Embarking on Equitable Change in Turbulent Times: A Study on Enabling Conditions for Dialogic Organizational Development

Rachael Banks

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In Multnomah County African American babies are twice as likely to die before their first birthday compared to white infants. Health inequities like infant mortality, pre-term births and low birth weight are due to medical and social factors, exacerbated by social injustice and are preventable. The cost of poor birth outcomes is enormous, especially if babies need a stay in the neonatal intensive care unit, costing on average $3500 per day. Health inequities are wicked challenges as evidenced by their complexity, duration, amalgamation of causes and interplay with external factors like healthcare, poverty and individual behaviors.

Multnomah County Health Department (MCHD) is addressing health inequities within a rapidly changing environment. The health system in Oregon is regionalizing by combining numerous healthcare providers into a Coordinated Care Organization (CCO) that will work from a single budget and operate within a networked governance system. Current health outcomes and a shifting healthcare environment necessitate organizational changes that allow for ambiguity, diversity and collective action.

Many Organizational Development (OD) and change efforts have taken place to address wicked challenges like health inequities, yet they still persist. The Multnomah County Health Department has committed to tackling poor birth outcomes and is embarking on an OD process to identify solutions that will address increasing healthcare needs while decreasing health inequities. Previous OD efforts have been partially successful at reducing poor birth outcomes but have been unable to significantly decrease the gap in health status.
Recently an increasing amount of literature describes a newer type of Dialogic OD and distinguishes it from classical, Diagnostic OD. The literature suggests that Dialogic approaches are well aligned with complex challenges where solutions require multiple perspectives. However, there is a shortage of literature on the conditions that enable Dialogic OD to succeed in complex organizational change settings.

This study addresses the gap in our current understanding on how to prepare organizations to embark on Dialogic OD. Specifically it will answer two research questions. Part A: For cases that are wicked, what are the pre-conditions needed to initiate Dialogic organizational change? Part B: Are there different enabling conditions for the two types of OD? In an effort to answer the aforementioned research questions, this capstone uses a quasi-experimental design relying heavily on qualitative methods. This study uses thematic content analysis from oral interviews to identify information relevant to the research questions.
Introduction

Overview of Study

The United States spends more money on healthcare than any other industrialized nation (Johnson, 2012). However, persistent health inequities\(^1\) continue for communities of color and low income people in the United States and Multnomah County (Casalino, 2007; Lu 2003; HEI Report, 2009, ULPDX, 2009). Infant mortality, low birth weight and prematurity are examples of health inequities addressed by the Maternal and Child Health (MCH) programs at Multnomah County Health Department (MCHD, 2009). Magis and Duc (2011) define “wicked” challenges as complex, difficult to understand and lacking proven strategies to address them. Similarly, health inequities are extremely complicated and contain a myriad of factors ranging from individual behaviors to community conditions such as healthcare availability and poverty (HEI report, 2009; Lu, 2003).

In addition to the complexity of poor birth outcomes the environment surrounding MCHD’s Maternal and Child Health programs is changing rapidly (Oregon.gov, 2012; Multco.us, 2012). Large healthcare initiatives like the Affordable Care Act (PPACA: Public Law 111-148, 2010) and Oregon Healthcare Transformation (Tri-county Medicaid Collaborative, 2012; Oregon. Gov, 2012) require that low income people have access to healthcare and are forcing Multnomah County to think differently about how public health services are provided. Due to the national and state economy, Multnomah County’s budget has been decreasing for the past 11 consecutive years amidst a consistent and increasing need for services (Cogen, 2011). In order to address persistent health disparities in a changing

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\(^1\) Health inequities are differences in disease rates or health outcomes between populations as a result of social injustice (MCHD, 2009; MCHD, 2011)
environment, MCHD must employ innovative thinking (Magis, 2011) and undergo an organizational change that prepares for health care transformation and increases the amount of people served with less revenue. “The reality of this circumstance has forced us to take a fresh look at our operations and to look for creative solutions to do more with less (Cogen, 2011).”

Organizational change is necessary in the MCH programs in MCHD since the current Early Childhood Services model does not produce the type of visionary conversations needed for solution-oriented transformative change. With a history of Diagnostic change efforts in MCH, MCHD must identify and implement conditions that lay the foundation for a different kind of organizational change to address health inequities (HEI, 2009), one that positions the agency to alter the service delivery model to affect more people and operate within a networked governance system created through Health Care Transformation (Multco.us, 2012; Oregon.Gov, 2012). The literature reveals a new form of OD that holds promise to produce the kind of visionary, imaginative and norm-changing conversations (Eisen, 2005; Cooperrider, 2005; Cooperrider, 2010) needed to convert the opportunities in the environment into a revitalized maternal and child health system that improves birth outcomes and decreases gaps in health status.

There are two types of OD in the literature. One is a classical, Diagnostic approach which utilizes assessment techniques to identify the problem in an attempt to implement the best solution (Haneberg 2008; Bushe 2009). Evidenced by long-standing health inequities, the

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2 The terms organizational development (OD) and organizational change will be used interchangeably in accordance with Haneberg (2005) statement “Most people agree that OD involves change and, if we accept that improvement in organizational functioning means that change has occurred, then, broadly defined OD means organizational change”.

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Diagnostic approach to change management has not proven fruitful in identifying innovative solutions to the multifaceted, changing issues of MCH. “Western conception of knowledge, including its romance with permanence, belief in progress, the search for reliable patterns beyond contingencies toward the service of predicting and controlling future events, has not fulfilled it’s promise (Cooperrider et., al. 1995, p. 158).” A newer field of study in OD has identified Dialogic OD efforts that engage participants in addressing wicked challenges that are complex, polycentric and highly variable (Maurer, 2010) However, Dialogic approaches need more study (Bushe, 2009) to fully unleash their potential as a tool for organizational success.

Authors such as Fernandez and Rainey (2006) and Brinkerhoff and Ingle (1989) have identified enabling conditions for initiating and implementing Diagnostic OD. There has been less study, however, on the pre-conditions for implementing Dialogic OD. “Because creating enabling conditions for different kinds of conversations to take place seems to be a key differentiator amongst the Dialogical practices, this seems like an excellent area for OD scholars to investigate (Bushe, 2009, p. 363).” The reasons are plenty why MCHD MCH needs to change. The question for this capstone is what are the pre-conditions\(^3\) that need to be in place to facilitate the required OD processes? “This may allow us to describe under what conditions Diagnostic OD is most appropriate and when Dialogic forms are more appropriate for effective change and development of organizations (Bushe, 2009, p. 365).”

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\(^3\) The terms pre-conditions and enabling conditions are used interchangeably to include the conditions needed to initiate an organizational change effort. These conditions are applied to the period when an organization is deciding and planning to initiate an organizational change.
Background

State Level Changes Impacting Multnomah County

Multnomah County, like the state of Oregon, is in a quickly changing environment (Multco.us, 2012; Oregon. Gov, 2012). The environmental context of healthcare and MCH is evolving and unknown. In 2011 the Oregon Legislature passed House Bill 3650, also known as healthcare transformation. This transformation will create coordinated care organizations (CCO) that re-imagine the way that healthcare organizations deliver healthcare into an integrated framework to accomplish the triple aim of reducing healthcare costs, improving population health through preventative care and improving the patient’s experience of care (Oregon. Gov, 2008). All the major health care systems and three counties from the Portland Metro area formed a tri-county Medicaid healthcare collaborative (Multco.us 2012). This collaborative will use global budgeting (Oregon.Gov, 2011) to determine reimbursement. “They will have one budget that grows at a fixed rate for mental, physical and ultimately dental care and will have flexibility within the budget to deliver defined outcomes (Oregon, 2012).” This is a radical departure from the current fee for services system where each provider and each health system are reimbursed for a service to a patient, not the patient’s outcome. “Currently providers are paid for treating illness, not for preventing it (Oregon.gov, 2012).” There are no best practices for this specific type of health care transformation. Oregon is the first state in the country to embark on this interdependent and networked system of healthcare for patients on Medicaid.

Like Oregon’s healthcare transformation, the Early Learning Council (ELC) will also be utilizing a collaborative approach by creating hubs of service that share resources (SB 909). The ELC was created by Senate Bill 909 during the 2011 legislative session. As part of the
overarching education initiative, the ELC will guide efforts to integrate and streamline existing state programs for at-risk youth and ensure all children are ready to learn when they enter kindergarten. These larger change efforts that are re-creating the way health services are delivered will impact the MCH programs in Multnomah County. These opportunities highlight the importance of having a change management process that can transform ambiguity and uncertainty into opportunities and action.

Current Situation in Multnomah County Health Department

As the local public health authority, MCHD is mandated (ORS 431.416) to provide services to high-risk children and families. Although committed to reducing birth disparities for African Americans (MCHD LPHA Plan, 2011), program staff express disempowerment, institutional racism, inadequate leadership and lack of motivation, as revealed through staff meetings attended by the researcher. An empowering approach to change management is needed in order to create novel solutions, leverage existing resources and save infant lives. The current MCH leadership culture has not produced empowering organizational change that addresses the gaps in health outcomes. Deficit-based language, hopelessness and mis-trust are common themes emerging from conversations among staff and the researcher. This problem-centered culture does not lay an adequate foundation for assets-based innovative leadership or preparation for an adaptive healthcare system. With a continued focus on explaining the rationale behind the current model (Multco.us, 2012), the traditional culture in MCH is failing to harness the future opportunities produced by the transforming healthcare environment.
Review of the Literature

The theoretical underpinnings of this report depend upon three fields of study under which this section will review: literature on health inequities, wicked challenges and literature on organizational development (OD).

Health Inequities

Persistent health inequities in infant deaths and low birth weight babies exist in Multnomah County despite MCH programs like Early Childhood Services receiving the largest single MCHD investment from general funds (MCHD, 2008; MCHD 2012). A variety of societal, medical and individual factors contribute to infant deaths and low birth weight (Lu, 2003). Health inequities are not natural—racism and social class play a role in these differences (NACCHO, 2002; HEI, 2009, MCHD 2011). They are unjust and costly. “Policy solutions should target root causes of racial and ethnic disparities and be developed with members of the communities most impacted (Urban League, 2009, HEI report, 2009)”. No single additional policy or program will effectively eliminate these inequities. Traditionally, MCHD has addressed health disparities using a program-by-program approach that targets a single disease or problem. These programs are distinct and often disconnected. Recent literature on the Life Course Theory suggests the greatest gains can be made by focusing on a mother’s health throughout the course of her life in a connected and strategic way (U.S. Dept. of HRSA, 2010; Lu, 2003).
Wicked Challenges and Organizational Complexity

The issues facing organizations like MCHD are increasingly complex (Armenakis, 1993; Cogen, 2011). The environment will become more turbulent due to an accelerating pace of change, inequality and interdependence inherent in the aforementioned transformation initiatives. “There will be increasing diversity and linkage across domains (Eisen, 2005).” Many factors contribute to the intricacy of modern problems including networked governance, a globalized economy and ineffective leadership (Friedman, 2009; Morgan, 2008). Like many organizations, the current inequities in MCHD are occurring against a backdrop of wickedness.

Due to the uniqueness and magnitude of changes occurring in the health system in Oregon, along with the complexity of birth outcomes and the need for collaborative solutions to dynamic problems, elements of the Dialogic OD appear to be aligned with the characteristics of wicked challenges. Wicked challenges are unbound (Magis, 2011) and span multiple domains including political, economic and social. “The nature of wicked challenges/issues is such that their successful resolution requires a collaborative approach (EMERGE Leadership Tool, 2011)”. Innovative thinking can identify solutions to wicked problems that “manifest a high degree of uncertainty, where the solutions are not readily evident and the proven strategies to address them do not exist (Magis, 2011, p. 3)”. As organizational challenges increase, organizations will benefit from having tools and skills to deal with wicked challenges. “New ways of organizing are required to mobilize human, financial and other resources necessary for facilitating action across sectors and communities that share common problems (Cigler, 1999, p. 87)”.
Health Inequities are Wicked Challenges

Health inequities in MCH are dynamic and ever-changing as scientific research, community wisdom and organizational expertise are incorporated into new understandings of causality and potential solutions. Issues facing leaders “call for solutions that cross individual agency boundaries, and in many cases, extend beyond the public sector (Brinkerhoff, 2002, p. 117; Lu, 2003). While there is not a uniform method to decrease health inequities, it is known that cultural competence will decrease negative experiences and improve outcomes for staff, patients and communities (Betancourt, 2002).

Literature on inequity demands the need to use various interconnected methods to dismantle the injustice present in organizations and policies (Curry-Stephens, 2010; ULPDX, 2009; HEI 2009). Some theorists believe that Dialogic OD has the potential to change the culture of an organization and flatten hierarchy (Cooperider, 1995, p. 167). The literature states that health inequities exist (MCHD 2008; MCHD 2009; HEI, 2009; Curry-Stephens, 2010); now it is time to move beyond this literature into solutions.

“Gergen (1978) has taken the single most important step in this direction with the proposal that the primary task of science is no longer the detached discovery and verification of social laws allowing for prediction and control. Rather he defines good theory in terms of its generative capacity… to challenge guiding assumptions of a culture, to raise fundamental questions regarding contemporary social life, to bring about reconsideration of that which is taken for granted and most important to furnish new constructions and alternatives of social action (as cited in Cooperrider 1995, p. 170).”

Based on the involvedness of health inequities, comprehensive solutions require collaborative action.
Organizational Development

There have been a plethora of books and studies written on the field of OD. Van de Ven and Poole (1995) reported a count of one million articles relating to organizational change. Authors who study OD have recognized a crisis of relevance, fragmentation, rival paradigms and competing voices. “Everywhere we look seemingly immutable ideas about people and organizations are being directly challenged and transformed on an unprecedented scale (Cooperrider, 1995, p. 157).” Discussions have occurred about the applicability of varying OD practices to current circumstances where “different trends or orientations to the practice of OD are primarily attributed to difference in underlying values, possibly connected to shifts in business needs and expectations as well as generational differences (Bushe & Marshak, 2009, p. 348).” Bushe and Marshak (2009) have identified Dialogic OD which is a “different kind of OD practice that has emerged where the underlying assumptions are not consistent with some of the original basic premises of classical or Diagnostic OD. Dialogic OD is often studied in comparison to Diagnostic approaches.

Classical/Diagnostic Organizational Development

Organizational Development has roots in science, philosophy and psychology. For the purposes of this paper, two types of OD will be discussed and compared: Classical/Diagnostic and Contemporary/Dialogic. “The ancestry of OD goes back to Carl Jung and Abraham Maslow, who fathered the humanistic branch of psychology, and Frederick Taylor, most known for scientific management (Haneberg, 2005, p. 8).” The positivist and modernist influence in classical OD offers strategies that strive for objective truths revealed through fact-finding, analysis and problem identification (Agryis, 1973; Maurer, 2010; Cooperrider 2010; Haneberg,
Diagnostic OD incorporates elements from a variety of fields and theorists. These theories have a shared premise that rational and analytic methods will identify data and problem-solving methods that will lead to desirable change. Methodologies congruent with these theoretical underpinnings include, but are not limited to, classical OD action research, socio-technical systems analysis, survey feedback and task-oriented team development (Fernandez, 2006, Haneberg, 2005, Bushe, 2009). The role of the practitioner or change leader in Classical OD is to create and manage change, and the primary task in Diagnostic OD is to diagnose the problem and create a plan to fix it. “Organization development practitioners help companies manage change and align people, processes and practices for success (Haneberg, 2005, p. 1).” Classical OD finds problems and implements processes to change people and outcomes.

Despite the profusion of OD theories, organizational problems increase as does the number of OD practitioners. “For every managerial challenge, there is a consultant willing to offer assistance - at a price (Bolman, 2008 p. 9).” Modern public organizations are facing decreased revenue in the midst of increased need for services and assistance. Eisen (2005) states that “our world is changing - along predictable and unpredictable lines which are affecting organizations and communities, some of which will become our clients (p. 188)”. The frequency of change suggests future study for new approaches. “With continuously changing economic,
political, and social environments, human resource and organizational development professions often need to rethink methods of engagement within organizations (Maurer, 2010, p. 268)”. The ubiquitous nature of change discussed earlier reinforces the need for dynamic and comprehensive forms of OD.

**Diagnostic Pre-Conditions**

In order to identify Dialogic pre-conditions largely unexplained in literature, this paper will begin with identified enabling conditions or necessary factors for the initiation of Diagnostic change management efforts (see table 1). The facilitative conditions revealed in literature “support and enhance the possibility of a successful outcome” (Brinkerhoff 1989 p. 493)”. There are generally between five to eight pre-conditions noted in literature with some variations on similar concepts. This paper discusses five of these preconditions: need for change; executive level commitment and support; resource allocation; multi-level agency involvement and openness to learning.
### TABLE 1: Diagnostic Pre-Conditions Identified for Classical Organizational Change

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<th>Pre-condition</th>
<th>Sub-propositions</th>
<th>Role of Senior Managers</th>
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<tr>
<td><strong>Need for Change</strong></td>
<td>- Communicate perceived gap between actual and desired performance</td>
<td>- Convince people change is needed</td>
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<td></td>
<td>- Craft a compelling vision</td>
<td></td>
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<td><strong>Top-management Support</strong></td>
<td>- Champion the cause</td>
<td>- Lead efforts</td>
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<td></td>
<td>- Maintain support and momentum</td>
<td>- Marshal resources</td>
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<tr>
<td></td>
<td>- Provide a plan; devise clear and specific strategy built on causal theory</td>
<td>- Lead communication</td>
</tr>
<tr>
<td><strong>Commitment to Change</strong></td>
<td>- Ensure top management support and commitment to change</td>
<td>- Act as, or appoint, an idea champion</td>
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<tr>
<td></td>
<td>- Individuals have skill and acumen to maintain momentum and overcome barriers</td>
<td>- Cultivate support by top-level leadership</td>
</tr>
<tr>
<td></td>
<td>- Avoid overtaxing</td>
<td>- Assign financial, technological and human resources</td>
</tr>
<tr>
<td></td>
<td>- Provide a plan; devise a clear and specific strategy built on causal theory</td>
<td>- Develop course of action and implementation strategy</td>
</tr>
<tr>
<td><strong>Multi-level Involvement</strong></td>
<td>- Build internal support and overcome resistance</td>
<td>- Ensure participation and commit resources to manage participation</td>
</tr>
<tr>
<td></td>
<td>- Secure participation of key beneficiaries</td>
<td>- Avoid criticism, coercion or threats aimed at reducing opposition</td>
</tr>
<tr>
<td></td>
<td>- Avoid criticism</td>
<td></td>
</tr>
<tr>
<td><strong>Openness to Learning</strong></td>
<td>- Willingness to innovate</td>
<td>- Avoid punishment for mistakes that result from innovation</td>
</tr>
<tr>
<td></td>
<td>- Take risks to achieve outcome</td>
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Numerous studies, books and authors discuss the importance of communicating a sense of urgency or perceived need for organizational change (Armenakis, 1993; Brinkerhoff 1989; Kotter 2008; Cigler, 1999).” A leader or change manager “must convince organizational members of the need for change and create a vision for change that is compelling (Fernandez, 2006). This need for change should be presented as an urgent matter that is strong enough to persuade people that it is in their best interest to change. Several leaders have described manufacturing a crisis to rally support (Kotter, 2008). Often the literature presents needs or problem statements that include external pressures, unacceptable costs, competition or other threats.
Another commonly cited pre-condition is commitment to change as evidenced by executive level support. Numerous studies and change processes claim support of senior officials and top management is imperative. It helps for an “individual to champion the cause for change” (Fernandez, 2006). A person with a leadership position should “provide employees latitude to conduct their work” and provide “employee development” opportunities (Tierney, 1999). Senior-level support should be included early in the process. Cigler (1999) discuss “early and continued support by elected local officials (p. 95).” Executives are seen to have the positional power to impact most of the other enabling conditions.

Often practitioners will discuss resource allocation as a major contributor to successful OD. Resources are presented as a necessary condition and discussed as a major reason for failure when they were insufficient. Resources are intertwined with power and politics which make them a key factor (Boleman, 2008, p. 196). Change requires adequate amounts of financial, human and technological resources to implement the desired actions. Brinkerhoff and Ingle (1989) describe a “commitment to change, including a willingness to assign resources to implement a proposed solution (p. 493)”. The resources called for in literature include financial, personal and technological.

In order to carry out successful change to implementation, many scholars and practitioners highlight the need for a plan that involves many layers within the organization. This is also referred to as multi-level agency commitment. Engaging with multiple people provides “ability to build and maintain positive and trusting relationships with people at all levels of the organization and with diverse points of view (Haneberg, 2005, p. 17). “Change is more likely to be successfully implemented when the social network in the organization is strongly
connected (McGrath, 2003, p. 325)” because it assumes that once an idea is adopted in one
location a connected network facilitates its dissemination through the organization.

Another category the literature discusses is openness to learning. This may occur through
flexibility, risk taking and a culture that allows for mistakes (Brinkerhoff, 1989; Tierney, 1999).
“In order for employees to engage in the necessary experimentation that brings about change,
they must have the necessary latitude in conducting their work (Tierney, 1999, p.120).” The
literature reveals many conditions for initiating Classical or Diagnostic OD.

**Dialogic Organizational Development (OD)**

Dialogic OD theory has in part come from recognition that there are a plethora of OD
trends and paradigms that may be different enough to warrant a new field of study. Parts of the
changes in OD are being fueled by exciting breakthroughs - what’s been called “the strengths
revolution in management (Cooperrider, 2010, p. 1)”. Studies on Dialogic forms of OD are built
on the premise that there are multiple realities that function within an organization,

“Recognizing the symbolic and relationally constructed nature of the organizational
universe, we now find a mounting wave of socio-cultural and constructionist research
which is all converging around one essential and empowering thesis: that there is little
about collective action or organization development that is preprogrammed, unilaterally
determined or stimulus bound in any direct physical, economic, material or deep-
structured sociological way” (Cooperrider, 1995, p. 157).

The goal of Dialogic OD is to “produce input for the ongoing social dialogue and praxis in a
society rather than to generate unequivocally verified knowledge (Maurer, 2010, p. 279).” This
method views assessment and intervention simultaneously. “Inquiry and change are not separate moments (Cooperrider, 2010 p. 16)”.

In addition to a spirit of inquiry and collaborative design of the future, Dialogic OD includes an appreciative view of the human being. Literature and studies from psychology, anthropology and public administration have demonstrated the value of a positive view of human beings, engaging people in civic engagement and the identification of shared vision (Bokeno, 2000; Cooperrider, 2010; Cooperrider, 1995). Douglas McGregor’s Theory X and Theory Y management models (1960) demonstrated that in order to succeed, companies must cultivate an organizational environment that engages and intrinsically motivates workers. “The last twenty years have seen considerable research done on the power of positive imaging and visioning (Boyatis, 2006, p. 512).” Positive approaches produce less tension. “Appreciative change awakens and builds on people’s natural disposition toward development; minimizing resistance by working on the positive side of the process (Eisen, 2005, p. 202).” Despite similar findings from a number of disciplines, this positive outlook remains underutilized in organization-wide efforts and has been described as “one of the greatest and largely unrecognized resources in the field of change management today (Cooperrider, 2005, p. 3)”.

Dialogic approaches are based on social construction theories that acknowledge subjectivity and the role that employees have in creating values and interpreting culture. This interpretation can be brought about through dialogue, reflection and visioning (Maurer, 2010, p. 278). Appreciative Inquiry (AI) is described as an “affirmative approach to personal and organizational transformation” that has the power to “enliven possibilities and engage people in
creating exciting new realities” (Grant, 2006; Haneberg 2005; Cooperider 2010; Gold 2001). Methods such as AI build on strengths and work to dismantle hierarchy and empower participants to hope and vision (Cooperrider, 2010). “At the core of appreciative inquiry is that reality is socially constructed and the world is created in conversations (Haneberg, 2005, p. 46).” Dialogue is a means of sharing and creating culture.

Discourse involves words which reveal meaning. “Dialogue between individuals or groups is often the basis for the creation of new ideas and can therefore be viewed as having the potential for creating knowledge (Gold, 2001; Muarer, 2010)” Rorty (1979) describes a theory where the mind acts like a mirror that reflects features of the world and captures them in words. “It is here, in the linguistic turn that postmodernism presents us with ideas that could reshape the way we think and do organizational theory (Cooperrider, 1995, p. 164).” In order to leverage the ability culture has in shaping meaning, an organization needs good storytellers. “Stories are magic in that they create alternate realities that move us, enter us, and pull us in (Bolman, 2006, p. 161).” Stories infuse life with meaning, faith and hope. Words, dialogue and culture are at the center of Dialogic OD approaches.

Given the foundational premises of Dialogic OD, “the role of the Dialogic OD practitioner is to act as a facilitator of events and constructor of a container within which client systems engage themselves rather than being a central actor in diagnosis, intervention and/or facilitation of interpersonal and group interactions “(Bushe, 2009, p. 358). Similar to Diagnostic OD the Dialogic OD practitioner minimally engages in content and instead focuses primarily on the process. In Dialogic OD there are infinite possibilities for successful implementation of
change efforts. The role of the practitioner is not to create and adhere to the plan of action, but rather to enable others to engage themselves in charting a pathway toward a better future.

**Dialogic OD Pre-conditions**

The literature on Dialogic OD pre-conditions is sparse. Several general themes are discussed under the concept of participation. Participation is an important part of all OD efforts and can produce innovation as well as decrease apprehension. The literature indicates that involving organizational members helps to reduce barriers to change by creating psychological ownership, promoting the dissemination of critical information (Betancourt, 2002). Phillip Cooper (2007) notes “broad participation and full implementation can be used to mitigate political resistance (p. 153, 172)”. To solve problems, Brinkerhoff and Crosby suggest “a shared analysis and joint action, both inside and outside of government (2002, p. 6)”. Wicked challenges like health inequities involve numerous agencies including health, education, public health and advocacy organizations.

**Gaps in Knowledge**

Regardless of the extent of models in use, practitioners have “yet to make a significant dent in problems plaguing organizations (Bolman, 2008, p. 9)”. Scholars and practitioners have questioned the relevance of OD and its ability to deal with opportunities and challenges facing modern organizations. The literature has revealed a need to use new or more comprehensive OD strategies to address these wicked challenges. Literature has identified a need to examine emerging practices of ‘meaning-creating’ or Dialogic approaches and to study their effectiveness in accomplishing lasting and profound changes.
Minimally represented in literature are the pre-conditions necessary to implement a Dialogic OD approach in organizational change efforts or a discussion about the extent to which Dialogic approaches need the same enabling conditions as other classical OD efforts. While some studies have examined the impact of Dialogic OD efforts, little has been published on the necessary precursors to implementing effective Dialogic approaches. The need exists, but the validity of these approaches in producing transformative change has yet to be fully documented and studied. Absent in the literature reviewed is the discussion of which organizations are more ripe for Dialogic approaches. A gap exists about the pre-requisites or enabling conditions needed for successful Dialogic change.
Research Design and Methodology

Research Questions

This capstone seeks to answer two research questions. Part A: For cases that are wicked, what are the pre-conditions needed to initiate Dialogic organizational change? Part B: Are there different enabling conditions for the two types of OD? In an effort to answer the aforementioned research questions, this capstone uses a quasi-experimental design relying heavily on qualitative methods. This study uses thematic content analysis from oral interviews and research tools to identify information relevant to the research questions. This section will discuss the participants, research methods and analyses.

Study Design

A study design was selected that included the qualitative aspects of the Dialogic Theory being studied. Like Dialogic OD, this research design allows for flexible, non-sequential analysis. The interview and analyses tools were created based on conditions the literature associated with Dialogic OD. This study design employs a “qualitative, quantitative, qualitative (Kumar, 2011, p. 105)” approach to research that “uses qualitative methods to determine similarities and the spread of diversity, uses quantitative methods to quantify the spread and then uses qualitative to explain the observed patterns”. Oral interviews were used to collect history, case information and to identify key factors.
Study Population

The study population is comprised of organizational change professionals who have been involved in Dialogic and Diagnostic change processes. The study includes a diverse group of organizational development consultants, project managers and participants of OD projects. This convenience sample was identified using a combination of a “snowball” (Kumar, 2011, p. 208) technique where practitioners were identified by former interviewees who agreed to contact or provide contact information for the people they referred.

The sample population included four major fields of study, including health, social justice and mental health and addiction. The interviewees had a range of experiences and professional roles within their public, private or non-profit organizations and had varying academic backgrounds from Bachelor’s degree to Ph.D. Four OD practitioners were interviewed along with one administrator, two project managers and two program directors. The study population consists of three men and six women. The races identified by participants include Asian, African American and Caucasian. The study population was selected based on their relevant experience, education, diversity and convenience. The cases discussed included patient-centered healthcare transformation, mental health system transformation, social justice advocacy to eliminate oppression and inequities, cultural competence consulting and on-going change management in public and private mental health and addiction agencies (see table 2).
### TABLE 2: Interviewees, Agency Name and Type of Organizational Development Experience

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Health or Service Agency</th>
<th>Case(s) Discussed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jeanine Beatrice</td>
<td>Project Manager</td>
<td>Oregon Health Authority</td>
<td>Mental health system transformation</td>
</tr>
<tr>
<td>Kristin Chung-Mei Lensen</td>
<td>Owner</td>
<td>Kristin Lensen Consulting</td>
<td>Cultural competency and oppression-centered change efforts in public agencies (health, justice)</td>
</tr>
<tr>
<td>Deborah Cockrell</td>
<td>Manager, Mid-County Clinic</td>
<td>Multnomah County Health Department</td>
<td>Patient centered care transformation</td>
</tr>
<tr>
<td>James Mason</td>
<td>Executive Director of Culturally Competent Care giving</td>
<td>Providence Health &amp; Services</td>
<td>Consumer driven transformation in Mental Health Hospitals</td>
</tr>
<tr>
<td>Selena Mason</td>
<td>Director and Consultant</td>
<td>Western States Center</td>
<td>Social justice advocacy campaigns in coalitions and non-profit agencies</td>
</tr>
<tr>
<td>Angela Mitchell</td>
<td>Patient Advocacy Coordinator</td>
<td>Providence Portland Medical Group</td>
<td>Patient-centered care transformation</td>
</tr>
<tr>
<td>Paul Potter</td>
<td>Project Director</td>
<td>Oregon’s Organizational Development Network, Oregon Health Authority</td>
<td>Organizational change efforts in public mental health agencies</td>
</tr>
<tr>
<td>Alana Heines*</td>
<td>Professor, Organizational Development Consultant</td>
<td>Heines Consulting</td>
<td>Cultural inclusion in human services and domestic violence services</td>
</tr>
<tr>
<td>Christopher Hamilton*</td>
<td>Program Analyst</td>
<td>Oregon Health Authority</td>
<td>Addictions and Mental Health Projects</td>
</tr>
</tbody>
</table>

* Interviews to discuss interview design and/or tool. Not used in analysis

### Data Collection Methods

Primary data was collected from oral interviews and entered into an interview tool (See Appendix B) with seven categories. An interview was chosen over a questionnaire for its ability to allow the researcher to discuss the meaning of concepts, clarify issues, record spontaneous responses and capture supplemental information. “The interview is more appropriate for complex situations, collecting in-depth information and has a wider application (Kumar, 2011 p. 149).” The interview was built upon pre-conditions identified in literature as necessary for the initiation of organizational change.
The interview tool contained 22 open-ended questions that asked about the catalyzing forces for the change and how the process and goals of the change efforts were determined. It identified key factors needed to initiate the change efforts. For the reference of the interviewer, the tool included example characteristics or potential answers that the questions may solicit which were divided into Dialogic and Diagnostic categories. As participants were speaking, information was entered electronically into the interview tool. Two interviews were used as pretests or in the development of the tool and were not used for the analysis in the findings section.

The Interviews

The interviewer conducted semi-structured interviews using the specified set of questions. Five of the interviews were conducted in person and four were conducted on the phone for participants who were not in the local area. In spite of the limitations, a structured interview tool increased the comparability of the data. During the interview process some follow-up questions were posed so the interviewer could better understand or clarify topics. When asked, the interviewer would re-word the questions, or break them down to make them more understandable to the interviewee. Elements of flexibility were introduced into the structured interview process to solicit a deeper understanding or maintain a conversational flow.

Data Analysis Plan

The first phase in the analysis was to document whether the problem was wicked or not. This included an analysis of how many wicked elements were present in each of the cases. The next phase of analysis used the wicked cases and determined if they used primarily Dialogic or
Diagnostic OD. The combination of the first two phases were the basis of the final phase to answer the research questions about the pre-conditions needed for Dialogic OD and the differences of pre-conditions of Dialogic and Diagnostic OD (see Diagram 1).

**Diagram 1: Data Analysis Diagram**

1. **Phase 1:** Determine wickedness using wicked scale
   - Wicked?
     - Yes
     - No

2. **Phase 2:** Identify wicked challenges that used Dialogic OD

3. **Phase 3:** Determine pre-conditions for Dialogic changes that addressed wicked challenges
   - Dialogic + Wicked
     - Part A: Identified new Dialogic preconditions
     - Part B: Differences between Diagnostic and Dialogic (mixed)
   - Yes
   - No (Diagnostic)
Phase One: Identify Wicked Elements

To determine wickedness, the researcher used a scale that took wicked concepts from the literature to allot points. The scale ranged from 1 to 7.5. There were five wicked concepts and each could be given a score between 0 and 1.5. The concepts were complexity, dynamism, interdependence, polycentrism and role of change agent(s). If the concept was not mentioned during the interview it was given a 0. If at least one aspect of the concept was mentioned it was given a 1. If multiple aspects of a concept were mentioned it was given a 1.5.

Phase Two: Identify Wicked Challenges that Used Dialogic OD

The next phase of analysis was determining whether a change process was Dialogic or not. For this verification, the researcher used a simple measure of whether the majority of answers from the interview tool utilized Dialogic approaches or Diagnostic. If the majority of answers drew from Dialogic concepts or if the need for change were Dialogic, the researcher categorized them as Dialogic. During this phase of analysis cases were labeled as either Dialogic or Diagnostic. All of the change processes were scored and placed on a continuum of wickedness from low to high (see Diagram 2).

Phase Three: Identify enabling Conditions for Dialogic Change

The third phase was content analysis that contained multiple two steps. Building off the analyses conducted previously, the third phase answered Part A of the research question by studying what conditions are needed for Dialogic change that can address wicked challenges. Themes from all of the interviews were compiled on a matrix. The Dialogic interviews were
extracted and analyzed for common Dialogic pre-conditions. This allowed for the identification of enabling conditions for Dialogic OD.

Once the Dialogic conditions were identified, Part B answered the second research question, Are the conditions identified for wicked, Dialogical challenges different from those identified in literature for Diagnostic? For this analysis, the Dialogic interviews were compared and contrasted to the common themes from the Diagnostic interviews. Factors that were repeated by numerous interviewees were extracted and compared to one other to determine areas of difference. Ultimately, the themes were placed into two categories: new Dialogic pre-conditions and a mixed category that contained elements of both Diagnostic and Dialogic concepts.
Findings

The findings will be presented in accordance with the phase in which they were discovered. In the following discussion section, the findings and conclusions will be grounded in literature and applied to future study.

Phase One, Analysis of Wickedness

Four of the seven cases analyzed were wicked. Using a scale from 1 (indicating a tame problem with no wicked concepts) to 7.5 (being totally wicked) the seven cases were analyzed. The average score was 4.5 with the lowest scoring 2 and the highest scoring 7. Four cases were found to be wicked by demonstrating a score of 4 or higher.

Phase Two, Determination of Dialogic or Diagnostic

The first phase of the analysis revealed that the wickedness of the problem correlated with the use of Dialogic methodology. The four most wicked challenges were also the four interviews that discussed using Dialogic OD practices and underlying premises. The two first phases of analyses were combined and placed on a continuum. The distribution of wickedness continuum is found in Diagram 2.
Diagram 2: Continuum of Wickedness

1 Not Wicked

2 Diagnostic Mental Health and Addictions

3.5 Diagnostic Patient Centered Healthcare Initiative

3.5 Diagnostic Patient Centered Healthcare

4.5 Dialogic Culturally competent Mental Health Projects

5 Dialogic Culturally competent Health and Justice

6.5 Dialogic Social Justice Advocacy

7 Dialogic Mental Health System Transformation

Banks, Embarking on Equitable Change in Turbulent Times
Phase Three, Analysis of Pre-conditions for Dialogic OD

Phase Three, Part A

After determining Dialogic OD was used to address wicked challenges such as health inequities, the analysis sought to identify answers to the first research question; what are the pre-conditions for initiating and planning for Dialogic OD that can address wicked challenges like health inequities? The findings below identify new Dialogic enabling conditions not specifically associated with Dialogic OD in the literature.

Pre-requisites Initiating a Dialogic OD Change Process:

1. 100% of the Dialogic interviews talked about using Dialogic OD to change the status quo.

   Dialogic Interviews that Identified Using Dialogic OD to Change Status Quo

   For three of the interviews altering the status quo was about planning a process to identify power differences in race, positional authority, and gender. One person said: “I haven’t seen a Diagnostic tool that looks at race dynamics. Many consultants don’t look at gender, race and wouldn’t have much to do with that. I always look at culture.” These interviewees said the goal was to plan a process that could build capacity of participants to create solutions to eliminate racial oppression. “This was critical because we worked with oppressed groups so we had to be careful not to further oppression by saying we know what was best.” For another interviewer, a
Dialogic process was used externally to give more decision-making power to local counties and used internally to give authority to staff. Eliminating oppression or changing the status quo was often the catalyst for initiating change.

In comparison, 2/3 of Diagnostic interviews also discussed changing the status quo for their patient-centered change management goals. This meant that doctors shared power either with teams or directly with patients through patient councils.

2. 100% of the Dialogic interviews identified participation as a key pre-condition and discussed **getting stakeholders to the table**.

All participants engaged stakeholders and some used stakeholder analysis to understand the stakeholders and their interests. “Making sure you know who all the stakeholders are and where they sit.” One interviewee talked about this a key step to crafting a “bullet-proof need statement that is in the best interest of all levels of people.”

Only one of the Diagnostic interviews talked about getting patients at the table.
3. 100% of Dialogic interviews suggested including those impacted by decisions in the beginning of change processes.

Dialogic Interviews That Identified Inclusion

100%

Total Interviews that Discussed Inclusion

All the Dialogic interviews discussed need to include those people impacted by the changes. For several cases, this meant including consumers in decision-making. “Consumers are a catalytic phenomenon.” Inclusion was described as a pre-condition to identifying the goals of the change process and not merely a means to getting buy-in for the decisions that were made by others.

100% of Diagnostic interviews also talked about including staff and/or patients in the change process. Some of these interviewees suggested including staff or patients later in the change process once the goals had already been determined.

4. 100% insisted on using natural leaders and unusual suspects in Dialogic OD.

Dialogic Interviews that Identified Natural Leaders and Unusual Suspects
Unusual suspects were referred to as people who were not usually involved in decision making either because they did not have traditional credentials or they were thought to oppose the efforts. The use of natural leaders and unlikely participants was discussed in several ways and in concert with other topics. One participant shared that there is much to learn by using unusual suspects. “There are so many assumptions about who is intelligent and who is not so when space is created, people are awed by each other.” Natural leaders were described as being more trusted and able to translate complex topics into simple language. “Who goes out and hires thugs to talk to kids about HIV? We did, and it was successful.” The use of unusual suspects and natural leaders was thought to make the change more palatable to others in the organization. “She breaks down the technical; she (name removed) can translate the bureaucratic and make it relevant.” “By having people on the team who usually wouldn’t be included, we found out with the right people we didn’t have to work to get everybody on board.”

One of the Diagnostic interviews discussed building consumer leadership. “Patients are powerful messengers.”

5. 75% of the Dialogic interviews talked about using a **team structure** for change management to **facilitate dialogue**.
Dialogue was discussed as a goal and a method. The goal was to plan a change management process where teams were empowered to identify goals of change process and share experiences. It was seen as a method to gain buy-in, communicate information, gather ideas and learn. Change process goals were decided by “forming work teams who use consensus to determine the goals.” Dialogue was discussed as a way to keep people whole without having to compromise their values. “You need a group level of partnership skills on how to hold conversations and how to mentor and support each other. To build partnerships, you have to have dialogue.”

In the Diagnostic interviews, one person discussed the co-location of teams to increase dialogue and to meet team goals. “We changed from provider-centric to team centric.” Another interview discussed using dialogue as a way to “convince others” to get on board with the change process goals.

6. 75% of Dialogic interviews discussed using a **strengths-based approach** that built off the assets of the staff, stakeholders and the agency.
The assets analysis was discussed as taking place before the change was officially initiated. “We don’t resource the work until we know what the activity is, and then we match teams using individual strengths and their diversity of strengths.” “Our strategic plan built off the strengths within the organization.”

None of the Diagnostic interviews specifically discussed strengths or assets.

7. 75% discussed **reflective culture** as a pre-requisite for Dialogic change processes.

    Dialogic Interviews that Identified Reflective Culture as Pre-Condition

These participants discussed having iterative planning processes geared toward learning. “Everybody has an understanding that it is a learning organization and mistakes are acceptable, they are learning opportunities.” A non-linear process allowed for the “taking of two steps
forward and one step back.” Reflective culture included periodically checking in about goals and taking time to re-image the vision. “Use an experiential learning model where you have shared experience and then reflect on it.”

While none of the Diagnostic interviews discussed reflective culture per se, one participant discussed iterative change management and quality improvement cycles.

8. 75% of the Dialogic interviews discussed the need for a culture of empowerment.

Dialogic Interviews Identifying Empowerment as Pre-condition

Empowerment was described as using a process that gave decision-making power to staff and eliminated the need for leadership to approve the decisions of the change team. “The team was structured so that it eliminated a chain of command. “Out of hundreds of decisions the change team made, only two needed formal approval from leadership.” Empowerment was also discussed in terms of providing training, coaching and support to patients or staff so that they felt prepared to participate in decision making. “We taught them how to love themselves, and other patients and workers.”
The Diagnostic interviews discussed empowering consumers. “You can talk about what patients want, but let’s ask them.”

9. 75% discussed the **diversity** of an agency positively impacting Dialogic change.

Diversity was discussed as enhancing the potential for change efforts. “Convene stakeholders that are diverse in race and culture, but also education and national origin.” It was also discussed as an outcome of assessment. “Look at the aspect of workforce diversity by food chain, by consultant and by contractors.”

One of the Diagnostic interviews discussed diversity of staff and patients. “We have very diverse staff and client population; we serve 60 different languages. We want to enhance the diversity of voices.”

10. 75% of Dialogic interviewees believe that executive leaders **minimize hierarchy** and give change participants authority.
Leadership was explained as leaders being willing to be the participants of the change or intervention and it also meant “each person doesn’t have to have all the qualities of leadership, but the team does.” Successful Dialogic OD happened when leaders gave change teams authority and let them make decisions. In other words a leadership culture where leaders used their power to facilitate the will of the people was seen as most conducive to Dialogic change efforts.

All the Diagnostic interviews discussed the role of leaders. They shared that the role of the leader is to determine parameters, allocate resources, lead the change and make decisions. “This field is full of people who are managers and frighteningly few leaders.”

11. 100% of interviews used stories to communicate successes.
Total Interviews who Used Stories to Communicate Successes

This was not in the content of a question. The interviewer noted storytelling as a method of communication that all of the Dialogic interviewers used. In fact, storytelling was also used in 100% of the Diagnostic interviews.

A summary of findings for new Dialogic Preconditions is found below in table 3.
<table>
<thead>
<tr>
<th>Dialogic Enabling Conditions</th>
<th>Interview Discussion Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan to Disrupt Status Quo</strong></td>
<td>• Examine power dynamics&lt;br&gt;• Social justice advocacy&lt;br&gt;• Eliminate oppression&lt;br&gt;• People in power recipients also receive intervention</td>
</tr>
<tr>
<td><strong>Stakeholders at the Table</strong></td>
<td>• Stakeholder analysis&lt;br&gt;• Craft need statements that appeal to stakeholders’ best interest</td>
</tr>
<tr>
<td><strong>Inclusion of those Impacted by Decisions</strong></td>
<td>• Include consumers in decision making&lt;br&gt;• Include staff who will implement policy changes</td>
</tr>
<tr>
<td><strong>Natural Leaders and Unusual Suspects</strong></td>
<td>• Utilize credible community members&lt;br&gt;• Include staff who can translate complex topics into simple language&lt;br&gt;• Create space for people who are not usually seen as experts</td>
</tr>
<tr>
<td><strong>Team Structure for Change Process</strong></td>
<td>• Teams work with others to foster buy-in&lt;br&gt;• Give authority to change team&lt;br&gt;• Foster dialogue and group partnership</td>
</tr>
<tr>
<td><strong>Strengths Based Approach</strong></td>
<td>• Foster hope&lt;br&gt;• Build on assets&lt;br&gt;• Meet people where they are</td>
</tr>
<tr>
<td><strong>Reflective Culture</strong></td>
<td>• Plan for iterative processes&lt;br&gt;• Re-vision goals&lt;br&gt;• Time, space and support for reflection and dialogue&lt;br&gt;• Use experiential learning model</td>
</tr>
<tr>
<td><strong>Empowerment Focused</strong></td>
<td>• Make people whole&lt;br&gt;• Betterment of people through training&lt;br&gt;• Shift power to those impacted</td>
</tr>
<tr>
<td><strong>Diversity</strong></td>
<td>• Range of experiences and viewpoints&lt;br&gt;• Mix formal and informal power&lt;br&gt;• Diverse gender and ethnic backgrounds</td>
</tr>
<tr>
<td><strong>Executive Leaders Minimize Hierarchy</strong></td>
<td>• Executive leaders share power&lt;br&gt;• Decision-making given to change teams&lt;br&gt;• Executive leaders further will of people&lt;br&gt;• Senior leaders first recipients of intervention</td>
</tr>
</tbody>
</table>
Phase Three, Part B: Comparison of Enabling Conditions in Diagnostic and Dialogic Interviews

After the new enabling conditions were identified for Dialogic OD, the analysis sought to answer the second research question, Are Dialogic pre-conditions initiated by OD practitioners different than the Diagnostic pre-conditions identified in the literature? The short answer is yes. The findings revealed a mixed category that combined elements of Dialogic and Diagnostic pre-conditions. In addition to new Dialogic pre-conditions, most of the Diagnostic pre-conditions theme areas were also discussed in the interviews. However, when Diagnostic pre-conditions were brought up in the Dialogic interviews, they were discussed in different ways and the interviewees focused on different things. The findings from the mixed pre-condition category are explained below.

Table 4: Mixed Pre-conditions: Both Diagnostic and Dialogic

<table>
<thead>
<tr>
<th>Diagnostic Pre-conditions</th>
<th>Mixed Pre-conditions Discussed in Interviews: Diagnostic and Dialogic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need for Change</td>
<td>• Address historic and systemic social inequity</td>
</tr>
<tr>
<td></td>
<td>• Act when culture not aligned to goals</td>
</tr>
<tr>
<td>Multi-level Involvement</td>
<td>• Involve unusual suspects</td>
</tr>
<tr>
<td></td>
<td>• Create work teams for dialogue</td>
</tr>
<tr>
<td></td>
<td>• Include stakeholders</td>
</tr>
<tr>
<td>Openness to Learning</td>
<td>• Mistakes not wrong</td>
</tr>
<tr>
<td></td>
<td>• Flexibility</td>
</tr>
<tr>
<td></td>
<td>• Must be able to say no</td>
</tr>
<tr>
<td>Develop a Plan to:</td>
<td>• Disrupt status quo</td>
</tr>
<tr>
<td></td>
<td>• Foster dialogue</td>
</tr>
<tr>
<td>Top Management Support</td>
<td>• Codify policy based on will of group</td>
</tr>
<tr>
<td></td>
<td>• Give authority to others</td>
</tr>
<tr>
<td></td>
<td>• Be the recipient of intervention</td>
</tr>
<tr>
<td></td>
<td>• Support group goals or get out of organization</td>
</tr>
</tbody>
</table>

When the Dialogic interviewees discussed the pre-condition of need, they did not talk about urgency like many classical OD efforts; they spoke in terms of longstanding or pervasive social injustice, about organizational behavior that was misaligned with goals and about creating
stories that appealed to the best interests of a variety of stakeholders. The Dialogic precondition of need identified is not dependent on a sense of urgency as with an acute threat, but rather appeals to values, mission and premises on equality. The discussion of need in the Dialogic interviews expressed value incongruence where agency actions were inconsistent with ideals. For a subset of interviewees this dissonance was expressed as cultural incompetence and systemic oppression.

The planning pre-condition in the Dialogic interviews was less rigid than in the Diagnostic interviews or literature. Dialogic interviewees described plans that demanded a strong commitment to risk taking, creating structures where people could talk to one another and where consumers and stakeholders could be at the table early in the change process before the goals were determined. This was different from the Diagnostic interviews that talked about a plan with milestones, deadlines and sequential linear steps. In the mixed pre-condition a plan was described more as a commitment to key conditions and not solely as an object or outcome.

Another key finding was the difference between the roles of leaders in the two sets of interviews. Both groups discussed the role of leaders. The Dialogic interviewees described a leader’s role as sharing authority in the change process and supporting the decisions of the group. Leaders were expected to be part of the solution and intervention, especially as it related to dismantling inequity. The task of leaders is to provide legitimacy to the change process by taking risks to support the recommendations of the teams and to make policies that sustain the will of the group and become institutionalized throughout the organization. Natural leaders were
given more weight in the Dialogic interviews and their involvement was seen as a key prerequisite for initiating a change process.
Based on the interviews conducted and literature reviewed, Dialogic approaches are more aligned with wicked challenges compared to Diagnostic approaches. The complexity and dynamism attributed to wicked challenges is consistent with literature describing Dialogic processes that are iterative, multi-faceted and refrain from identifying one single reality or solution (Bushe 2009; Eisen 2005; Mauer, 2010). Trends reveal that complexity is mounting and the environmental pressures facing organizations are well documented (Freidman, 2009; Magis, 2011; Boleman, 2008). It is quite clear that OD needs to employ new methods to address the escalating diversity of participants and intricacy of situations. As the internal opportunities and environment surrounding organizations become more compound, “OD practitioners are called on to adapt their intervention strategies and develop appropriate competence to carry them out effectively (Eisen, 2005, p. 188)”. This research confirmed that Dialogic OD is being used to, and has the capacity to, address wicked challenges.

The interviews revealed a preference to use Dialogic approaches with OD that sought to change the status quo, eliminate oppression or transform to a desired state that was novel or never been tried before. Expert opinion combined with relevant implications from literature illustrate that Dialogic OD approaches are compatible with goals that tackle inequities stemming from race, gender or other power differentials. “These newer forms of OD attempt to construct Dialogic containers and methods of collective inquiry that directly affect consciousness or mindsets or prevailing belief systems more than behavior (Bushe, 2009, p. 362).” The acknowledgement of multiple realities in Dialogic OD is consistent with multi-cultural
perspectives that view diversity as the norm. Interviewees drew on empowerment and cultural competence frameworks in designing their Dialogic approaches. Health disparities can be improved by culturally competent care which is defined as “need for all health systems and providers to be aware of and responsive to patients’ cultural perspectives” (Bentancourt, 2002). Dialogic OD should be used to increase the cultural competence of organizations seeking to reduce disparities.

The applicability of Dialogic approaches with multi-cultural endeavors may be in part due to the cultural implications of classical OD which is heavily studied by, and used in White male culture. “One of the characteristics of White male culture is a low tolerance for ambiguity (Proudman, 2005, p. 3).” Diagnostic approaches to organizational change have similar roots to western white male culture which is largely predictable, sequential, linear, and individualistic (Proudman, 2005). “Dialogic inquiry requires careful planning and skillful application of techniques that lead participants to dialogue through inquiring into accepted norms and mental models and allowing them to question dominant values (Maurer, 2010, p. 278).” This type of dialogue rarely occurs automatically or naturally (Proudman, 2005, p. 2). In order to truly examine the unacknowledged norms, an inquiry should include an outsider’s perspective and unusual suspects since culture is relatively invisible and totally normal to the people who are within it (Boleman, 2008; Welp, 2001, McIntosh, 1988).

**Dialogic Enabling Conditions Revealed Through Study**
The study revealed ten enabling features for planning the initiation of Dialogic OD processes as summarized in Table 3. The enabling conditions fall in four major categories which are discussed below.

**Willingness to Disrupt the Status Quo**

In order to embark on Dialogic OD organizations, leaders and other members of the dominant culture must be at least be willing to examine the status quo and the assumptions behind it. More likely organizations should be prepared to dismantle the status quo as a result of group inquiry and thoughtful examination of how current systems block or foster the fulfillment of shared values. For example, most organizations do not value inequality, but often when policies and practices are examined it is found that inequality is built into various levels of operations (HEI, 2009; Urban League, 2009). All the Dialogic interviews described the intent and outcome of changing the status quo and used methods such as minimizing hierarchy and inclusion of diverse or unlikely participants. This concept was utilized in a variety of circumstances, but shared a common theme of eliminating unequal power dynamics, especially as they related to demographics and positional authority. Based on the interviews and theoretical underpinnings of Dialogic OD, it follows that an organization should not embark on Dialogic OD if they are interested in keeping the power structure in their organization unexamined and intact.

**Use of Collaborative Team Structures**

Team structure was seen as a condition and structure for initiating Dialogic OD.

“Employees should have the ability to self-organize their own knowledge and practice networks
to facilitate solutions to new or existing problems and to generate or share knowledge (Gold, 2001, p. 189).” To back up interview findings, the literature also discusses the value of group learning and interactions. “Truly collaborative ventures are system-changing (Bentancourt, 2002; Cigler, 1999, p. 88).” Among the interviewees the use of teams were seen as the primary structure for assessment, discussion and decision making. “The field of OD must develop intervention strategies that support collaborative decision making among multi-party, multi-organization, and total-system arrangements (Eisen, 2005, p. 197).” In the interviews, dialogue and group learning were facilitated in teams that included stakeholders and those impacted by policy decisions. Workplace learning “is best understood in terms of the communities being formed or joined and personal identities being changed (Bokeno, 2000, p. 245).” Empowered change teams are vital to beginning a Dialogic approach and are a method to establish change goals and implement solutions.

Reflective Culture and Practice

Reflective processes and cultural norms must be in place in order to initiate an approach to inquiry that relies on dialogue to explore how meaning is created. “Dialogues seek and depend on the ability and willingness to engage in reflection, both individually and collectively (Bokeno, 2000, p. 241). When designing Dialogic OD efforts, participants must build in time for stakeholder engagement, partnership development and reflection. This engagement occurs through a critical reflection upon current practices, in particular through an examination of the beliefs, values, tacit assumptions and mental models informing and shaping practices (Maurer, 2010, p. 278). The interviews discussed this need for reflective culture that was manifested in a variety of practices including building in time to reflect on “how current methods align with the
organizations goals”, space to “re-imagine the mission and vision of the organization” and an iterative process that encourages people to check in. In order to initiate a Dialogic OD, there must be a strong historical precedent for using reflection to improve performance or a dedication to allow time for reflective practice.

Focus on Empowering Staff and Consumers

Another conditional factor that emerged was empowerment described in the interviews as both a method and an outcome. “Innovative types of capacity building that hone collaborative skills play important roles in preparing communities and their organizations for the changes associated with complex partnerships (Cigler, 1999, p. 99).” The interviewees insisted on empowerment in all phases of OD efforts from design to implementation and maintenance. “With the right environment, culture, and structure, most organizations can build a successful workplace where workers feel engaged and needed (Haneberg, 2005, p. 4).” Empowering employees was both a pre-requisite for the initiation of change efforts and a mark of successful implementation. In these findings, empowerment was closely linked with strengths-based approaches and an appreciative view of human beings. The change practitioners conducted assets mapping and built from strengths to empower participants. The literature is filled with instances where people are more motivated and less resistant by discussing strengths compared to weaknesses and deficits (Rath, 2008, Haneberg, 2005, Nye, 2008; Boleman, 2006).

Mixed Preconditions: Combining both Diagnostic and Dialogic

In addition to the Diagnostic enabling conditions found in literature and the new Dialogic pre-conditions found in the interviews, a third category blends characteristics of Diagnostic and
Dialogic pre-conditions. This mixed category is used when interviewees discussed enabling conditions such as need for change and top management support, but added additional elements not identified in the Diagnostic literature. These mixed pre-conditions were discussed differently in the interviews and combined characteristics of both Dialogic and Diagnostic OD. Furthermore, the enabling conditions in the mixed category revealed different understanding of classical OD pre-conditions.

The mixed category of enabling conditions was most evident for support of executive leaders. Both Diagnostic and Dialogic interviews highlighted the need for invested leaders, but leaders played a different role in Dialogic OD. In the Dialogic interviews the leader’s role was to give space, allow risk-taking, show willingness to be the ‘guinea pigs’ and to empower others. A leader’s role is to give away power. Bokeno (2000) discusses organizational conditions such as:

> the creation of safe spaces where interactants feel free to access and engage in deeper and more disclosive levels of discussion about organizational issues and unencumbered by the “expert” knowledge, streamlined databases, and refined perspectives that typify more formal and “legitimate” settings and channels (p. 243).”

In the Diagnostic literature and interviews the formal leaders set parameters, led change efforts and were the key communicator and expert, whereas the staff were expected to accept the changes or receive consequences. In the Dialogic interviews leaders were expected to either “get on board with the changes of the group or get off the ship.”
The enabling condition ‘need for change’ was identified in the mixed pre-condition category for a subset of the interviews. The need for change was discussed in a similar way as Diagnostic literature and it was also discussed by the Dialogic interviewees in a different way. The nuance seemed to be related to the sense of urgency that often accompanies Diagnostic approaches which highlight cost, external forces or potential threats as motivating factors. Kotter (2008) states “not pumping up the urgency is the number one error in change management and the reasons why transformation efforts fail”. The Dialogic interviews discussed need less in terms of an acute threat and more in terms of dissonance, social injustice, behavior that was misaligned with goals and creating multi-faceted needs statements that appealed to the best interests of a variety of stakeholders. Due to the historic and pervasive nature of the oppressions that preceded the need in the subset of Dialogic interviews, the sense of urgency was not tied to a pressing impending event or threat. The need for change was conveyed in terms of an opportunity to improve practice through cultural competency, a desire to change the stories around the organization or an aspiration to produce more positive experiences.

**Implications for Organizational Development**

**When to use Dialogic OD**

The findings from the research and literature suggest that Dialogic approaches should be used for scenarios that involve a diversity of opinions or experiences. Multifarious situations with a range of viewpoints occur in many fields of study. Dialogic approaches should be used when the participants seek to examine or shift the status quo within an organization or community. If early assessments reveal wicked problems that involve shared power, a need for innovative solutions, empowering leadership and a long-term commitment, a Dialogic approach
should be used as a means to get buy-in and agreement on change goals. Dialogic approaches are well suited for initiating change efforts because “organizational members can increase their awareness of the variety of experiences within the system and how social reality is being constructed in their system with the purpose of creating alignment and support for change (Eisen, 2005)”. Organizational Development professionals should use Dialogic OD when a problem is bigger than any one agency, when seeking to broaden mindsets beyond what currently exists and when multiple people need to be inspired to act.

Dialogic OD is well suited for wicked challenges as they do not have one easily defined and well-studied solution. Wicked challenges need innovative solutions that can “integrate lessons gleaned from praxis and research, and venture into the unknowable with vision, openness to generative learning and an expanding capacity to work with complexity (Magis, 2011)”. Dialogic approaches have been found to “unleash the creative potential” (Cooperrider, 2010) and should be used help OD practitioners find a range of solutions. Cooperrider and Whitney (2005) question if problem-centric OD has run its course. “Could it be that we as a field have reached the end of problem solving as a mode of inquiry capable of inspiring, mobilizing and sustaining significant human system change?” Dialogic approaches should be used when revealing a solution is more important than completely understanding the problem.

Academic institutions like Portland State University, training programs and other educational centers should teach appreciative approaches that “shift the problem solving deficit-based views of intervention” and “foster the capability to make collaborative decisions at the periphery of organizations based on consistency with organizational purpose” (Eisen, 2005, p.
In order to create more organizational conditions conducive to Dialogic OD, academics and practitioners need to increase comfort and familiarity with convening, facilitating and evaluating dynamic praxis. Eisen’s Delphi study names several emerging competencies needed for OD practitioners, including complex systems thinking, global trans-domain systems work, culture work, continuous learning, innovation, Dialogic reflection and systems-wide leadership. The Executive Masters in Public Administration (EMPA) has many of these competencies embedded in courses and curriculum. Next steps should include integrating teachings of Dialogic methods in Organizational Development, Human Resources, Policy Development and Global Leadership courses. To fully incorporate Dialogic premises into textbooks and other teachings, a better articulation of the skills and the accompanying theoretical premises needs to be demonstrated through practice.

In the assessment phase, OD consultants should work with others to discern if the Dialogic and mixed enabling conditions are in place. If all the Dialogic pre-conditions are in place a Dialogic approach should be used, especially for wicked challenges. If the pre-conditions are not all in place, a determination should be made if the goal is to work toward securing the Dialogic and mixed pre-conditions or if the change is better suited for Diagnostic efforts. If there is a commitment to a long-term change process and the Dialogic preconditions are in place, the literature strongly suggests that positive and engaging Dialogic approaches are more likely to secure buy-in, engage stakeholders and motivate employees, which have been shown to produce better results.
When Not to Use Dialogic OD

When there is a lack of Dialogic preconditions, unwillingness to change the status quo or little respect for diversity, OD practitioners should avoid using a Dialogic approach. Change processes with pre-identified goals, short timeframes and disempowered participants do not align with Dialogic premises. Dialogic OD should not be used when the hierarchy determines goals and action steps. It is not a way to “solve problems and fulfill goals predetermined before the project begins (Maurer, 2010, p. 275)”. Dialogic approaches are not advantageous when the catalyzing forces and metrics are totally quantitative, set solely by external parties, problem focused or hierarchical. Dialogic approaches are meant to decide “what you want for the organization for the future not what you wish to avoid” (Cooperrider, 2010, p. 20).

To maintain the credibility of the emerging field, practitioners should be careful not to present Dialogic approaches “as a wolf in sheep’s clothing”. There are potential negative repercussions for embarking on a Diagnostic approach under the guise of a new, empowering Dialogic change. This concern was highlighted in the interviews. Authenticity and to fidelity to the model were felt to be especially important to building trust with communities or persons who have had ample previous experiences with being left out or oppressed. Dialogic approaches need to be truly engaging and empowering.

Limitations of Study

There are several limitations to this study based on research design and scope of the project. Due to the small sample size and qualitative methods, findings are not generalizable to all health, mental health or social justice change processes. Furthermore, the research findings
are not generalizable to all other content areas and fields of study. Beyond the scope of this research was an extensive analysis of the importance of the substance or content area to the applicability or feasibility of using Dialogic OD.

At times in the interviews the boundary between initiation and implementation of OD was unclear. This was partially due to the nature of questions used to help the researcher determine which categories to place the cases in for analysis. In an effort to gather sufficient information to make a determination if a case was Dialogic, the interviewer asked questions about the goals of a process and the method of collecting information. These questions asked the interviewees to think beyond the initiation phase. After sharing information on the overall change process, the researcher asked interviewees to think back to the most important initiation factors. This line of questioning quite possibly contributed to the blurring of the initiation phase with the implementation phase.

**Implications for Future Research**

Studies about the implementation and outcomes of Dialogic OD need to take place. The researcher learned a great deal about necessary factors for the implementation of change processes and sustaining momentum, but they are outside the scope of this study. The study collected, but did not analyze, information about the relationship of Dialogic pre-conditions and change outcomes. Practitioners who utilize Dialogic OD would help the field tremendously by documenting and evaluating their work, which could better articulate key factors and necessary competencies for successful implementation and continuation of Dialogic OD. There is much more to be learned about when to apply a Diagnostic, Dialogic or combination of approaches.
“Greater clarity and differentiation could help avoid unknowingly mixing and matching Diagnostic and Dialogic practices that in combination may be inappropriate, out of alignment, or even counterproductive (Bushe, 2009, p. 363)”.

There are also several implications for leadership development and mandatory skills for OD practitioners. The There is more to be learned about how leaders and practitioners assess, promote and cultivate Dialogic pre-conditions. With pervasive, unjust and persistent health disparities, more study should focus on the specific ways in which people utilizing OD can move beyond problem identification. “The shift from problem-solving and deficit-based views of interventions to an appreciative view should continue (Eisen, 2005, p. 197).” What are effective ways for leaders to frame need statements for pervasive problems that benefit people in power? What are fields that already teach core competencies needed for Dialogic OD? A range of competencies and skills in addition to, and sometimes instead of, the classic list of OD competencies need to be studied and utilized by Dialogic OD practitioners (Bushe, 2009).

It is clear from the study findings that Dialogic approaches are being utilized in social justice fields, but this study did not explore if certain fields or content areas are more conducive to Dialogic OD. The field would benefit from studies that determine if Dialogic OD works better in public or private settings. What issues are best suited for Dialogic OD approaches? Does the success of Dialogic OD vary depending on where it is applied? Increased study on Dialogic approaches will accelerate its use in organizational settings.

Summary
An organization’s ability to implement effective solutions is based upon its ability to envision solutions to wicked problems. “Public leadership is a vision-directed and values-centered process that engages leaders in a relationship with followers in the purposeful advancement of the human and ecological public good both now and in the future (Ingle, 2011, p. 8-9).” A leadership culture that is positive, futuristic, engaging and fearless is a vital part of an organization’s ability to address wicked challenges (Eisen, 2005). Dialogic OD efforts can contribute to leadership culture that is congruent with its values and builds on strengths to harness opportunities. Dialogic approaches can be designed to examine the status quo, empower participants and simultaneously use inquiry and action-planning to address wicked challenges like health inequities.
APPENDIX A: Capstone Reflections

What are the leadership implications of my project?

The leadership implications from my project are substantial when carried through to implementation. Dialogic OD provides the opportunity to take interpersonal and group leadership skills to an organizational level. Creating organizations that encourage full potential through strengths-based approaches is truly exciting. In a shared-power world, it is imperative that leaders and organizations develop skills to facilitate diverse groups and coalitions to action. The positive dimensions in Dialogic OD are a welcome and refreshing reframe for the field of health inequities that has been focused on quantifying the deficits.

Multnomah County Health Department’s MCH program can, and should, set up processes to move from fear and uncertainty to appreciative inquiry and positive action. The health problems we are striving to tackle are significant. Infant deaths and birth outcomes are major indicators of a nation’s health. Two major external change efforts and an internal restructure are producing massive amounts of uncertainty and anxiety instead of hope and excitement. Successfully planning and then later implementing a Dialogic OD approach can prepare MCHD to be at the forefront of a new era in networked healthcare that costs less, provides better services, improves the health of the population and improves the patient’s experience of care.
What leadership lessons did I learn from the project?

I am reflecting on the value of using methodology and rationale that fits with the Dialogic OD theory. I used concepts that were Diagnostic and linear to outline my project and these may likely not be the best measurement concepts. In an attempt to design a rigorous and defined research project, I used fairly linear concepts of organizational change. The term pre-condition implies that it is a discreet step that happens before another step in a logical progression. I learned through the interviews and in reflective discussions with my Faculty Advisor that these pre-conditions did not happen solely in the beginning or designing phase. The enabling conditions identified through interviews were prerequisites, methods and outcomes. The way I framed prerequisites in the capstone was largely a western notion, distinct and separated from other parts of the process. Dialogic theory would suggest that a precondition is iterative and may need to be re-examined through continuous reflective process.

I re-learned the concept of leading from where you sit. In talking with people who I deem experts, I learned there was a role that my project was playing in educating them about aspects of Dialogic OD which some of them had not heard of even though they may have been practicing it to some degree. People were hungry to discuss successes and how including overlooked groups of people was both gratifying and successful. In a true Dialogic sense, learning is not one-directional.

How did I synthesize my learning from the EMPA in the process of undertaking and completing my project?
I am able to see how ethics, systems thinking, wicked challenges and leadership skills come together. In writing the capstone I reviewed books, studies and cases assigned throughout the EMPA program. Of special relevance were Organizational Behavior and Development, Leadership for Individuals and Groups, Global Leadership and Ethics. There are several connections between courses and readings with the concepts and findings in my capstone. Multiple theories are embedded within the capstone: Bolman and Deal’s (2008) four frames for OD; Joseph Nye’s contextual intelligence; and strengths-based leadership discussed by Rath and Conchie (2009).

Agencies and leaders who want to eliminate health inequities must employ a range of skills such as contextual intelligence. Contextual intelligence is both “a capability to discern trends in the face of complexity “and “adaptability while trying to shape events” (Nye, 2008, p. 88). It allows leaders to adjust their style to the situation and to their followers needs. Dialogic approaches can be a method to increase contextual intelligence and understanding of current situations. Morgan and his colleagues describe the need for public servants to “see trends and developments down the road” (p. 345). In a broad sense, the need to understand the systems and context is paramount to my ability to see windows of opportunity and to understand how to create opportunities to give voice to others. Organizational contexts are made up of multiple perspectives or frames.

Bolman and Deal (2008) describe four frames that operate within organizations: structural; human resources; symbolic/cultural; and political. These frames provide another way to view the similarities and difference of Diagnostic and Dialogic OD. The structural frame is
amply discussed in classical and Diagnostic OD. “Where the human resource approach emphasizes dealing with issues by changing people, the structural perspective argues for putting people in the right roles and relationships (Bolman & Deal, 2009 p. 47).” The structural frame, like many forms of OD, “assumes that organizations work best when rationality prevails over personal agendas and extraneous pressures and that structures must be designed to fit current circumstances.” Structural redesigns are the most commonly types of interventions discussed in the literature. “Although intended to rationalize individual functions or units within an organization, structural elements have often had the unintended consequence of inhibiting collaboration and sharing of knowledge across internal organizational boundaries (Gold, 2001 p. 188)”.

Dialogic OD is cultural intervention of sorts by focusing on people within an organization who create and maintain cultural meaning. Haneberg (2005) describes culture as a part of the organizations system that involves “shared assumptions and beliefs, unwritten values and rules of an organization” (Haneberg, 2005; Bolman, 2006; Gold, 2001; Buchanon, 1999). Although harder to quantify, these authors discuss politics and culture being integral to OD and must be at least considered and at best fostered to have successful OD efforts. Culture and politics are just as important in organizational change as are individual behavior and organizational structure.

The international field experience to Vietnam illuminated the courses and readings on politics and culture. Expanding beyond the parameters of the United States allowed me to
examine American values and the propaganda associated with communist polities. In my Vietnam travel journal I wrote:

“In Vietnam, I often heard government officials speak of the common good or the will of the people. I heard it more in Vietnam in one week than I’ve heard it in months in the United States. American pluralism is supposed to ensure the will of the people is served through competition. Yet precious energy is spent fighting against other interests instead of implementing the will of the people. Dare I suggest that we have much to learn…from communism (Banks, 2011).” Like Dialogic OD, the Vietnam trip immersed me in dialogue with people from various backgrounds and experiences and it allowed me to examine my assumptions, beliefs and preferences. The journey changed the way I viewed myself and enlarged the range of opportunities I highlight for my daughter.

**How am I going to use this project for my future development as a leader?**

Within my program, I am going to work with others to assess to what extent the Dialogic pre-conditions are in place with the goal of implementing and evaluating a Dialogic OD effort to decrease health inequities. In my new role as a Program Director in the MCH field, I need to ensure that people know their strengths and have adequate time to participate in the Dialogic process. I will help design a Dialogic change process that builds on hope and motivations. We will reframe inequities from a deficit base by gathering information about strengths of community and how they can be assets in health.

I will use this capstone as motivation to continue to have courageous conversations about race, class and power. I will also practice the skills of the wizard to inspire hope. These skills
include passion, creativity and faith. “The wizard relies more heavily on magic and mystery than the warrior on strength and skill (Bolman, 2006, p. 164).” Courage will enable me to persist in the face of uncertainty and challenges. Passion supports a level of aspiration that goes well beyond what others see as realistic: “Faith derives from a profound conviction that the chosen purpose is both worthy and achievable (Bolman, 106).” Creativity offers challenging and inspiring new ways to frame where we are and where we can go from here. In a time of declining resources, Dialogic OD change teams must build on faith and conviction to reach a solution we have never seen before.

There are many questions embedded in the area of health disparities that produce leadership opportunities. Due to the wickedness of the problem, the questions cannot be fully answered without engaging numerous people in the shared vision of healthy people. I believe that the foundational principles of ethical leadership and Dialogic approaches help to soothe staff and partner anxiety and foster creativity and innovation during these times of uncertainty. What is certain is that we must act to save the lives of children and prevent the grief of parents. The leadership skills learned in the EMPA, the curriculum provided and the EMERGE tools have taught me to empower others to act.

I am ready.
### Appendix B: Interview Tool

#### Phase 1: Determine Wickedness

<table>
<thead>
<tr>
<th>Question</th>
<th>Potential Answers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1)</strong> How many organizational change efforts have you been involved in?</td>
<td></td>
</tr>
<tr>
<td><strong>2)</strong> Please think about a recent change project that addressed health inequities (or you think was successful)?</td>
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*MULTI-LEVEL INVOLVMENT WITHIN ORGANIZATION

<table>
<thead>
<tr>
<th>Question</th>
<th>Potential Answers</th>
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<tbody>
<tr>
<td><strong>3)</strong> Who had authority or was in charge?</td>
<td>Central authority</td>
</tr>
<tr>
<td><strong>4)</strong> Was your org. or program dependent on others to achieve results?</td>
<td>Independent</td>
</tr>
<tr>
<td><strong>5)</strong> How complex or difficult to understand was the OD effort?</td>
<td>Predictable</td>
</tr>
<tr>
<td><strong>6)</strong> How dynamic (ever-changing) was the change effort? What was the duration?</td>
<td>Clearly resolved</td>
</tr>
<tr>
<td><strong>7)</strong> What was your role?</td>
<td>Direct</td>
</tr>
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</table>

**Time-frame**

<table>
<thead>
<tr>
<th>Question</th>
<th>Potential Answers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>8)</strong> What theories (authors) have influenced the change process? What</td>
<td>Classical science, positivist, modernist philosophy, LEAN, Interpretive approaches, social constructionism critical and</td>
</tr>
</tbody>
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Banks, Embarking on Equitable Change in Turbulent Times
<table>
<thead>
<tr>
<th>Question</th>
<th>Potential Answers</th>
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<tbody>
<tr>
<td>was your view of the organization?</td>
<td></td>
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<tr>
<td>* view of human behavior</td>
<td>human will response as rational profit-maximizers, Theory X, pro-bureaucracy</td>
</tr>
<tr>
<td>* Institutional bias</td>
<td>postmodern philosophy, humans empowered to be preventative, Theory Y, pro-people</td>
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<table>
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<tr>
<th>*NEED FOR CHANGE OR URGENCY</th>
<th></th>
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<tbody>
<tr>
<td>9) What events prompted the change process (catalytic forces)?</td>
<td></td>
</tr>
<tr>
<td>*Problem Solving Orientation</td>
<td>Problem, need to change behavior and what people do, curative, solutions from analytics, reactive</td>
</tr>
<tr>
<td>10) What information did you gather prior to the change process?</td>
<td></td>
</tr>
<tr>
<td>*Methods of learning</td>
<td>Objective: Quantitative data, weaknesses</td>
</tr>
<tr>
<td></td>
<td>Subjective: Stories, quotes, assets</td>
</tr>
<tr>
<td>11) How was information gathered?</td>
<td>Databases, tracking and management systems, surveys, productivity, audits, performance evaluations</td>
</tr>
<tr>
<td></td>
<td>People, satisfaction, case studies, stories, focus groups, observations, Community based participatory Research, value clarification</td>
</tr>
<tr>
<td>12) How were the goals or vision state determined?</td>
<td></td>
</tr>
<tr>
<td>*Goals</td>
<td>Rational and analytic processes, top- down, a priori</td>
</tr>
<tr>
<td></td>
<td>Negotiated, bargained, through political process, by participants</td>
</tr>
<tr>
<td>13) What were the goals of the change process and how did you define equity?</td>
<td>Structural changes, personnel changes, attainment of pre-stated targets, solving discrete problems</td>
</tr>
<tr>
<td></td>
<td>Cultural, political or motivational factors, creating capacity to address issues as they arise, disrupt status quo</td>
</tr>
<tr>
<td>14) Who benefited (or was burdened) by the goals?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Status quo, increased profit, principles of utility, concentrate resources/power, focus on bureaucracy</td>
</tr>
<tr>
<td></td>
<td>Disrupts status quo, distribute resources, principle of intentionality, social capital, close gaps, focus on people</td>
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<table>
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<tr>
<th>*COMMITTMENT AND SUPPORT</th>
<th></th>
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<tbody>
<tr>
<td>15) How was leadership involved in the project? Who else was involved and how were they persuaded to participate?</td>
<td>Leadership determined priorities and set targets. OD consultant/practitioner outlined process Staff implemented process Evaluator/analyst measured</td>
</tr>
<tr>
<td>*Leadership</td>
<td>Leadership provided structure and processes to produce generative ideas Internal staff facilitated process Staff set goals, targets and measured progress</td>
</tr>
<tr>
<td>Question</td>
<td>Potential Answers</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------</td>
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<tr>
<td><strong>Plan</strong></td>
<td></td>
</tr>
<tr>
<td>16) What were the components of the plan? Did you use a visual?</td>
<td>Measure, track, manage, implement, evaluate</td>
</tr>
<tr>
<td></td>
<td>Create, develop, dialogue, reflection, iterative</td>
</tr>
<tr>
<td>17) What data/information was used to determine success?</td>
<td>Efficiency, quantity, objective truths, budgets, schedules, networks determined a</td>
</tr>
<tr>
<td></td>
<td>priori and used to control, quantitative</td>
</tr>
<tr>
<td></td>
<td>Satisfaction, effectiveness, quality, subjective experiences, participation,</td>
</tr>
<tr>
<td></td>
<td>qualitative</td>
</tr>
<tr>
<td><strong>Phase 3: Determine Dialogic Preconditions</strong></td>
<td></td>
</tr>
<tr>
<td>What were Critical Factors/conditions?</td>
<td></td>
</tr>
<tr>
<td><strong>Resources</strong></td>
<td></td>
</tr>
<tr>
<td>18) What do you think were the most important factors that facilitated</td>
<td>Sense of urgency, identified problem, money, poor results, impending threat</td>
</tr>
<tr>
<td>the initiation of the change efforts?</td>
<td>Employee motivation, opportunity, commitment, expertise, training</td>
</tr>
<tr>
<td><strong>Openness to Learning</strong></td>
<td></td>
</tr>
<tr>
<td>19) What were the factors that got/kept people engaged in the change</td>
<td>Assigned as part of job, concern about quitting, wanted to finish work-plan</td>
</tr>
<tr>
<td>effort?</td>
<td>Challenge, contribution to larger efforts, motivated, excited</td>
</tr>
<tr>
<td>20) What were the efforts that led to the successful adoption of the</td>
<td>Leadership directive, top-down communication</td>
</tr>
<tr>
<td>changes?</td>
<td>Leadership support, horizontal communication, innovation, risk-taking</td>
</tr>
<tr>
<td><strong>Continuity of Efforts</strong></td>
<td></td>
</tr>
<tr>
<td>21) What are the key factors that led to the on-going implementation of</td>
<td>Work-plans, timelines, tracking and managing results, distinct, manageable</td>
</tr>
<tr>
<td>the project?</td>
<td>Shared vision, values, transparent process, empowered employees, linked to other</td>
</tr>
<tr>
<td></td>
<td>efforts</td>
</tr>
<tr>
<td>22) Anything else you’d like to share about necessary factors for starting</td>
<td>Change can be better managed</td>
</tr>
<tr>
<td>meaningful change in a complex, changing environment?</td>
<td>Change can be initiated and motivating</td>
</tr>
</tbody>
</table>

*Categories and questions informed by Diagnostic OD literature on reconditions such as: Brinkerhoff and Ingle (1989) and Fernandez and Rainey (2006)
References


Banks, Embarking on Equitable Change in Turbulent Times


