiding coalition step. Other steps from Kotter's 8-Step Model with applicability to Principle 4 are creating short term wins, consolidating gains, and anchoring new approaches into the culture.

Stakeholders involved in collaborations will have accepted the change and modified their behaviour accordingly. Change Implementers and Agents from the stakeholder groups' advisory

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committee would provide procedural, legislative, and ethical advice with regards to the project's development and implementation. The existence of this committee would ensure continued alignment of the project with organizational and community values, ensure the project's continued relevance, and increase the sustainability of the project upon implementation completion.

According to Stacey's Complexity Theory, an advisory committee would also increase the potential for agreement on this issue through "continual interaction between humans who are all forming intentions, choosing and acting in relation to each other" (Stacey, 2002, p. 187). The main focus in this phase is increasing the diversity of stakeholder voices, in the spirit of continuous learning and double loop feedback mechanisms through the fast cyclical nature of PDSA-like models, built-in reflection phases, and the advisory committee.

RAP principle 5. The next principle describes the importance of "supportive leadership that is actively involved in the change process" (Boustani et al. 2010, p. 143), which aligns with the development of an advisory committee, supportive leadership, and a participative approach. Adaptive leadership supports both distributed leadership and a sliding transactional-transformational leadership approaches. Distributed leadership is also the standard in health care organizations, and in alignment with this OIP's theoretical lens. Additionally, a collaborative leadership approach is already taken interdepartmentally, and professional practitioners within departments including the neuropsychology department maintain high levels of autonomy (Mintzberg, 1979).

Referring back to Kotter's (1996) model, this phase includes the empowerment, short term wins, consolidating gains, and anchoring new approaches into the culture steps. Note that this is not the final phase; the RAP principles exist simultaneously within a continuous iterative

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cycle. This is also why some of Kotter's steps occur more than once throughout the RAP framework. According to the Kubler-Ross model (1969) and the Transtheoretical model (Prochaska et al., 1992), although most stakeholders in this phase will have accepted the change, others will require additional support from leadership such as more positive reinforcement or more direct involvement with the change process.

Principle 5 also provides leadership with the action to take according to the PoP's placement on Stacey's Complexity Matrix. Accordingly, Figure 3 illustrates that high levels of agreement but medium levels of certainty require judgemental decision-making (Cawsey et al., 2016). This involves developing a strategy that focuses on a shared vision, where the goal state is congruence with the organizational culture. Based on the above analysis, 'what' needs to change is the organizational system related to the delivery of assessments to French-speaking patients, involving an improvement and increase of French and bilingual language services. This current delivery system is inconsistent with current organizational culture and values and affects the department's efficiency and efficacy. The solution to the PoP will be most effective if it supports and is supported by distributed and adaptive leadership, is implemented reactively using an adaptive approach (Cawsey et al., 2016), is directed by a stakeholder advisory committee, and is presented with a quality improvement focus. This should result in increased congruence between stakeholders, patient care, and organizational values.

In sum, the combined RAP principles (Stroebel et al., 2005) and Kotter's (1996) 8-Step Model will support the organization and stakeholder needs during the change implementation, and Stacey's Complexity Theory provides a best-fit approach for leadership strategy.

Possible Solutions to Address the Problem of Practice

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There are several possible solutions to address the PoP, in consideration of the critical organizational analysis that determined *what to change*: an organizational system related to the delivery of bilingual language services that is incongruent with current organizational culture and values and affects departmental efficiency and efficacy. The following three solutions suggest modification of the following current organizational practices: student placement, student onboarding, and patient assessment. Each solution provides two methodologies through which the solution can be implemented. A fourth solution suggests the application of all suggested modifications. Together, they provide a reasonable solution to the PoP that is within the author's scope of practice. Below, Table 2 illustrates anticipated resources for each PoP solution. Note that the initial time investment is a cumulative number of hours required by a minimum of two staff members collaborating in a participatory approach. Total expenditures were calculated based on the average hourly salary of specialized practitioners, and twenty graduate students joining the organization annually.

Table 2

Anticipated Resources for Potential PoP Solutions

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	Modify student placement practices		Modify student on-boarding practices		Modify patient assessment practices	
	Method 1 Questionnaire	Method 2 Language Testing	Method 1 Supervisor Matching	Method 2 Training	Method 1 Patient Disclaimer	Method 2 Patient Test
Initial Time Investment	1-3 hrs	37.5 hrs	1-2 hrs	2-5 hrs	30 min	<10 min
Continuous Time Requirement	20 min / student	5 hrs / student	1-2 hrs / student	30min -1 hr / student	2 min / patient	<10 min / patient
Expenditures (\$)	0-150 / questionnaire order (annual)	200 / student (continuous)	-	0-200 / material investment (initial)	-	-
Total Initial Expenditures (\$)	120	1 500	80	400	20	<10
Total Continuous Expenditures (per year)	410	8 000	1 600	800	-	-

Solution 1: Modify student placement practices. The first solution involves a change in the student placement practices of the organization, and introduces the application of student language competency measurement. Below are two possible methodologies:

1. Students would be required to complete a questionnaire during the placement process to self-assess language competency, and for interviewers to assess students' language abilities. This information would contribute to informed placement decisions. As seen in Table 2, the additional time of administration and scoring of this questionnaire is twenty minutes per student. The standardized questionnaires may be ordered along with the other assessment materials used in the department, or a simple questionnaire may be designed by the department that focuses on specific needs. Akin to an additional interview question, this solution would require little additional time, and few financial resources as seen in Table 2, with an initial time investment of one to three hours. If ordering, the cost of the questionnaire would be approximately \$150 CAD

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per year or less. Total initial expenditures for this method is \$120 CAD, and the total continuous annual expenditures including the purchase, administration and scoring of the questionnaire is \$410 CAD.

2. Students would be required to undergo standardized second language testing to meet bilingual position criteria, similarly to employees hired into the organization. As seen in Table 2, the additional testing and scoring time per student is five hours. This solution would involve a change in placement policies with regards to students, and may have consequences with regards to hiring practices in other areas of the organization, as well as with the student's associated educational institution. Due to the additional placement requirement, the timeframe for establishing a placement for students would be increased. As well, there may be a financial burden of additional language testing on the organization's language center, of approximately \$200 CAD per student. However, the policies and procedures for the assessment of second languages in this organization are already in place. Staff member would initially have to invest time to research organizational guidelines, develop a proposal for department and organizational management to include this new policy, attend meetings, and complete policy revisions. This initial time investment is estimated at 37.5 hours. Total initial expenditures for this method is \$1 500 CAD, and the total continuous annual expenditures including testing and scoring of assessments and expenditures to the organization's language center is \$8 000 CAD.

The objective of this solution is for the organization to gain knowledge of what are the language competency levels of their new students. Assessing and monitoring levels of student language competencies at the initial placement stage provides the organization with a baseline for future comparison or correlations, and may also influence other organizational practices, such

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as language and other training. It may also influence the organization to change their student placement requirements to include a higher level of bilingual competency.

This solution aligns with current organizational culture of continuous learning and improvement through research and evidence-based practice. The solution also aligns with the organizational culture of French-English bilingualism, and legal requirements to provide bilingual services.

Solution 2: Modify student on-boarding practices. The second solution involves a modification or addition to the organization's current student on-boarding practices. On-boarding refers to the period of time after the student is hired, and involves matching the student to a supervisor and completing any mandated organizational training before beginning to see patients. There are two possible methodologies:

1. Based on the student's strengths and needs, the students' language competency level should be taken into consideration when matching with a supervisor. For example, a student with low language competency levels would be placed under the supervision of a neuropsychologist with high language competency levels. The initial time investment to determine the methodology for matching students to supervisors would require one to two hours, as seen in Table 2. This practice requires minimal financial resources, and would involve informal language competency coaching by the supervisor throughout the student's practicum; a one to two hour continuous time investment per student. The practice also ensures that an assessor with required levels of language competency is available for patient assessments. The additional competency coaching would not lengthen the overall practicum time frame, however this method would involve allocation of time towards student-development of language competencies for

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neuropsychologists and specialized practitioners, which may detract from time towards completing the student's practicum requirements. Total initial expenditures for this method is \$80 CAD, and the total continuous annual expenditures for student-supervisor matching is \$1 600 CAD.

2. Based on student's strengths and needs, a language competency training component may be added to the student on-boarding process. Training involves the development of language competency tools and development opportunities for students. Language competency training focuses on the socio-linguistic or socio-cultural competencies involved in patient-care, and would involve online or in-person training through the use of pre-existing materials or via the development of new material. As seen in Table 2, depending on the level of involvement, developing new materials may have lower levels of expenditure ranging from zero to \$200 CAD for materials, but involve more time (two to five hours). Both online and in-person training would involve additional time requirement for students and on-boarding process modifications, approximated at thirty minutes to an hour per student. Staff training is an important part of the organization's current on-boarding practices, providing employees with position-specific mandatory and optional online and in-person training with regards to topics such as health and safety, and diversity and inclusion in the workplace. The development of student-specific language competency tools and supports would align with current organizational practices. As well, the topic of language competency may be recognized as value-added to other positions in this health care organization, and the training developed for students could be added to other student on-boarding practices or general staff hiring practices outside of the psychology department. Total initial expenditures for this method is \$80 CAD including the initial time and

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material investment, and the total continuous annual expenditures for student training is \$ 800 CAD.

A possible criticism is the perception that by taking additional time to develop language competencies, the solution places a greater emphasis on training for improved patient care, as opposed to requirements for completion of student's practicum. Although the author cannot influence what is included on student's practicum requirements, language competency has been argued as an area that merits more emphasis, particularly in a multi-lingual health care setting (Valencia-Garcia & Montoya, 21017). The above solution is not emphasizing patient care over reputation and values around excellence as an institute of learning. The objective is to achieve a better balance between the two priorities, and thereby a better alignment with overall organizational culture.

Solution 3: Modify patient assessment practices. The third solution involves a modification of the department's current patient assessment practices. Both practices take place before the assessment: during the patient interview phase with the neuropsychologist and student. There are two possible methodologies:

1. Include a language competency disclaimer for students during the consent-to-treatment phase of the interview, prior to conducting the patient assessment; the student's ability level in assessing a patient in French will be disclosed to the patient. A checkmark box will be added on the patient's consent form as a reminder for the student to complete this additional step during the interview. This method involves an initial time investment of only thirty minutes to complete the modifications on the consent-to-treatment form, as seen in Table 2, and is supported by research as an element that should already be present on patient consent forms (APA, 1993;

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APA, 2002a; APA, 2002b; Valencia-Garcia & Montoya, 2018). The addition of this element will require a continuous time investment of only two minutes per patient, and is in alignment with the organizational culture, as well as the professional ethics of the field, solving the ethical dilemma and value incongruence caused by current assessment practices. Although patients may not receive optimal service with regards to language competency as a direct result of this solution, they will be provided with enough information to make an informed decision as to the quality of their health care. Total initial expenditures for this method is \$20 CAD, and the total continuous annual expenditures are nil as time spent per patient varies widely and the additional minutes will not have an impact on overall assessment efficiency.

2. If it is unclear whether the patient's level of bilingual competency surmised during the interview is acceptable for an English assessment, the neuropsychologist and student would include a short verbal comprehension test with standardized cut-offs. If patients demonstrate a higher level of language competency in French, this should be taken into consideration when assigning the patient's assessor. To remind staff of the importance of language competency disclaimers before patient assessments, a checkmark box will be added on the patient's consent form with regards to consideration of assessor's language competency. This method would increase the provision of appropriate language services during patient assessments. The method would have no financial component as seen in Table 2, as this test is already available in the department at nil cost. The initial time investment to integrate the test into the interview process is under ten minutes, and the continuous time requirement involves an additional ten minutes during the interview. This time would be fully off-set as this test is regularly employed anyways during the assessment period. The test would thereby serve a dual purpose of determining appropriate language of assessment, and evaluating language abilities as part of the regular

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neuropsychology assessment. Total initial expenditures for this method is under \$10 CAD and the total continuous annual expenditures are nil.

The objective of this solution is to provide fair and high-quality neuropsychology assessment to patients, ensure patients are respected including their right to decline treatment if there is perceived risk, and keep practitioners within the department accountable to the highest standard of patient care within the practice of neuropsychology. The intended cultural change is once again the achievement of a greater balance of current organizational values: quality of care versus efficiency of care. Consequences to the solution include patients requesting bilingual assessors, which may put a strain on staff availability and resources.

Analysis. All three solutions build on existing organizational processes and policies. Language testing policies and processes are in place for hiring employees into bilingual positions; training policies are in place for employees and there are multiple mandatory competency requirements; and ethical guidelines and policies are in place and reinforced for neuropsychology assessments. However, the solutions differ from current processes and policies in that they are more closely aligned with the organizational culture and values, and they focus exclusively on students.

The modification of processes and policies surrounding student placements and practicums generally involves additional layers of approvals through affiliated educational institutions, and the discipline's provincial and federal boards of practice. The proposed two methodologies for solutions 1 and 2 provide an advantage of choice, whereby the first method for each solution requires few to no resources and does not involve a change in policy or significant approval levels. The second method for each solution involves a permanent change in

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hiring, on-boarding, and assessment policies. They are included here as a tangible goal to consider and work towards once the first method has been successfully piloted for several cycles.

Due to the various factors influencing the PoP, each solution focuses on a different area on the continuum. Solution 1 (Modify Student Placement Practices) focuses on the beginning of the continuum, where students are selected to enter the organization. The advantages of this solution are that the benefits of developing a knowledge base of the language competency levels of students hired may affect other areas of processes as well, including on-boarding training, supervision, and patient assessment practices. The consequences of this solution are the potential resource and time requirements, and data collection monitoring. There is also the potential of a shift in applicants for student positions, due to the language competency testing: some highly qualified students may be discouraged from applying due to the additional requirement. As a positive consequence, students with higher levels of language competency may be encouraged to apply.

Solution 2 (Modify Student On-boarding Practices) focuses on events following the student placement, and provides students with language competency tools and support. This solution supports student learning and development, and increases the student level of language competency which also benefits patient care. However, this solution requires initial measurement of language competency levels and would ideally be implemented in combination with Solution 1. The online or in-person training method also requires the most resources to develop and deliver.

Solution 3 (Modify Patient Assessment Practices) focuses on the beginning of the patient-assessment, once the students have been hired and are fulfilling their patient-contact time

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requirements. This solution does not need to be used in tandem with Solution 1 and 2, and solves the ethical dilemma and value incongruence caused by current assessment practices in a direct and simple manner. However, this solution does not increase student language competencies as does Solution 2, and it does not provide the organization with a knowledge base of their students' language competency on which to build greater organizational capacity as does Solution 1. As noted above, consequences to Solution 3- patients requesting assessors with higher levels of language competency- may result over time with the need to implement Solution 1.

All three solutions help to close the ethics of care (Nortvedt, Hem, & Skirbekk, 2011) gap describe by the PoP. By modifying student hiring processes, the organization is accounting for its patient population linguistic care needs. By modifying student on-boarding processes, the organization is developing student's expertise in language competency, reducing the risk of ethical tensions arising during patient assessments. Lastly, modifying patient assessment practices involves transparency of abilities and informed consent to treatment, which enables the assessor to provide individual and context specific care (Nortvedt, Hem, & Skirbekk, 2011). Unfortunately, the implementation of any single solution in isolation does not guarantee the resolution of the PoP gap, since the cause is multifaceted.

Solution 4: Modify all practices cyclically. As the cyclical nature of the above solutions becomes more apparent, an alternative solution may be to incorporate one method from each of the three solutions, as seen in Figure 4. As the solutions are implemented and results are monitored, the second more involved method may be implemented. In this manner, each area of the PoP is addressed, and the interdependence of each is acknowledged and used to the organizations' advantage. Additionally, this approach is aligned with an iterative adaptive

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learning and non-radical approach (Cawsey et al., 2016) recommended through the organization and change model analysis.

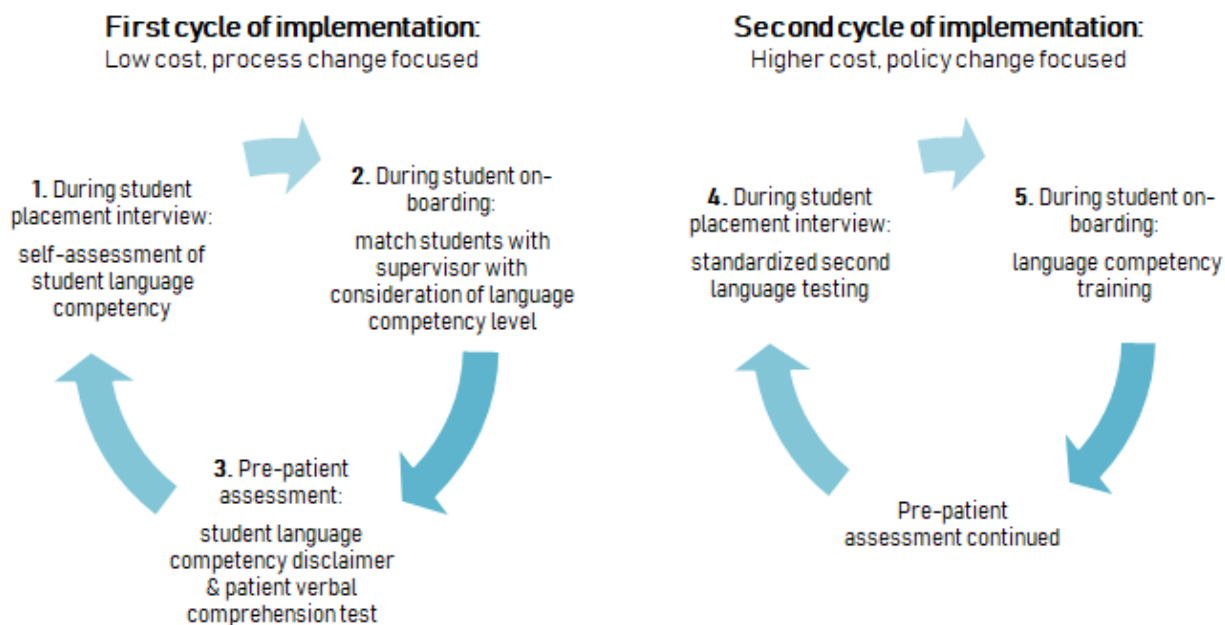


Figure 4. Solution 4. This figure illustrates the chosen solution to address the PoP, addressing both the patient and student experience.

The intended organizational change would be organizational learning and process improvement, to better align with current culture and values, provide better support to students, neuropsychologists and specialized practitioners, and improve patient care. Initial resources needs for the implementation of the process-focused method would be low and better-received by stakeholders. As stakeholder buy-in increases and pilot project results are tracked, more resources may be invested for the implementation of the policy-focused method. However, compared to Solutions 1, 2 and 3, overall timelines for implementation would be longer (approximately three years), and resource needs would be higher.

Within Solution 4, there are also two strategies to consider. The first stage of the implementation model would be the Solution 1 process method. Required resources would be

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planned and the methodology would be determined by the stakeholder advisory committee. The data gathered from the language competency self-assessment measures would then be used to determine student needs in the Solution 2 process method. While these two methods are in progress, the Solution 3 process-method will be implemented for patient-assessments. The results from all three solutions will be monitored during a full student practicum cycle of eight months, and then analyzed for trends, cost-benefit, and stakeholder and organizational consequences. Based on the results of this pilot project, the stakeholder advisory committee may choose to incorporate the policy-method of some or all of the solutions.

Alternatively, one policy-method will be introduced at the beginning of each new practicum cycle, incrementally substituting the process-method for each solution. This method ensures continuous revision of the change strategy based on collected evidence in a double-loop learning approach, and aligns strongly with the values of transparency. The increased opportunity for feedback and study also increases opportunity for stakeholder participation and democratic decision-making. Based on the organizational analysis, change implemented reactively using an adaptive approach would be most effective. Based on Stacey's Complexity Matrix, high levels of agreement but medium levels of certainty required judgemental decision-making (Cawsey et al., 2016), which involves developing a strategy that focuses on a shared vision, where the goal state is congruence with the organizational culture. The second method of gradually and purposely implementing the process-method solutions followed by the policy-method solution is incremental, forward-looking and vision focused, and will therefore be used in this OIP implementation.

In sum, four solutions were considered for addressing the PoP gap, with anticipated resources described in Table 2. While each solution provided a process-method change and a

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policy-method change in the areas of the student and patient experience, the chosen solution will implement change in each area over two cycles. This pilot project approach is aligned with the PDSA model, and is supported by adaptive leadership.

Leadership Ethics and Organizational Change

The following section discusses ethical considerations and challenges in the OIP, and mitigation strategies at the individual, stakeholder group, and organizational level. These include ethics related to the University of Western and writing the OIP, principles of ethical and adaptive leadership, collaboration and compromise strategies, the use of ethical contracts, organizational ethics, communication strategies, and research ethics. The below considerations will be employed preventatively to minimize challenges.

Similarly to the implementation model for this OIP, ethical considerations and challenges are viewed in a cyclical, feedback double-loop. As ethical challenges arise, my focus will be to consider the challenge and potential consequences from several points of foci: the individual, the main stakeholder groups, the department, the organization, and the community. This method, in alignment with Symbolic Interactionism, focuses on the interactions and outcomes of decisions, and moves away from a dichotomy of ethical choices.

Educational institution ethics. In the writing of this OIP, ethical considerations include the University of Western's OIP organization anonymity policies, the consideration of potential ethical challenges described within this section and the author's declaration of professional conflict of interest. These strategies will support the clarity and transparency of the author's project, and minimize potential harm or risk towards the subject organization.

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Leadership ethics and strategies. Ethics in leadership benefit from the application of ethical and adaptive leadership principles, for both the individual, and group settings. Individual ethics relate to Principle 5 of the RAP cycle (Stroebel et al., 2005), which focuses on supportive leadership. Since the implementation plan requires the use of both adaptive and distributed leadership, individual ethics relates to not only myself, but followers and potential leaders. According to ethical leadership, leaders and followers can be driven by different ethical focuses, such as ethics of care, ethics of justice, and ethics of critique (Starratt, 1996). In the context of this health care organization, there is a propensity to focus on the ethics of care, which refers to “the dignity and worth of individuals” (Ehrich, Klenowski & Spina, 2015, p. 199). Authentic leadership includes significant self-reflection and self-awareness, the mutual development of both leaders and followers, and promotion of an inclusive organizational environment (Avolio & Gardner, 2005).

These elements of ethical and authentic leadership would be beneficial on all levels: at an individual level, for the advisory committee, and stakeholders. They also align with adaptive and distributed leadership, in its democratic approach, continuous learning, and acknowledgement of changing internal and external contexts. Through the development of the OIP, the author has participated in significant self-reflective and self-awareness practices with regards to values and leadership. Once the advisory committee is formed, these practices will be encouraged on an individual and group discussion level, to support development of ethical leadership (Crossan, Mazutis, Seijts & Gandz, 2013) throughout the change process (RAP Principles 1, 2, 3 and 4).

A potential challenge is the varying ethical positions and beliefs between stakeholders. In this context, the objective becomes attainment of ethical understanding, whereby through self-reflection and discussion, an understanding of the differing points of view is achieved as opposed

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to agreement on one point of view. Additionally, the stakeholder advisory committee might make use of Mintrop's (2012) "assigning weights according to a rank order of normative importance" (p. 702) in consideration of differing points of view. For example, when there is a disagreement on action tasks, the committee can discuss an order of importance, thus ensuring that all action tasks are considered.

The use of an "ethical contract" for the advisory committee and other Change Drivers and Implementers may be developed as a reference document to guide potential conflict and encourage greater stakeholder understanding and collaboration. It will also mitigate the increased potential of decision-making disagreements in distributed leadership. An ethical contract would include the development of shared values, as described in RAP principle 1 (Boustani et al., 2010), as well as the guiding vision. In conjunction, a communication plan will be developed to ensure clarity of strategy, dissemination of information, and fair input from various stakeholders. Communication and ethical guidelines will both be subject to periodic revision.

As an informal leader, I will continue to operate within a value-based framework according to the moral principles of transparency, equity, and democracy. As I move through the development of this OIP and implementation of the change plan, I will practice self-reflection and self-awareness, regularly examine my belief system, and actively seek feedback and criticism from my peers and colleagues. Through distributed and adaptive leadership, I am ensuring diversity of perspectives. Through my change models, I am ensuring a flexible approach that emphasizes continuous and adaptive learning. Through my communication plan and ethical considerations, I am ensuring transparency of the project's steps and objectives.

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Organizational ethics. With regards to organizational ethics, the advisory committee would verify the need for ethics approval for the implementation of all solutions and methods of the OIP. Based on the current implementation plan, the method-process solutions would not directly affect patients, however both students and patients would be notified of the pilot project, and if required would be briefed on the risks and their right to decline participation. However, based on previous procedural changes in this department, due to the quality improvement nature of this change implementation, consent to participate may not be necessary.

Organizational values and culture would also be respected throughout the change process, and will be used as a baseline for the advisory group's ethical stance. However, due to the emergent and changing nature of organizational culture, organizational values and ethics may also change over the course of the OIP implementation. In order to remain relevant and ensure continued organizational learning and capacity building, ethical considerations for the project will be revised every eight months alongside the implementation cycle, since ethics is "a dynamic and continuing activity rather than an adherence to a system of moral codes and principles enshrined in formal policy statements" (Niesche & Haase, 2010, p. 2 from Ehrich, Klenowski & Spina, 2015).

Other ethical considerations include appropriate data storage and sharing practices with regards to the pilot project. These will align with the organization's existing policies with regards to quality improvement projects. Application of principles of research ethics such as minimizing the risk of harm and avoiding deceptive practices will also be applied. Additionally, neuropsychologist and specialized practitioner stakeholders must continue to abide by the psychologist ethical principles and codes of conduct throughout the OIP implementation,

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including beneficence and nonmaleficence, fidelity and responsibility, integrity, justice, and respect for people's rights and dignity (American Psychological Association, 2017).

In sum, the educational institution, leadership, and organizational ethics have been considered during the development of this OIP, and will be applied and regularly examined throughout the change implementation process.

Summary

Chapter 2 discussed the merits of adaptive leadership, distributed leadership, and the transactional approach in leading change using the Reflexive Adaptive Process framework (Stroebe et al., 2005) and Kotter's (1996) 8-Step Model. The organizational analysis using Stacey's Complexity Theory determined the need for a vision focused, reactive and incremental approach to implement the process and policy-method solutions in the areas of student hiring, student on-boarding, and patient assessment. Lastly, ethical considerations and challenges were discussed, with mitigation strategies at the individual, stakeholder group, and organizational level. Next, chapter 3 will discuss the plan implementing, monitoring, and communicating the organizational change process.

Chapter 3: Implementation, Evaluation and Communication

Chapter 2 discussed leadership approaches to change, the framework for leading the change process, a critical organizational analysis, four possible solutions to address the problem of practice, and leadership ethics and organizational change. The final chapter 3 provides three overlapping plans for the implementation, monitoring, and communication of the organizational change.

Change Implementation Plan

This section discusses the implementation plan strategy, goals, and priorities, based on the organizational analysis. The transition management plan follows, discussing stakeholder engagement, the five phases of the implementation plan, desired outcomes, and potential limitations.

Strategy for change. Chapter 2 discussed how the RAP model (Stroebe et al., 2005) in combination with Kotter's 8-steps (1996) best addressed the PoP, solutions, and overall organizational change. The change plan mirrored elements of the PDSA cycle (Moen & Norman, 2009) methodology with regards to built-in 'study' or 'check' points promoting learning and opportunities for modifications. In alignment with Symbolic Interactionism, this change plan provided significant opportunity to manage anticipated stakeholder reactions as well as the current organizational culture and values through reflection, identifying and building shared values, improvement of team functions through the formation of an advisory committee, and supportive leadership (Stroebe et al., 2005).

Stacey's Complexity Theory determined that there are high levels of agreement but medium levels of certainty in this organization with regards to the PoP; therefore, change will be

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most successful through the use of judgmental decision-making (Stacey, 2002). This involved developing a strategy that focuses on a shared vision, where the goal state is congruent with the organizational culture (Stacey, 2002). The goals of the implementation plan are to increase opportunities for the development and measurement of student language competency, and increase opportunities for P-O fit improvement and measurement. Priorities of the planned change are two-fold: (1) develop a shared vision with significant input from ‘followers’ and (2) emphasize congruence with the organizational culture (Stacey, 2002).

The shared vision will be supported by the adaptive and distributed leadership approaches described in Leadership Complexity Theory (Uhl-Bien et al., 2007; Uhl-Bien & Marion, 2009), as well as the advisory committee and the project team. The advisory committee will be a voluntary committee comprised of members from the main stakeholder groups: students, neuropsychologists, and specialized practitioners. This committee will lead using a distributed leadership approach. The committee will provide input from the main stakeholder groups affected by and involved in the proposed change. The project team will be comprised of two or three students and specialized practitioners who are able to volunteer a larger amount of time to the implementation plan. I will be part of this project team. The project team will have a reporting function to the advisory committee.

The RAP model (Stroebel et al., 2005) and Kotter’s 8-steps (1996) correspond to more than one phase of the PDSA cycle (Moen & Norman, 2009), emphasizing the iterative, cyclical nature of this change implementation plan, as well as the built-in flexibility. The PDSA-style change plan also provides considerable flexibility with regards to modifications based on changing stakeholder needs and organizational context. Overall, this method supports stakeholder buy-in to the change plan. It also provides social and organizational actors an

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opportunity for input and innovation that they may not have had if the situation remained status quo. In alignment with complex adaptive systems (CAS) and Complexity Theory, other departments within the organization may also feel the ripple effects of the change and shared leadership vision, as all departments and stakeholders within the organization are interconnected.

Congruence with the organizational culture will be achieved through emphasis on the end state of P-O fit. There are two main elements within the culture to focus on: the culture of performance efficacy and efficiency as demonstrated by the Rational Economic View and the Internal Processes View (Quinn, 1988), and the culture of bilingualism and community leadership. Overall, increased stakeholder congruence, or P-O fit, is another advantage or improved situation for social and organizational actors, as lack of congruence may cause negative feelings in students and specialized practitioners, with subsequent negative organizational effects (Bao et al., 2013; Edwards & Cable, 2009). Both these values are already ingrained in the overall organizational strategy, therefore congruence with these values will be presented as a quality improvement project. Quality improvement projects shift the focus away from current ‘problems’ or ‘gaps’ and focus on the end state of increased congruence. In the context of health care, quality improvement projects better support organizational learning, stakeholder capacity building, and sustained organizational change compared to other more linear conceptual models (Boustani et al., 2010).

Taking the results of Stacey’s Complexity Theory and the organizational analysis into consideration, the strategy for change will focus on developing a shared vision with stakeholders, practicing adaptive and distributed leadership, and increasing organizational culture congruence which will result in quality improvement. These priorities are supported by the RAP model (Stroebe et al., 2005) and Kotter’s 8-steps (1996). Figure 5 visualizes the project implementation

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timeline, including level of risk associated highlighted in green (low risk) and yellow (some risk).

Deliverable	Details and Performance Metrics	Timeline	Responsible Party
Pre-implementation			
Goal 1: Development of a Project Team.	Composition: 2 students, 1 specialized practitioners	1 month	Me
Goal 2: Development of an Advisory Committee.	Composition: 2 neuropsychologists, 1 administrative personnel, 2 students, 2 specialized practitioners	2 months	Project Team
Goal 3: Development of three questionnaires.	Questionnaires : P-O fit for staff (Q1), language competency questionnaire for students (Q2), patient-care questionnaire for supervisors (Q3) Development of dashboard to visually track data	2 months	Project Team Advisory Committee
Implementation			
Goal 1: Establishing a benchmark for the three questionnaires.	Phase 1 of Implementation Plan 1. Administer questionnaires Q1, Q2, and Q3 2. Score and input data into dashboard	Year 1, months 1-4	Project Team Neuropsychologist interviewing the students
Goal 2: Students are provided with some language competency tools.	Phase 2 of Implementation Plan 1. Student-supervisor matching based on Q1 2. Continued administration of Q1, Q2, and Q3 at the beginning of student hiring, mid-practicum, and upon completion of practicum 3. Score and input data into dashboard	Year 1, months 5-8	Project Team Neuropsychologist determining the student-supervisor matching
Goal 3: Staff P-O fit is improved as compared to baseline.	Phase 3 of Implementation Plan 1. Add verbal cut-off language test for patients before assessments 2. Add language competency disclaimer at the beginning of assessments 3. Continued administration of Q1, Q2, and Q3 at the beginning of student hiring, mid-practicum, and upon completion of practicum 4. Score and input data into dashboard	Year 1, months 9-12	Project Team Student and neuropsychologist during the patient interviews
Goal 4: Implementation plan for phases 1-3 is modified and improved as needed.	1. Continued administration of Q1, Q2, and Q3 at the beginning of student hiring, mid-practicum, and upon completion of practicum 2. Score and input data into dashboard	Year 2	Project Team Advisory Committee
Goal 5: Student hiring guidelines are modified to include	Phase 4 of Implementation Plan 1. Modified student hiring guidelines are proposed to organizational leadership, with	Year 3, months 1-6	Project Team Advisory Committee

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language testing component.	<ul style="list-style-type: none"> 2. evidence-support from phases 1-3 2. Track number of students who have completed language testing and received organization-standardized language levels 3. Continued administration of Q1, Q2, and Q3 at the beginning of student hiring, mid-practicum, and upon completion of practicum 4. Score and input data into dashboard 		
Goal 6: Student on-boarding guidelines are modified to include language competency component.	<p>Phase 5 of Implementation Plan</p> <ul style="list-style-type: none"> 1. Modified student on-boarding guidelines are proposed to organizational leadership, with evidence-support from phases 1-3 2. Student feedback gathered on effectiveness and efficiency of new training component and materials 3. Continued administration of Q1, Q2, and Q3 at the beginning of student hiring, mid-practicum, and upon completion of practicum 4. Score and input data into dashboard 	Year 3, months 7-12	Project Team Advisory Committee
Post-implementation			
Goal 1: Lessons learned are developed and shared with department and community.	<ul style="list-style-type: none"> 1. Evaluation of all performance metrics and development of findings 2. Development and implementation of OIP of continuity plan 3. Communication deliverables to staff and community. 	Year 4, months 1-8	Project Team Advisory Committee

Figure 5. Implementation Plan. This figure illustrates the goals, main steps, performance metrics and associated risk level for each phase of the implementation plan.

Transition management plan. The following section will describe strategies for stakeholder engagement; identification of supports, implementation issues, and intermediate goals for each phase of the solution implementation; and acknowledgement of limitations. The proposed solution described in chapter 2 includes a modification of student placement practices, student on-boarding practices, and patient assessment practices. During implementation, phases 1 and 2 will implement changes requiring few to no additional resources. Phases 4 and 5 will implement changes requiring more resources, longer approval processes, and changes in organizational policies and guidelines. Phase 3 also requires few to no resources, however there is no second cycle requiring additional resources or policy modifications.

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Stakeholder engagement. Stakeholders will have varying reactions to the proposed changes based on their values, experiences, and motivation, as discussed in the Change Drivers section of chapter 1. Based on the reasons for potential resistance, different strategies will be employed. Using the discovery and dream elements of appreciative inquiry approach (Cooperrider & Srivastva, 1987), I will ask questions about what is working well with regards to language competency and the assessment of bilingual patients, and how the organizational culture is supportive. This method will help me as an informal leader build a vision – one that does not criticize the organization, but rather builds on its strengths. This method also ensures that all stakeholders agree on the problem. I will also use the collaboration and humility aspects of humble inquiry (Schein, 2013) to direct stakeholder focus on organizational risks associated with gaps in organizational support for language competency and associated risks of ethical incongruence. The advantage to this method is to build stakeholder trust and buy-in as an informal leader. This communication and interaction method will allow me to better understand the organizational culture through stakeholders “perception of the world” (Blumer, 1969, p.2). As stated by Blumer (1969) in Symbolic Interactionism, “meanings are derived from social interactions and group life” (p. 2), and through my interactions, I will also be creating networks of meaning towards the recognition of the identified culture gap. Stakeholder engagement will be discussed in-depth in the communication section below.

Neuropsychologists who are prone to resist change (negative reaction) have a high potential for both “threat” and “cooperation”, therefore a collaborative or an involvement approach would be beneficial (Cawsey et al., 2016; Kotter & Schlesinger, 2008). This will be accomplished through the formation of a change implementation advisory committee, thereby increasing the potential for commitment to implementing the change plan, as well as input of

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relevant information (Kotter & Schlesinger, 2008). Their current state of commitment is described as passive supporter due to the culture of innovation and research, with an anticipated state of commitment of active supporter (Cawsey et al., 2016). Due to the formal authority in this stakeholder group, if there is significant resistance to change from this stakeholder group, negotiation and agreement approaches will be employed (Kotter & Schlesinger, 2008). These may include modification of the implementation plan based on neuropsychologist feedback to ensure participation and buy-in. Students are Change Recipients with an anticipated ambivalent reaction, high potential for cooperation and low potential for threat. Their current state of commitment is described as neutral, with an anticipated state of commitment of passive supporter (Cawsey et al., 2016). This stakeholder group will also benefit from an involvement strategy (Cawsey et al., 2016), as well as education and communication approaches (Kotter & Schlesinger, 2008).

Stakeholders and other change agents will form the implementation plan advisory committee, and will include neuropsychologists working within the organization, particularly if they are currently supervising students, as well as students completing their practicum within the organization. Most stakeholders in the advisory committee will have some formal authority, which will increase the validity of and buy-in to the implementation plan. Other potential change agents would include past students from previous years, and other specialized practitioners within and outside the organization. The main criteria for participation would be the stakeholders and change agents motivation and commitment, and the relevance of second language competency in their area of work or study.

As seen in Figure 5, the project team will be primarily responsible for administration of questionnaires and tracking questionnaire responses. The advisory committee will lead OIP

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decision-making through a distributed leadership approach, and will primarily be responsible for socializing staff, departmental and organizational leadership to the project. Neuropsychologists who are part of the advisory committee will lead the student hiring and on-boarding policy modification proposals in phase 4 and 5, as their hybrid role of leader and practitioner can “act as boundary spanners interpreting policy requirements and translating them to improve clinical care” (Fitzgerald & McDermott, 2017, p. 111). Other neuropsychologist stakeholders will be responsible for the administration of specific questionnaires, such as Q1 during the student interviews, as well as the adoption of the modified patient interview described in phase 3.

Facilitation and support will be provided by the advisory committee to individuals who are resisting due to adjustment problems (Kotter & Schlesinger, 2008). Time for understanding and adjusting plans as necessary to accommodate stakeholder’s reactions and input are built into RAP principle 3 “tension and discomfort are essential and normal during change” (Boustani et al. 2010, p. 143) and Kotter’s (1996) sense of urgency step; and RAP principle 2 “creating time and space for learning and reflection is necessary” (Boustani et al. 2010, p. 143) and Kotter’s (1996) stakeholder empowerment and communication steps. These steps will occur a minimum of once during each phase of the solution implementation, providing multiple opportunities to adjust plans during to implementation process to respond to employee concerns.

Implementation plan. The following section will discuss the five phases of the implementation plan, with regards to supports and resources, potential implementation issues and how they will be addressed, and how to build momentum through intermediate goals to achieve the desired future state. Figure 5 provides an overview of the implementation timeline and Table 2 describes potential resources. The project’s timeline will be measured in blocks of four months for phases 1-3 in alignment with student’s practicum timelines. This will ensure that the same

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students are present for the duration of each new phase, thus reducing the potential disruption of their studies with new information or methodologies for patient assessment mid-trimester. Phases 4 and 5 will be implemented in blocks of six months each, due to the added potential challenges surrounding approval processes for organizational guideline and policy modifications. Once implemented, each phase should continue to be practiced as additional phases are added.

Phase 1. As shown in Table 2, supports required for this phase are low, with little additional time and few financial resources required. Students would complete the questionnaire (Q1) during the placement process to self-assess language competency, and for interviewers to assess students' language abilities. The interviewer would provide the student with the questionnaire, and it would be scored following the interview by the interviewer or a specialized practitioner. Results would be inputted electronically to track and determine a benchmark for student language competency. Potential issues include whether students are obligated to fill out the additional questionnaire, if there will be full-disclosure regarding use of the questionnaire results, and whether students can opt out. This would be determined by the advisory committee beforehand.

Students, specialized practitioners, and neuropsychologist will complete a person-organization (P-O) fit questionnaire. These stakeholder groups are familiar with the methodology of new initiatives and programs, and are already socialized to the importance of questionnaire participation. This questionnaire (Q2) will provide a benchmark for stakeholders' perceived alignment with current organizational practices. Neuropsychologist supervisors will also complete a questionnaire on perceived efficacy of current processes to meet patient language needs, to provide a benchmark for Q3.

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Administration of these questionnaires will identify stakeholder perceptions for benchmarking purposes, as well as reflection purposes. Through this exercise the various stakeholder groups will identify tangible areas of organizational practice that reflect the current organizational culture, specifically the culture of performance efficacy and efficiency as demonstrated by the Rational Economic View and the Internal Processes View (Quinn, 1988), and the culture of bilingualism and community leadership. This will engender both self-reflection and stakeholder discussions and interactions, through which further meaning-making and interpretations may impact the actual/seen organizational culture (Mack, 2010).

Phase 2. Supports required for phase 2 are also low, as seen in Table 2. Based on the student's strengths and needs determined by the questionnaire, the students' language competency level will be taken into consideration when being matched with a supervisor. The supervisor in question would then provide informal language competency coaching throughout the student's practicum, as determined by need (1 to 2 hours of coaching per student). Language competency coaching involves observational learning by the student of the supervisor assessing French-speaking patients. This method also provides the student with increased opportunity to ask questions related to French or bilingual patient assessments. The additional coaching would not lengthen the overall practicum timeframe, and buy-in would be encouraged through education and communication of the importance of language competency for students and assessment of patients (Kotter & Schlesinger, 2008). This dynamic ensures there will always be someone with strong second language competency available for assessments; this benefit will be highlighted. This additional training would not require an official change in practicum requirements; it would be framed as an additional support for students who are assessing bilingual patients in a bilingual organization. Performance will be measure by number of

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successful student-language matches. At the end of their practicum, students will fill out a similar questionnaire as the one provided during their interview (Q1), to determine progress made in self-assessment of language competency. These results will be tracked and monitored against benchmark results.

This phase is intended to provide students with language competency tools and support, in order to begin to address the ethics of care (Nortvedt, Hem, & Skirbekk, 2011) incongruence within the organizational culture related to patient-centered care. Currently, specialized practitioners train students in a non-standardized or non-regulated manner to assess patients using non-validated French-language materials and speaking instructions, which jeopardize the validity of the assessment itself and disrupts the ethics of care (Nortvedt et al., 2011). By providing students with language-specific support, the health care staff within this department will be better equipped to provide bilingual health care services to patients.

Phase 3. As shown in Table 2, this phase would have no resource implications as this test is already available in the department at nil cost. During the patient interview, the neuropsychologist and student would administer a short verbal comprehension test with standardized cut-offs to the patient, to determine whether the patient should be assessed in French or in English. If patients demonstrate a higher level of language competency in French, this should be taken into consideration when assigning the patient's assessor. The time requirement involves an additional ten minutes during the interview, however this time would be fully off-set as this test is regularly employed during the assessment to determine verbal fluency for the purpose of clinical diagnosis. The test would thereby serve a dual purpose of determining appropriate language of assessment, and evaluating language abilities as part of the regular neuropsychology assessment.

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This phase will also include the addition of a language competency disclaimer for students during the consent-to-treatment phase of the interview, prior to conducting the patient assessment. This method does not involve any additional resource. The adoption of this phase would bring stakeholder and staff closer to achieving congruence with the ethics of psychology and organizational culture of compassionate patient centered care. The questionnaire for stakeholders assessing P-O fit (Q2) will be re-administered following the implementation of this phase, as well as the questionnaire for neuropsychologist supervisors measuring perceived efficacy of assessment processes to meet patient language needs (Q3).

This phase addresses multiple areas within the ethics of care (Nortvedt et al., 2011) gap, increasing congruence between the organizations' culture of patient-centered care and bilingualism and administration of the neuropsychological assessment to patients.

Intermediary phase. This intermediary phase was added to enable further data collection and measurement based on the first three phases. As results from the performance indicators are monitored and analysed, positive trends will be celebrated. Alternatively, certain phases can be dropped if no benefits are seen by the advisory committee. Based on the Transtheoretical model, this phase will also provide stakeholders more time to accept the change, develop self-efficacy, and incorporate new behaviours into their daily routine (Prochaska et al., 1992). This phase also encourages stakeholder interactions and the creation of meaning-making in response to findings (Blumer, 1969), for greater recognition of the identified culture gap and movement towards greater congruence with the organizational culture (Stacey, 2002). Note that during this phase, new students will continue to enter the program through phases 1, 2, and 3.

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Phase 4. Based on results accumulated during the status quo year, the implementation plan will move to the next two phases, which generally require medium to high levels of support with increased potential for issues (highlighted in yellow to demonstrate some risk in Figure 5). Supports required for phase 4 are medium to high, and include the involvement of the organization's language testing department as well as Human Resources. Students would be required to undergo standardized second language testing to meet bilingual position criteria, similarly to employees hired into the organization. This solution would also involve a change in placement policies with regards to students. Due to the additional placement requirement, the timeframe for establishing a placement for students would be increased. As well, there is a financial burden of additional language testing on the organization's language center, however the neuropsychology department does have funds for this purpose. Despite these additional resources, the policies and procedures for the assessment of second languages in this organization are already in place, greatly reducing the resource burden. The number of students with organization-recognized language competency results will be used as a performance indicator. Additionally, questionnaires Q1, Q2, and Q3 will continue to be administrated at regular intervals to students, staff, and student supervisors, at the beginning of student hiring, mid-practicum, and upon completion of practicum.

Phase 5. This phase would also require medium to high levels of support and resources. Based on student's strengths and needs, a language competency training component can be added to the student on-boarding process. This would involve online or in-person language competency training, through the use of pre-existing training materials or via the development of new material (potential resources estimation seen in Table 2). Both online and in-person would involve additional time requirement for students estimated at one to two hours. Following this

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process, students would once more self-assess their language competencies (Q1), as well as provide feedback on the efficacy and relevance of resources used. Stakeholders would also complete the P-O fit questionnaire (Q2) to determine the effect of this phase on P-O congruence. Potential issues include the high resource requirement, the additional time that students would spend in on-boarding, and the time staff would spend on developing training resources and modifying on-boarding guidelines and policies. To reduce these burdens, many tasks could be “out-sourced” to the teaching and learning department, and Human Resources.

Neuropsychologists within the advisory committee have influence over outsourcing these training resources. The number of training resources can also grow and improve with time.

Through the modification of policies, both phases 4 and 5 further emphasize congruence with the organizational culture and P-O fit, and anchor the new approaches into the culture (Kotter, 1996).

Outcomes. As seen in Figure 5, the OIP’s goals are divided into three sections: pre-implementation, implementation, and post-implementation. Kotter (1996) identified the importance of short-term wins to build stakeholder engagement, commitment, and motivation during the change process. Short term outcomes or ‘wins’ include general focus on stakeholder awareness and knowledge, and include the development of a project team and advisory committee, developing/determining the three main questionnaires, and establishing the benchmarks. These goals establish stakeholder knowledge of the PoP gap, and buy-in and engagement with the change plan. The intermediate outcome for the implementation plan is the change in behaviours of stakeholders and staff with regards to language competency and patient assessment, measured through changes in post-test administrations of Q1, Q2 and Q3. Goals include providing students with language competency tools, and measuring improvement of staff

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P-O fit from baseline. A second intermediate outcome is the modification of hiring and onboarding guidelines and policies in phases 4 and 5. These outcomes align with Kotter's (1996) building on successes and starting a change in the organizational culture, as well as the RAP model (Stroebel et al., 2005) of learning and reflection. Post-implementation goals include developing lessons learned and sharing them with the department and community, as well as having the language competency program developed by the OIP evaluated. Long-term goals are more challenging to measure and attribute cause, and would involve an increase in the quality of bilingual patient assessments and resulting health benefits.

Limitations. The above timelines will fluctuate based on organizational needs and priorities. As well, through the built-in reflection and discussion steps of the RAP model (Stroebel et al., 2005) in combination with Kotter's 8-Step Model (1996), the advisory committee may decide to implement several phases at once, or eliminate phases based on resources or performance results. Additional performance indicators will likely be suggested by the advisory committee. It is also important to note that the advisory committee members themselves will not remain static, based on staff turnover, changing priorities, and workload. As well, although the advisory committee is effectively the solution implementation lead, organizational management may intervene at any phase with input which may significantly alter the direction of the project. Ideally, organizational management will work in tandem with the advisory committee in a dual operating system (Kotter, 2014). Other limitations include delays in the modification of policies and guidelines, and financial restrictions. Finally, although this section attempts to delineate supports and resources required by phase, there are multiple unknown factors that may increase or reduce these resource requirements. To offset this

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limitation, the project timeline provides realistic timelines with measureable goals, and multiple opportunities for revision and modification of phases

Change Process Monitoring and Evaluation

As discussed in chapter 2, the RAP model (Stroebel et al., 2005) and Kotter's 8-steps (1996) follow a Plan Do Study Act (PDSA) cycle (Moen & Norman, 2009). According to Taylor and colleagues (2014), PDSA models in the health care context include several features: iterative cycles, a prediction-based test of change, small-scale testing, the use of data over time, and documentation. The following section will focus on both "the process of intervention" (Figure 6) and "the results achieved" (Figure 5), employing qualitative and quantitative measurement and evaluation tools following the PDSA cycle (Jacobs, Barnett & Ponsford, 2010, p.40).

Each subsection of the PDSA cycle will also incorporate MEL strategies: monitoring, evaluation, and learning tools that support tracking change, gauging progress, and assessing change. MEL strategies can be used for changes of all sizes, from pilot projects to large scale organizational changes, to ensure that programs/projects are achieving or progressing towards the desired objectives. In adaptive leadership approaches, MEL is a feedback system that allows leaders to continuously assess the changing internal and external context through monitoring of data, and evaluation of evidence/findings (Jacobs, Barnett & Ponsford, 2010). This way, leadership can alter the program/project activities faster based on these findings or trends, and thus adapt rapidly. MEL strategies also produce tangible, data-focused evidence and results, which aligns with the transactional leadership approach; followers will be able to see their progress as the change plan is implemented, thus providing further incentive to continue. In order to further empower stakeholders and in alignment with distributed leadership, data collection be

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completed in a participative approach (Jacobs, Barnett & Ponsford, 2010) by the project team and the advisory committee.

Plan. Tools and measures discussed in chapter 1 of the OIP focus on benchmarking to establish the need for change and organizational readiness. In this pre-implementation phase, it would be beneficial to review multiple sources of data and triangulate evidence in order to establish and increase reliability of findings. The combination of methodologies permitted me to establish evidence-supported needs and readiness for change, and demonstrate the current Person-Organization fit incongruence and culture gap. The tools and methodologies used during the planning stage can be used multiple times (short MEL cycles), to establish trends in organizational readiness and the PoP. These lines of evidence should be carefully documented to support and record learning, as well as support knowledge transfer (Taylor et al., 2014). As seen in Figure 6 during pre-implementation organizational readiness is assessed using the OR4KT tool (Gagnon et al., 2014; Gagnon et al., 2018), and the advisory committee's engagement with change will be assessed through the Line Manager Attitudes and Actions scale (Randall et al., 2009).

Deliverable	Details	Timeline	Responsible Party
Pre-implementation			
Goal 1: Stakeholder buy-in for change plan.	<ul style="list-style-type: none"> • OR4KT • Line Manager Attitudes and Actions scale • Focus Groups 	3 months	Project Team Advisory Committee
Implementation			
Goal 1: Implementation plan is adjusted according to stakeholder satisfaction and feedback.	<ul style="list-style-type: none"> • Change satisfaction survey • Semi-formal interviews • Score and input data into dashboard 	Year 1, 2, and 3, every 4 months	Project Team Advisory Committee
Goal 2: Implementation plan is evaluated and modified as required, based on lessons learned and	<ul style="list-style-type: none"> • Continued change satisfaction survey and semi-formal interviews • Score and input data into dashboard • Focus Group 	Year 2	Project Team Advisory Committee

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evidence.	<ul style="list-style-type: none"> • Study and improvement exercises for OIP, including PESTEL and risk analysis 		
Post-implementation			
Goal 1: Implementation plan is evaluated and modified as required, based on lessons learned and evidence.	<ul style="list-style-type: none"> • Continued change satisfaction survey and semi-formal interviews • Score and input data into dashboard • Focus Group • Study and improvement exercises for OIP, including PESTEL and risk analysis 	Year 4	Project Team Advisory Committee
Goal 2: OIP project evaluation.	The implemented OIP is evaluated as a program by an internal or external evaluator to determine relevance, effectiveness, and efficiency.	Year 5	External program evaluation consultant OR internal organizational evaluator

Figure 6. Monitoring, Evaluation, and Learning Plan. This figure shows the main steps for monitoring and evaluation of the implementation plan, the roles and responsibilities of key change agents, and milestones.

Focus groups led by the project team will also be conducted using respectful open-ended questions to determine change readiness, and discuss organizational strengths in alignment with appreciative (Cooperrider & Srivastva, 1987) and humble inquiry (Schein, 2013). This exercise will encourage open-dialogue of stakeholder perceptions and values which construct the current organizational culture. Based on the learning, I can move into the next phase of the PDSA cycle.

Do. As described in chapter 2, the proposed solution includes a modification of student placement practices, student on-boarding practices, and patient assessment practices. The first cycle of change implementation of phase 1 and 2 will implement a version of the solution that requires few to no resources and does not involve a change in policy or significant approval levels. The second cycle of change implementation of phase 4 and 5 will focus a version of the solution that requires more resources, longer approval processes, and changes in organizational policies and guidelines. This method of starting with a small-scale PDSA, and then build on the

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results and increased stakeholder buy-in, allows “change to be adapted according to feedback, minimises risk and facilitates rapid change and learning” (Taylor et al., 2014, p. 293).

During pre-implementation as seen in Figure 5, the project team and the advisory committee will develop or order the questionnaires (Q1, Q2, and Q3). The first questionnaire focusing on student language competency assessment (Q1) can be constructed using the Language Experience and Proficiency Questionnaire (LEAP-Q) (Marian, Blumenfeld & Kaushanskaya, 2007) and/or the Ethnic-Sensitivity Inventory (ESI) (Ho, 1991). LEAP-Q is a validated questionnaire for self-reported proficiency and experience for bilingual and multilingual speakers, and ESI is a self-assessment tool for cultural competency in a clinical setting. The second questionnaire addressing P-O fit (Q2) will be borrowed from Bretz and Judges’s (1994) 15 item Person-Organization Fit Questionnaire. This questionnaire is intended for all stakeholders and staff within the departments. A third questionnaire to be developed (Q3) will be administered to student supervisors regarding perceived efficacy of current patient interview and assessment practices to respect patient’s preferred/primary language.

As seen in Figure 5 in implementation, Q1 will be administered by the interviewing neuropsychologists to students to determine their language competency during the hiring/on-boarding process (pre-test). Q2 and Q3 will be administered by the project team to the advisory committee and other departmental staff. Q1, Q2, and Q3 will be re-administered to students every four months. Questionnaires will be scored and tracked by the project team, and other departmental staff volunteers. Data will be visualized on an excel dashboard by the project team, and updated throughout the implementation plan. All data will be protected and stored following organizational guidelines, and will be the responsibility of the project team and the advisory committee. Results of all questionnaires will remain anonymous. Through distributed leadership,

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the advisory committee will recommend modifications in the project based on the aggregated results.

As seen in Figure 6, to monitor and evaluate the process of intervention, the project team and the advisory committee will administer change satisfaction surveys and lead semi-formal interviews with departmental staff and stakeholders every four months, to determine how the implementation plan is perceived. For example, do staff see value in the process? What are the perceived areas of strengths and challenges in the implementation plan? Are roles and responsibilities of stakeholders in the process well-understood? The project team and advisory committee will also complete these surveys. Similarly to evidence collected from the project efficacy, data will be visualized on an excel dashboard by the project team, and updated throughout the implementation plan. Participation of the advisory committee and volunteer departmental staff in data collection and monitoring will encourage stakeholder empowerment and buy-in (Jacobs, Barnett & Ponsford, 2010), as well as anchor the change in the organization's culture (Kotter, 1996).

Study. As discussed previously, each implementation phase contains a MEL cycle, through the continuous assessment of Q1, Q2, and Q3, as well as staff satisfaction surveys and interviews. These 'study' or 'check' periods allow the advisory committee to readjust the activities or milestones of the implementation plan as evidence is collected, and provides further opportunity interpretation of findings and new meaning-making (Blumer, 1969) in alignment with Symbolic Interactionism. Between phases 3 and 4, the change implementation plan also includes a one year 'maintain status quo' phase. This phase is for the sole purpose of 'study' and continuous monitoring, evaluating, and learning (MEL). As described by Moen and Norman (2009), "measurement of data over time helps understand natural variation in a system, increase

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awareness of other factors influencing processes or outcomes, and understand the impact of an intervention” (p. 291). Over the year, the data collected and tracked by the project team through the dashboard as seen in Figure 5 and 6 will help “predict whether a change will result in improvement under the different conditions you will face in the future” (Moen & Norman, 2009, p. 9). These collected performance indicators will form trends based on which the advisory committee can better lead/plan for the following phases. These should be compared to the predictions and objectives developed during the planning stage (Taylor et al., 2014), to ensure continued progress towards long term goals. Data collected thus-far should also be compared to the ‘plan’ benchmark lines of evidence, to ensure that the pilot project is still valid. For example, a new PESTEL and stakeholder analysis might be undertaken by the project team, as new staff will have different perspectives, and new environmental context may influence the project’s objectives. The study phase can also include several focus groups to gather stakeholder feedback on the change implementation at various stages. The study phase gives stakeholders the time to practice these new behaviours, and integrate them into their daily workplace activities, aligned with the planned change goal of an incremental implementation. The study phases also provides the advisory committee with sufficient time to plan for the resources needed for the phases 4-5, as these phases are more resource-intensive phase.

A second study phase occurs post-implementation, once the five implementation phases are completed. As seen in Figure 5 and 6, all data from the performance metrics (Q1, Q2, and Q3), including staff satisfaction surveys, interviews, and focus groups are aggregated. Additional focus groups will be held, before overall findings on both implementation plan effectiveness and results are developed. These findings will be discussed by the project team and advisory committee, and lessons learned will be developed and shared with the departmental and

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organizational leadership. Study and improvement exercises for the OIP, such as an additional PESTEL and risk analysis may be completed, to determine whether the project should continue or undergo modification. As seen in Figure 6, a further objective study of the OIP can be conducted if the project becomes a permanent program in the organization, through the completion of an internal or external program evaluation to determine continued relevance, effectiveness, and efficiency of the program and its delivery.

Act. Phases 4 and 5 provide longer term solutions to the PoP problem, following a significant “learning” period. The first several months of phase 4 are dedicated to the advisory committee to modify student hiring guidelines for mandatory language testing. Following management approval of this change, performance indicators tracked by the project team include the number of students who have completed the language testing, and received organization-standardized language levels as seen in Figure 5. This data will be monitored and aligned with the evidence from the PDSA plan step with regards to staff language records for bilingual and French positions. The evidence will then be compared to municipal or provincial trends in health care staffing positions and patient needs.

Similarly, the first several months of phase 5 are dedicated to the advisory committee modifying student hiring guidelines for language competency training, as well as the development and purchasing of material. Following the implementation of language competency resources, students and specialized practitioners using the resources will provide feedback on their usefulness or efficacy as seen in Figure 5. The project team will track student feedback on the new process using the dashboard, and the advisory committee will take this into consideration and modify resources as needed to ensure value for money.

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During both phases 4 and 5, the questionnaire for student self-assessment of language competencies will continue to be administered, and trends in the project's impact on student language competency can be monitored and evaluated by the advisory committee. Similarly, the P-O questionnaire for all stakeholders and the questionnaire for student supervisors will continue to be administered, to establish potential impact and value of the project. Overall findings developed during the post-implementation phase will determine whether the project will continue or required modification, and findings visualized on the implementation plan dashboard will be used to perpetuate further PDSA cycles.

Building off of the potential resources described in Table 2, Figure 7 considers the resources and expenditures required for the implementation timeline based on activities delineated in Figure 5, Figure 6, Table 4, and Table 5. The following expenditures are based on twenty staff members, twenty students, six supervisors, and the average hourly wage of specialized practitioners, and include materials, departmental staff time, and language testing fees. Total expenditures over four years of pre-implementation, implementation, and post-implementation is \$ 16 741 CAD.

Timeline	Implementation Plan	Monitoring Evaluation and Learning Plan	Communication Plan	Total Expenditures (CAD \$)
Pre-implementation	Material: \$ 600 Time: 7 hours	Material: \$ 250 Time: 4 hours	Time: 50 hours	Initial Expenditure Investment: 2 861
Implementation	Language Testing Fee: \$ 8000 Language Training: 20 hours Time: 37 hours	Time: 20 hours	Time: 40 hours	Continuous Annual Expenditure: 12 680
Post-implementation	<i>Optional: 116 hours for evaluation of the program</i>	Time: 20 hours	Time: 10 hours	Expenditure Investment: 1 200

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Figure 7. Resources and Expenditures for Change Implementation. This figure shows the material, time, and fee investments associated with the implementation plan, monitoring evaluation and learning plan, and communication plan.

In sum, various tools and methodologies have been, and will be used in the implementation of the OIP to ensure best fit with the leadership approaches and the PDSA cycle. MEL strategies and a participative approach will be used within each phase, as well as on a larger scale with phases 1-3 and 4-5 including a ‘maintain status quo’ phase. The intention in using multiple methodologies, such as existing and new performance and Human Resources data, internal and external/environmental scans, stakeholder interviews, observations, and literature and research reviews, is to increase the validity of the findings on which the advisory committee can make evidence-informed decisions.

Plan to Communicate the Need for Change and Change Process

The above implementation and evaluation sections contained elements of the communication plan. In the following section, I discuss the communication elements within the RAP model (Stroebe et al., 2005) and Kotter’s (1996) model, and the use of appreciative inquiry (Cooperrider & Srivastva, 1987) in building trusting relationships with stakeholders and awareness for the need for change. Next, I discuss communication strategies and methods by stakeholder group to clearly and persuasively communicate the need for change, including elements from humble inquiry (Schein, 2013). Finally I explain the communication deliverables throughout the OIP implementation, including communication owner, method, frequency, and audience.

Building awareness. The RAP framework includes elements of communication throughout its guiding principles, such as sharing of the vision, mission, and values; the presence

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of tension and discomfort; improvement teams; and full participation of stakeholders in the change process (Boustani et al., 2010). Similarly, the need for communication is integrated into several of Kotter's (1996) steps. For example, (1) establish a sense of urgency, (2) create a guiding coalition, (3) develop a vision and strategy, (4) communicate the change vision, (5) empower employees for broad based action, and (6) create short term wins (Kotter, 1996), all involve stakeholders with the change process, giving them a voice and thereby increasing change buy-in and continued relevance.

While keeping the above in mind, the overarching approach to communication taken in this change implantation is humble inquiry: "the fine art of drawing someone out, of asking questions to which you do not already know the answer, of building a relationship based on curiosity and interest in the other person" (Schein, 2013, p. 21). In chapter 1, I describe my leadership position as being framed by Complexity Theory, which denotes that leadership "does not lie in a person but rather in an interactive dynamic, within which any particular person will participate as leader or a follower at different times and for different purposes" (Lichtenstein et al., 2006, p. 3). This complements my view on leadership, where the leader's role is to lubricate and direct the creation of meaning similarly to an orchestra conductor, to ensure organizational relationships are conducive to forward movement (Schein, 2014).

In the context of communication, humble inquiry denotes that how we interact with stakeholders forms "the basis for building trusting relationships, which facilitates better communication and, thereby, ensures collaboration where it is needed to get the job done" (Schein, 2013, p. 19). In order to establish a sense of urgency (Kotter, 1996) and create tension and discomfort (Boustani et al., 2010), I will begin by inquiring among stakeholders about the organizational risks associated with potential patient complaints and the ethical incongruence

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based on the PoP gap, focusing on face to face communication where possible as it is the most effective communication channel (Klein, 1996). Table 3 describes the communication strategy I will employ by stakeholder group. By asking stakeholders about the need for change instead of telling them about it, I will be able to build more trusting relationships, and increase stakeholder buy-in.

Table 3

Building Awareness for Change

Stakeholders	Potential Questions/Concerns	How the Change will be Framed	Humble Inquiry Elements	Appreciative Inquiry Elements
Neuropsychologists	Affect on patient assessment efficiency? Need for additional resources?	Risk mitigation Quality improvement Increased organizational value congruence		
Students	Affect on practicum timeline? Affect on quality of practicum?	Improve language competencies Modern assessment standards	Use a participative approach for interviews and focus groups	Inquire about the positives
Specialized Practitioners and other health care staff	Need for additional resources? Change/modification of workload or work tasks?	Increased organizational value congruence Quality improvement Opportunity for involvement/input	Show humility Ask open-ended questions	Share stories Create a shared future
Department and Organizational Leaders	Need for additional resources? Aligned with departmental/organizational priorities? Aligned with organizational culture?	Risk mitigation Quality improvement Increased organizational value congruence Alignment with external (PESTEL analysis) and research trends	Be an active listener	

This method also aligns with the appreciate inquiry approach, as the focus is redirected away from the negative and accusatory. The humble inquiry approach is also an advantage for my informal leadership status. The OIP requires me to collaborate with colleagues within an advisory committee, as well as stakeholders from upper management. There will be many

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situations in which “[I] may find [myself] in various kinds of interdependencies in which open, task-relevant information must be conveyed across status boundaries” (Schein, 2013, p. 81).

Having established a trusting and authentic relationship beforehand will facilitate these types of communication. All stakeholders involved in the change implementation (advisory committee and project team) will attend a kick-off orientation phase, to share the principles of adaptive and distributive leadership, and the vision for change. Both appreciative and humble inquiry approaches will also be used in the conduct of interview and focus groups during implementation and post-implementation.

Neuropsychologists and students. Table 3 demonstrates the OIP’s main stakeholder groups, and their potential reactions to change. Utilized in the stakeholder analysis, the QCV model (Quinn, 1988) is employed again to determine best methods of communication with stakeholders. Neuropsychologists are internal stakeholders with high decision-maker power and influence (Cawsey et al., 2016), and an Internal Process view concerned with stability and efficiency (Quinn, 1988). The proposed change should therefore be framed as a method that supports the department and organization’s future stability and efficiency.

The PoP and OIP will therefore be framed as a plan for risk mitigation and quality improvement, as seen in Table 3. The Internal Process view shares similarities with the Human Resources view, with regards to an internal focus, therefore these stakeholders may be more open to the inclusion of additional training practices and alignment of processes with organizational values (Quinn, 1988). Therefore, an additional method of framing the OIP is by emphasizing the future increase in organizational value congruence. Students are internal stakeholders with low decision-making power and influence (Cawsey et al., 2016). According to the QVC model, these stakeholders may have an Open Systems view, which shares similarities

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with the Rational Economic View with regards to an external focus (Quinn, 1988). Students may therefore be more open to a change process that focuses on efficiency, goal setting, and maximizing output (Quinn, 1988). The PoP and OIP will therefore be framed as opportunities within the practicum to improve language competencies, and assess patients in alignment with modern standards of cultural and linguistic ethics. Students will also be assured that these opportunities will be supported by the required additional resources.

Specialized practitioners and other health care staff. The following stakeholder group may include specialized practitioners, as well as other health care staff working within the department without formal leadership authority. Concerns about the organizational change will focus on the potential need for additional resources, and the resulting change or modification of personal workload or tasks. The need for change, approached within the framework of appreciative inquiry, will focus on the current organizational value incongruence, and personal responsibility towards transparent and high quality patient care. Potential increase or modification of workload will be discussed in the context of quality improvement, and as an opportunity for staff input and involvement. Based on level of interest, the possibility of joining the advisory committee will be discussed.

Department and organizational leaders. As described in chapter 1, the leadership culture in this organization tends towards the transactional (Vera & Crossan, 2004), due to the economic context and risk-reduction focus. Decision making is largely top-down, although discussion forums and panels with management are regularly embedded in the process of large scale organizational changes. However, professional practitioners within departments, including the neuropsychology department, maintain high levels of autonomy (Mintzberg, 1979). This environment provides opportunity for informal leadership to advance appropriate and relevant

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initiatives, including the implementation of projects and pilot studies, when supported by management and formal leadership at the departmental level. As well, all initiatives must be aligned with the organization's risk-reduction and efficiency focus, while upholding the reputation for patient centered and quality care, and student teaching and training excellence. Therefore, concerns in this stakeholder group may include the need for additional resources, and alignment with departmental and organizational priorities and culture. The need for change will be approached as an opportunity for risk mitigation and quality improvement, as well as increasing organizational value congruence.

Communication strategy. Once the approach to framing the need for change has been established for each stakeholder group, a communication strategy for pre-implementation and implantation can be auctioned.

Table 4

Pre-implementation Communication Strategy

Producer	Audience	Method	Deliverable	Frequency
Change initiator	Students and specialized practitioners	Informal meeting	Evidence infographic Project critical path Pilot proposal document	Weekly (4x total)
Project Team	Neuropsychologists	Meeting	Evidence infographic Project critical path Pilot proposal document	Bi-weekly (4x total)
Advisory Committee	Department leaders	Briefing document Meeting	Evidence infographic Project critical path Pilot proposal document Abbreviated OIP document	1x
Advisory Committee	Organizational leaders	Briefing document Meeting	Pilot proposal document	1x
Project Team	Other health care staff	All staff meeting	Evidence infographic Project critical path Pilot proposal document	Bi-weekly (4x total)

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Table 5

Implementation Communication Strategy

Producer	Audience	Method	Deliverable	Frequency
Project Team	Advisory Committee	Internal Shared Network Meeting as necessary	Status update Action items follow-up Budget usage Updated dashboard/wins	Weekly
Advisory Committee	Department Leaders	Briefing document Meeting	Status update Action items follow-up Budget usage Updated dashboard/wins	Monthly
Advisory Committee	Organizational Leaders	Briefing document	Status update Budget usage	Monthly
Advisory Committee	Departmental staff	Staff meeting	Status update Updated dashboard/wins	4x per year
Advisory Committee	Organizational Staff	Internal email	Contribution to organizational newsletter Status update and wins	Monthly

As seen in Tables 4 and 5, there are five elements in the communication strategy: the producer of the communication deliverable, the intended audience, the method by which the communication product is distributed, the communication product or deliverable, and the frequency of communication.

There are two main producers other than myself, the change initiator: students and specialized practitioners. These stakeholder groups will form the project team, which will complete much of the day-to-day tasks required of the pilot project such as monitoring of data and communicating with the advisory committee. The next group, which includes neuropsychologists, specialized practitioners and students, will lead the OIP implementation and be a significant producer of communication deliverables. An important benefit to the committee is that various stakeholder groups will be represented, thus increasing the committee's ability to communicate to these stakeholder groups in a meaningful and relevant manner. This step reflects

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Boustani and colleagues (2010) improvement teams and full participation of stakeholders, as well as Kotter's (1996) (2) create a guiding coalition and (5) empower employees for broad based action.

During pre-implementation as seen in Table 4, communication methods include meetings and briefing documents. Meetings create an opportunity for discussion and exchange of ideas, in a participatory approach. Briefing documents will be used in conjunction with meetings for department and organizational leaders. Deliverables for most audiences include sharing evidence via infographic. Infographics are a combination of evidence and visuals that enhance the message or findings to a specific audience, using strategies associated with the field of marketing. The critical path is also a one-page document, with a timeline of the main implementation steps and milestones. The pilot proposal document is a three-page briefing document that includes the main elements for management to know about the project such as rationale, resources, and objectives. Finally, the abbreviated OIP document is an expansion of the pilot proposal, focusing on the implementation, evaluation, and communication phases.

As buy-in from each stakeholder group is reached, support for the project will grow and further increase potential project approval by departmental and organizational leadership. With the support of formal authority (neuropsychologists), the advisory committee can then advance the project proposal with department leaders, who can in turn advance the proposal to organizational leaders. Once formally approved at all levels of leadership, the project team can present the proposal to the other health care staff at the All Staff meeting. Approval at all levels of leadership is necessary as the implementation plan requires bottom-up support to ensure understanding and buy-in.

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Once the pilot project has been approved, the implementation communication strategy seen in Table 5 begins. The advisory committee will receive weekly updates with regards to project status, budget, and dashboard through the organization's internal shared network from the project team. In turn, the advisory committee will provide the department leads with a briefing document and meeting on a monthly basis. A similar but more succinct update will also be provided to organizational leaders on a monthly basis. Status and dashboard updates will be conveyed every four months at the department staff meeting, in order to provide other health care staff with the opportunity for input and discussion. The advisory committee will also contribute to the organization's monthly newsletter. In alignment with (6) create short term wins (Kotter, 1996), the updated dashboard, which will illustrate the projects progress as well as wins, will be available for all departmental health care staff to see/access throughout the implementation plan. This plan can also be modified as the change is implemented, to better support stakeholder needs.

Post-implementation communications will include lessons learned in the form of meetings and open-forums, and will include all departmental staff. Using aggregated evidence from the dashboard, the advisory committee will determine whether the project should be expanded or prolonged, and a second proposal will be brought forward to departmental and organizational leaders. Because of the ethical sensitivity of this internal pilot project, communication to patients and the wider community should focus on wins and benefits of the change: organizational systems quality improvement for increased capacity to serve the bilingual community and care for patients. This can take the form of a contribution to the annual newsletter throughout the implementation stage, or at the end of the implementation. If successful, this pilot project could be further developed into a case study or research document to

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be submitted for publication in education or psychology journals, to serve as an example for integrating language competencies into student practicums for improved patient care.

In sum, this section discussed how to build stakeholder awareness of the need for change through Kotter's (1996) steps and the RAP framework (Stroebel et al., 2005), as well as select elements of humble inquiry (Schein, 2013) and appreciative inquiry (Cooperrider & Srivastva, 1987). The change will be framed to each stakeholder group in consideration of their unique views as analyzed through the QCV model (Quinn, 1988). The communication strategy for pre-implementation, implementation, and post-implementation apply a variety of methods and deliverables to ensure a participatory approach that respects current organizational leadership hierarchy.

Next Steps and Future Considerations

The focus of this Problem of Practice and Organizational Improvement Plan was on increasing the ethical practices of student assessments of bilingual and French-speaking patients, largely through improving language competency. To ensure sustainable change for the department and organization, a distributed leadership and participatory approach was purposefully used throughout, to increase stakeholder buy-in and ownership of the project. A shared vision was developed through open dialogue and celebration of the organization's strengths, which will withstand internal and external changes. And my values of transparency, democracy, and equity, aligned with the organization's values, guide the implementation of the OIP and provide a roadmap for other change leaders to follow.

As this organization's patient population continues to evolve, next steps would include widening the scope of language competency to include multilingualism, and the development of

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cultural and multilingual competency. Multilingual competency focuses on the assessment of patients with who speak multiple languages, including but not limited to French and English bilingualism. Cultural competency could be developed in tandem with language competency, to support quality of assessments, as well as patient care more generally.

Note that although informed by literature and research, the leadership approaches and the theoretical framework used to develop this OIP were subjective to the author. Other organizations or departments who may use this OIP as a platform on which to build their own change plan should modify their methodology based on their unique organizational context, experiences, and needs, including leadership approaches and theoretical framework.

This PoP and OIP grew out of an observed gap in the organizations' stated and practiced culture in the area of bilingualism. Although the author is not in a formal leadership position, with appropriate leadership approaches and change implementation frameworks, impactful organizational change can be achieved. With continued reductions in health care funding and increasing trends in patient loads, informal leaders will continue to grow in the outer margins of health care organizations (Fitzgerald & McDermott, 2017). And with them, continued organizational change.

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