A STRATEGIC ANALYSIS OF MENTAL HEALTH SERVICES IN THE CENTRAL OKANAGAN

by

Micheal Morrill

M.A., University of Calgary, 1991
B.A., University of Calgary, 1987

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APPROVAL

Name: Mike Morrill

Degree: Master of Business Administration

Title of Project: A Strategic Analysis of Mental Health Services in the
                               Central Okanagan.

Supervising Committee:

_____

Dr. Aidan Vining
CNABS Professor of Business & Government Relations
Senior Supervisor
Faculty of Business Administration

_____

Dr. Edward Bukszar
Associate Professor
Second Reader
Faculty of Business Administration

Date Approved: _Apr. 5/06_____

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ABSTRACT

Many public sector organizations are struggling to meet community demand. Waitlists raise concerns about access, and over-stretched caseloads jeopardize quality. In serving young children with delays and disabilities, the Central Okanagan Child Development Association (COCDA) is facing the same challenge.

To keep pace with the increased demand, the COCDA decreased the intensity of service. Case management practices were allowed to drift. These adjustments shifted the COCDA to a mixed differentiation strategy. Quality is emphasized for some services, but a high volume, adequate quality strategy is accepted for others.

Considering the COCDA's history, human resources, mission and vision, and culture, the appropriateness of a mixed strategy was assessed. Several alternative strategies were evaluated. From this, a recommendation was put forward to adopt a combination strategy. Under this strategy, cost-based methods are targeted for less popular services, while better quality standards are applied to high demand services.

This strategy also fits well with two emerging forces in the COCDA's environment: increased contract accountability, and a more competitive labour market.

DEDICATION

This project is dedicated to my family and to all those who are making a difference in a child's life.

ACKNOWLEDGEMENTS

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1 INTRODUCTION

1.1 Introduction to the Organization

The Central Okanagan Child Development Association (COCDA) is a non-profit organization dedicated to serving young children from birth to age six with special needs. In serving children with special needs the COCDA offers a range of programs, including: the Infant Development Program (IDP), Speech-Language Pathology (SLP), Physical Therapy (PT), Occupational Therapy (OT), Supported Child Development (SCD) and Behaviour Intervention (BI).

The infant and preschool years are a prime time for rapid development and growth (Kid Source On Line, 2005: National Centre on Birth Defects and Developmental Disabilities, 2005). It is during this period that many key developmental milestones are achieved (Greenspan and Wieder, 1998, p. 358; Allen, Paasche, Langford and Nolan, 2002, p. 62). However, in comparison with the entire lifespan, the window of opportunity during the infant and preschool years is relatively short. For this reason the COCDA emphasizes an early intervention approach. A commitment to early intervention means identifying developmental delays or risks of delay, and developmental disorders in the early stages (Greenspan et al., 1998, p.358). When delays and disorders are identified early, it extends, and thus maximizes, the timeframe over which services and supports can be delivered. Maximizing service and support is extremely important since the early years are one the most malleable periods of growth in the human lifespan.

In delivering early intervention child development services to infants, preschoolers and their families, the COCDA follows two different strategies. One approach is proactive and based on anticipation, where strategies and support are preventative in nature and intended to avoid further developmental delays. The second strategy is more remedial or rehabilitative in nature. A rehabilitative approach focuses

on mitigating or reversing the impact of delays and disorders on a child's development. In promoting healthy child development, these two approaches are not mutually exclusive. Preventative and rehabilitative approaches tend to blend together so that further delays are prevented and existing delays are corrected as much as possible.

The COCDA's preventative and rehabilitative services are also delivered in two different formats. At times, early intervention child development involves working directly, hands-on with the infant or preschooler, while at other times it takes an indirect approach. An indirect approach places the focus on the parent, or caregiver and not the child. Indirect services consist of coaching parents or other caregivers on how to promote healthy child development, and on transferring specific strategies and skills. The indirect method extends beyond the family's home to also include the broader community. For example, skills and strategies are also transferred to daycares and preschools, to ensure as many of the child's caregivers as possible are empowered to promote growth and development.

The COCDA's main mandate is clearly focused on promoting healthy child development and early intervention. A secondary mandate also exists. In promoting healthy child development the COCDA also attempts to address family support issues with parents and extended family.

Similar to the COCDA's multi-faceted approach to early intervention child development, family support is provided in several different ways. Frequently family support is provided one-on-one by offering emotional support and empathizing with parents as they try to come to terms with the challenges facing their family. At other times, family support is provided to parents and siblings by connecting them with a parent, or sibling support group. During group meetings coping strategies are discussed and hopefully, supportive, beneficial relationships are formed and carried forward outside of group meetings.

Although stress, a sense of isolation, and unresolved issues can be major, in-depth issues for families, it must be remembered that family support is a secondary focus for the COCDA. The level of need fluctuates as families go through periods of crisis, but there are definite limits as to how much support the COCDA can offer to families.

The vast majority of families access COCDA services free of charge. Instead of a user fee the agency is funded through several contracts with the Provincial Government's Ministry of Children and Family Development (MCFD). These contracts buy a finite level of service, which the agency administers and allocates to families on behalf of the community. Under this arrangement the agency determines the frequency and intensity of service delivered to each child. If the family is interested in accessing a more frequent, more intense level of service, there is little leeway to accommodate this wish.

To some extent the distribution of services, including duration and intensity, is determined by best practice in the child development field. As the number of referrals continues to increase, holding the line on best practices is becoming more difficult. The tension between best practice and oversubscribed services is an extremely difficult balancing act. Considering the different pressures pulling in different directions it is easy for the organization to lose focus, which in turn leads to the improper allocation of resources.

The COCDA originally registered as a non-profit organization in the Central Okanagan in 1966. Due to this history the agency has long standing relationships with families, referral partners and stakeholders. This history is significant in terms of the agency's reputation, an important commodity for a non-profit organization. As far as non-profits go, the COCDA is a large organization with approximately fifty three full-time equivalent (FTE) positions.

1.2 Promoting Healthy Child Development

Child development is a critical population health issue. Healthy children reduce the demand on the health care system, the community support system, and the education system (National Center on Birth Defects and Developmental Disabilities, 2005, Public Health Agency of Canada, 2006). In addition to its impact on social systems, healthy child development reduces family stress (Kid Source On Line, 2005). Since it is such an important public health concern, several public services address child development.

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In the province of British Columbia, Health Authorities, or more specifically Community Health Centres, provide well child clinics and immunization programs to monitor and promote health, and to prevent illness. Most provinces are funded through the Federal Government to operate head start programs, where children from at risk families and families facing socioeconomic challenges, are sponsored to attend an early childhood education program.

In the case of the COCDA, the focus on child development is narrower than a population health perspective. In promoting healthy child development the COCDA serves a specific target group, namely children with a delay, or at risk of delay, and children with a disability. In identifying developmental delays and disorders, the range and level of need is rather broad. For example, a referral might be received for a child with a slight articulation delay. This delay is only noticeable when the child says certain words or phrases, and can be corrected through a relatively small number of sessions with a Speech-Language Pathologist (SLP). At the other end of the continuum, many referrals are also received for children with lifelong disabilities, such as Cerebral Palsy, Down Syndrome and Autism Spectrum Disorder to name just a few. Some of these children will require lifelong support. Thus the phrase, children with special needs, refers to this whole continuum of minor delays to life-long disabilities.

To better define the field of child development and the work the COCDA concentrates on, the following framework in Table 1 provides a concrete definition of the different areas of development. When child development is observed and assessed, seven major areas of skill development are considered.

Table 1: The Seven Major Areas of Child Development

Gross Motor:	How children can use their large muscle groups to run, jump, climb, etc.
Fine Motor:	How children use their small muscle groups to pick-up, handle and fit small objects, to build with block, to complete puzzles, etc.
Cognitive:	The child understands of object permanence, concepts such as large and small, classification, and problem solving.
Language and communication	The development of receptive language, or what the child understands and expressive language, what the child can say. Gestures and non-verbal communication are also included in this area of development
Self-Help:	Skills include independent feeding, dressing and Toileting
Emotional Development:	The child's affective display, regulation, and control of emotions.
Social Development	Attachment, level of cooperative play, empathy and relatedness. Landry (2002), pp. 3-4

Source: Landy (2002, pp. 3-4)

Typical child development, "...involves a number of qualitative shifts or reorganizations that allow a child to increasingly adapt to the environment (Landry, 2002, p. 2). For this reason the early years are extremely critical for lifelong learning and growth. The infant and preschool years provide a broad-based foundation for acquiring skills through out the life cycle (Allen, et al., 2002, p. 14)). To provide some sense of the importance and breadth of this foundation, during the early years children learn to:

- Move about, to gain a sense of independence in moving from one place to another, to explore and experiment.

- Become skilled at grasping, holding and manipulating increasingly more complex objects.

- Become increasingly able to take care of their own personal needs, such as toileting, dressing and eating.

- Acquire their native language and use it in a variety of ways to get what they need from others around them.

- Develop the ability to think, form ideas, solve problems, make judgements and influence others.

- Respond with increasingly sophisticated words and gestures when others speak to them or attempt to influence them.

- Discover ways to get along with and interact with other. Allen et al. (2002, p. 14)

All experts agree that what happens during the early years has significant implications for the school age years and adulthood. For this reason, the promotion of healthy child development is seen as an essential public service.

1.2.1 Early Intervention

Since the infant and preschool years are such an important stage in the human lifespan, academics and interventionists in the child development field emphasize an early intervention approach, and the COCDA is no different. One source summed up the importance of early intervention child development as follows,

> "The therapeutic program must begin as early as possible – at the first sign that something is wrong – because the more quickly the child is engaged and interactive, the more quickly she'll start learning and the fewer maladaptive behaviours she'll develop to cope with her difficulties." (Greenspan et al., 1998, p. 385)

With a child's early years holding so much potential for growth and development, it is important for the COCDA to get involved and to offer support as soon as possible after a developmental delay or disorder is identified. Given the importance of the early years, not only must service providers offer a quality child development program, services must also be timely and accessible, two qualities that can be difficult to achieve.

1.3 Waitlist and Caseload Pressures

Over the last seven years the number of children[1] referred to the COCDA for support with a developmental delay or disorder has significantly increased. This is

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[1] In industry jargon, number of children is usually described as the number of unique children to distinguish this count from the number of referrals received. Some children may be referred to several programs upon their initial referral; hence, the number of referrals received by the agency is much higher than the number of unique children referred. For the purposes of this discussion, the term number of children is used as the equivalence to number of unique children.

particularly the case in recent years, as depicted in Figure 1. From April 1997 to March 2002 an average of one hundred and sixty six children were referred to the COCDA every year. In comparison, between April 2002 and March 2005 the average number of children referred on an annual basis increased to two hundred and sixty seven. The difference between these two averages represents an increase of sixty one percent from the 1997 to 2005 period.

Figure 1: The COCDA's External Referrals 1997 to 2005

Central Okanagan Child Development Association
Referral Statisitics
Number of Unique Children Referred 1997 to 2005

Note: Data for 1999 to 2000 is missing.
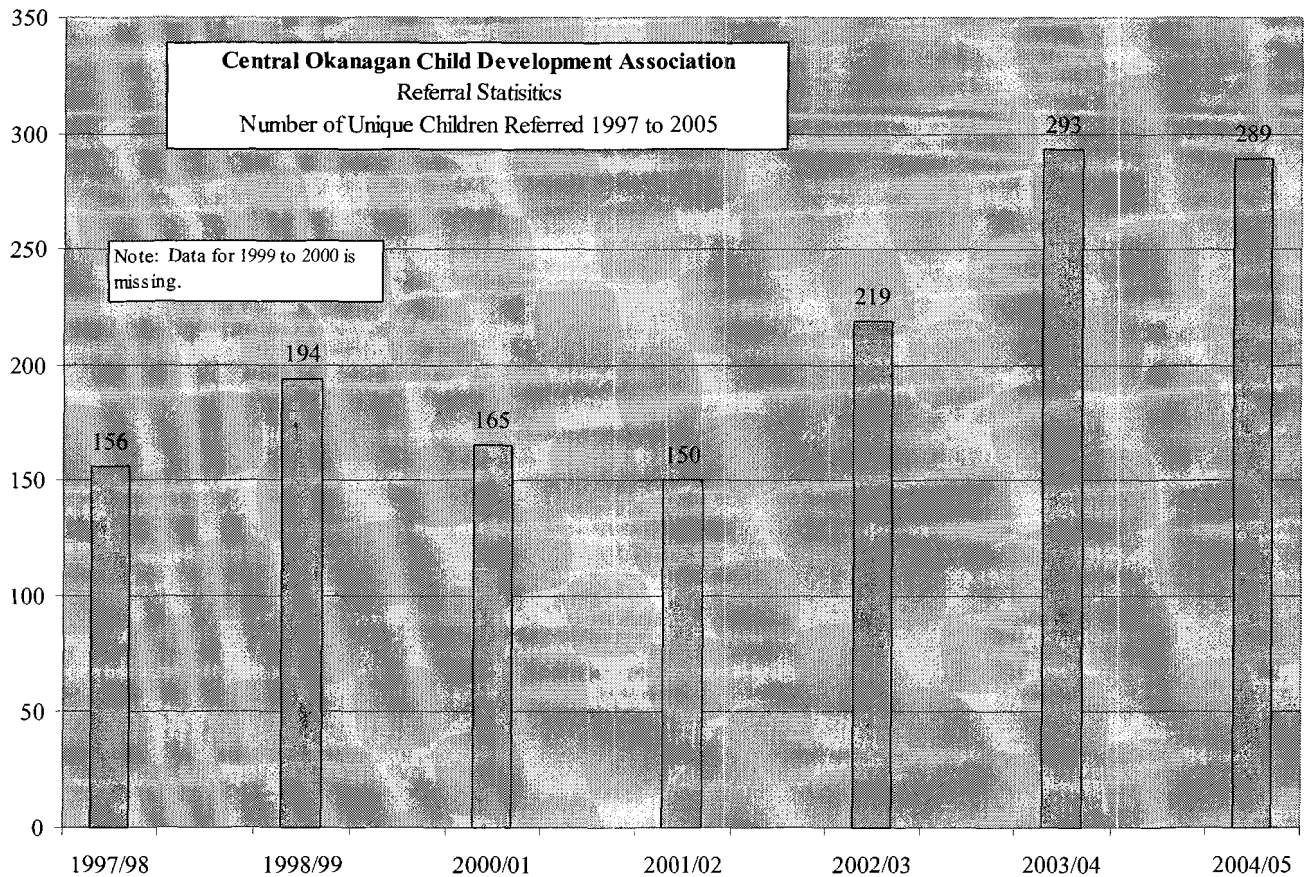
Although the number of children referred has increased by almost two thirds, the available resources, mainly the staffing to deliver service has not increased at the same rate. In 1999, the COCDA had seven FTEs across IDP and the Early Intervention Program (which includes Speech-Language Pathology, Occupational Therapy, and Physical Therapy). Added to this mix was SCD with a staff roster of twenty four FTEs, bringing the total to thirty one FTEs[2]. By 2005 this FTE count for the three programs

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[2] The BI program is not included in this tally as this program was not created until the summer of 2001. As a result the BI program is excluded from this comparative analysis.

(IDP, Early Intervention Program and SCD) has increased to thirty two point seven FTE, which is only an approximately a six percent increase. This very modest increase in staff pales in comparison to the growth in referrals, and clearly points to a significant gap between demand for services and available resources.

Although an increasing number of referrals is difficult in itself, another related pressure is emerging. Many of the referred children now require extensive intervention over an extended period time from several different programs. Not only is the total number of referrals climbing, the number of children referred with complex, multiple needs is also increasing. This trend is readily apparent in the BI program. In 2001 this program was serving six children, all under age six, diagnosed with an Autism Spectrum Disorder. In February 2006 this same program has an enrolment of twenty eight children.

Increasing referrals, combined with a more complex, more demanding caseload is a major challenge for the agency. Considering the agency's commitment to quality, accessible and timely service, these two trends in the COCDA's referral pattern are worrisome and highly problematic. It is creating a significant strain for the agency.

The growing gap between the volume and acuity of referrals, and the available staffing, impacts on two areas. Historically, some COCDA programs have tended to carry a waitlist. On an annual basis the SLP program gets the most referrals and as a result, has always carried a waitlist. The PT program also has a history of carrying a waitlist. For the other programs, however, the reality of a waitlist, or at least one that is noteworthy, is a new concept.

When the wait-time for the SLP program was at its worst in 2002, children were waiting close to eighteen months from the date of referral to their first SLP visit. The SLP waitlist now ranges from six to eight months, but this is mainly due to a major change in caseload management practices.

The other Early Intervention services, PT and OT also have wait-times in the neighbourhood of six to eight months. IDP has gone from no waitlist, where now typical referrals will wait in the neighbourhood of six weeks before service is initiated. Not only has the wait-time increased, the number of children on the waitlist has also climbed. Recently the waitlist for IDP reached a dozen children, which is the highest it has ever

been during the program's twenty-four year history in the Central Okanagan. Even the SCD program, which is well resourced and can exercise creative case management options, now has a waitlist.

To provide a better description of the COCDA's waitlist status, Table 2 provides a snapshot of waitlists statistics as of the end of January, 2006. One of the more telling statistics contained in this data, is the number of children who have been waiting a minimum of five months or more for service. Across the various programs thirty nine children have been waiting a minimum of five months for service. This means that almost one-third of all children on a COCDA waitlist have been waiting at least five months for service, since the date of referral.

Table 2: COCDA Waitlist Statistics, January 31, 2006

Program	# on WL	1 Mnth	2 Mnths	3 Mnths	4 Mnths	5 Mnths or more
IDP	9	1	5	3	0	0
SLP	50	18	8	5	7	12
PT	26	5	4	5	3	9
OT	32	10	4	5	4	9
SCC	10	0	0	0	1	9
Total	127	33	16	15	15	39

Note: WL = Waitlist

As the number of referrals has increased, it is not surprising program waitlists have felt the impact. This waitlist trend is highly problematic. Given the importance of early intervention and the limited window of opportunity for boosting developmental gains, a wait-time of any length is a significant lost opportunity. When wait-times are stretching to six, eight or more weeks, the intent to deliver early intervention is getting lost. Looking at the referral trend depicted in Figure One, the evidence suggests that wait-times will continue to be a major area of concern for the COCDA.

To keep wait-times from becoming too excessive the COCDA has responded by adopting ad hoc caseload management strategies across all its services. The essence of these case management practices has been to increase the rationalization of the COCDA's resources. In rationalizing services the main outcome has been to decrease

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the intensity of support provided to children and families. For IDP, SLP, PT and OT, children are generally seen less frequently than in the past. To help manage more referrals and the resulting impact on waitlists, practitioners are spending less time with individual clients than in the past. In other words, to meet the growing volume of demand, the COCDA has responded by decreasing the quality of service.

Such caseload management strategies certainly help to keep wait-times from getting too excessive, and help to keep the gap between referrals and available resources from becoming too large. However, the flip-side to this strategy is that children and families are getting a less intense service than in the past. The reduced intensity affects the quality of outputs and most likely the quality of outcomes. Children and families are getting less support, less guidance, less hands-on therapy, less monitoring than before. In terms of program quality, this change in caseload management, and the resulting impact on quality, means the COCDA is delivering a less differentiated service.

Changing the intensity of its services was a quick reaction to rising demand. This change, however, carries significant strategic implications. If the challenge is to deliver quality early intervention services, is the implementation of less intense services a sound strategic move? The shift to a less differentiated service strategy was done with little planning. It could very well be the case that other more advantageous strategies are available. Perhaps there are other service strategies, where output can be increased with a minimal impact on service quality. The purpose of this strategic analysis is to investigate this possibility.

Since it is important to get to children with special needs as early as possible, and to get it right, service timeliness and quality are critical issues. Hence, the focus of this project is to closely examine the existing service model, in terms of timeliness and quality, and to investigate the merits of other possible service models in an effort to find the best formula for serving community demand with the available resources. The COCDA has been adapting to increased demands for service in an emergent, ad-hoc manner. To be better stewards of scarce community resources, the rationing of services needs to be more strategic. In response to growing community demand the main goal of this project is to carry out an analysis and to develop a strategic plan for implementing early intervention child development services.

1.4 Summary of the Problem

The level of demand for COCDA services has significantly increased in the last three years. As a result, all COCDA programs now have waitlists, and lengthening wait-times. In addition to the impact on waitlists, the upward trend in referrals is also affecting service. The main impact is on the intensity of service. Practitioners are simply not able to schedule as many visits and sessions per child, as in the past.

2 COCDA PROGRAMS, SERVICES AND CLIENTS

In Chapter One the COCDA's mandate and background were provided, followed by a description of the growing gap between demand for service and available resources. In this section a more thorough description of the COCDA's programs, services and clients will be developed. From a strategic analysis perspective, a thorough understanding of a non-profit organization's programs and services helps to identify activities that have inadvertently become new services, or could become new services (Boardman and Vining, 2000, p.398). One role of the strategic analysis is to determine if these new activities represent an opportunity for growth, or a drift from the organization's focus. In identifying services, it is also necessary to link activities to clients. This connection reveals the different service segments each client group values, which is an important prerequisite to meeting client needs (Boardman and Vining, 2000, p. 400). This chapter will not identify opportunities for growth, indicators of organizational drift, or the organization's value chain, but the description of programs, services and clients will provide the basis for these sorts of analysis in subsequent chapters.

2.1 COCDA Program Descriptions and Staff Compliment

In promoting healthy child development through an early intervention approach, the COCDA offers a range of programs for children and their families. Each of these programs is concerned with preventing and rehabilitating developmental delays and disabilities. Each program, however, has its own area of focus regarding a particular aspect or attribute of child development. There is some overlap across different disciplines, but there is also a focus for each program that distinguishes it from others. Before discussing how these programs form the foundation for service delivery to children and families, a definition of each program area is provided.

2.1.1 The COCDA's Program Descriptions

The program which receives the highest number of referrals, collectively known as the Early Intervention Program (EIP), consists of the following group of pediatric therapies: Occupational Therapy (OT), Physiotherapy (PT) and Speech-Language Pathology (SLP). Each of the three is considered to be a separate discipline with its own area of focus.

Starting with the discipline of OT, this form of therapy focuses on, "the relationship between the child's disability and his/her ability to perform age appropriate life skills, extending from early play and self-help skills, [to] school related activities" (Province of B.C., Ministry of Health, 1992, p. 25). Areas of focus for OT are, "...fine motor adoptive abilities, social/emotional skills, self care skills, perceptual skills, visual motor coordination, fine motor coordination, sensory integrative and motor planning abilities, early cognitive development, attention allocation, and special seating, positioning and aids" (Province of B.C., Ministry of Health, 1992, p.25).

There is some similarity between OT and PT in that both forms of therapy are concerned with motor skills. The main distinction between the two is that in general OT concentrates on fine motor skills, while PT addresses gross motor concerns. In terms of gross motor issues PT focuses on, "...muscle tone, range of joint movement, reflex activity, balance and equilibrium reactions, presence and absence of abnormal patterns of movement, and the child's level of gross motor development" (Province of B.C., Ministry of Health, 1992, p.25).

As another discipline in the Early Intervention Program, SLP addresses the development of language skills and the treatment of communication disorders (Province of B.C., Ministry of Health, 1992, p.25). In more clinical terms SLP deals with, "...oral motor functioning, such as chewing, sucking and swallowing, speech, including breath control, voice, nasality and articulation, auditory and expressive language, augmentative communication and technical aids" (Province of B.C., Ministry of Health, 1992, p.25).

While the Early Intervention Program can be subdivided into specialized disciplines, the Infant Development Program (IDP) and the Supported Child Development (SCD) program are more general in nature, focusing on global child development rather than a particular aspect of development. The mandate of IDP is to

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assist families in, '…making the optimum use of available resources, to educate parents about the factors pertinent to the growth and development of their child, and to transfer skills to parents that enable them [to boost] their own child's development (Province of B.C., Ministry of Health, 1995, p. 8). With a client base of young infants and toddlers, IDP emphasizes parent support and education, over working directly with the child one-on-one.

The SCD program is available to preschool and some school age children, who require extra support in order to be included in an early learning care centre, such as, a preschool or day care. As a service, SCD, "…assists families with finding an early learning care centre, and consults with parents, early learning care staff and team members to develop an individual program plan for the child" (COCDA 2004-2005 Annual Report, p.6). SCD programming is delivered through three avenues: (1) providing child-specific training for community staff, (2) providing additional staffing, known as SCD Program Assistants at the preschools and daycares, and (3) providing behaviour screening and consultation.

The Behaviour Intervention (BI) program consists of three streams of service, one for children over age six, one for children under age six and the third, an intensive intervention program with limited space for children under age six. Each of these behaviour intervention programs are only available to children diagnosed with an Autism Spectrum Disorder (ASD).

The "Over Six" BI program is currently in transition. Up until recently the "Over Six" program offered one-on-one sessions in the family's home two times per week. Through this format a total of four hours were delivered every week. This one-on-one program is being phased out and will be replaced by a different format. In the new "Over Six" program, only group sessions for socialization and skill building will be offered.

In contrast, the "Under Six" BI program is a more intensive service than the "Over Six" option, providing ten to twelve hours of one-on-one sessions per week in the family's home. The "Under Six" program follows a mixed format, using a combination of applied behaviour analysis, also known as discrete trial learning, and natural teaching strategies, such as imitation and modeling (McDonald, L., Alexander, J., Kyslea, G.M.,

and Drummond, J., 2001). In December 2005 this program added a new format through the introduction of group therapy sessions twice a week at the COCDA.

The third stream of the BI program provides the most intensive service. This program, commonly known as Early Intensive Behaviour Intervention (EIBI), provides twenty hours of intervention time per week. As the case with the "Under Six" program, the EIBI program consists of group sessions at the COCDA and one-on-one sessions at the family's home. In addition to behaviour interventionists, the EIBI program is also comprised of SLPs and OTs who work with the behaviour team to incorporate strategies from these disciplines into the behaviour program. The intensity of the EIBI program makes it a rarity in early intervention child development services. MCFD has only funded three of these programs across the province, and at the Kelowna site the program's capacity is limited to eight children at twenty hours per week.

The ASD Assessment Team is a separate entity from the BI program. The ASD Assessment Team was first established in 2001 and assessed between ten and fifteen preschool children every year. The volume of work was such that it was a stretch to classify ASD assessments as a separate program. However, the number of referrals for this program has increased dramatically. In this fiscal year, 2005-2006, thirty children were assessed.

Several external partners are members of the ASD Assessment Team, including a Child Psychologist and a Child Psychiatrist. From within the agency, an SLP and when caseload permits an OT, round out the remainder of the team. Each internal and external team member carries out their own assessment prior to a scheduled assessment day. This information gets pooled during the team meeting and group observation on the team assessment day. Generally, two children are seen on the team assessment day.

2.1.2 Allocation of Full-Time Equivalents by Program

To provide a sense of the staff resources allocated to each program, a breakdown of the full-time equivalents (FTEs) is provided.

Table 3: Allocation of FTEs by COCDA Program

PROGRAM	FTE	COMPOSITION
IDP	2.6	1 FTE Program Coordinator; 1.6 FTE Consultant
EIP	8.5	1.8 FTE Program Coordinator 3.2 FTE Speech-Language Pathology 1.5 FTE Physiotherapy 2 FTE Occupational Therapy
SCD	24.8	1 FTE Program Coordinator 2 FTE Program Consultants, 0.8 FTE Visual Language Interpreter 21 FTE Program Assistant
BI	14.7	0.8 FTE Behaviour Coordinator 2.5 FTE Behaviour Assistant 9.5 FTE Behaviour Assistant 0.9 FTE Speech-Language Pathology 0.5 FTE Occupational Therapist 0.5 FTE Scheduler
ASD Assess	0.4	0.3 FTE for Speech-Language Pathology 0.1 FTE for Occupational Therapy
Total	51	Full-Time Equivalents

To clarify the nature of some of the staff resources listed in Table 1, "Allocation of FTEs by COCDA Program", all Program Coordinators carry a significant caseload. At best half a day per week, the equivalent of a 0.1 FTE of every Program Coordinator position, is dedicated to supervision and management responsibilities. In addition to the FTEs listed in Table 1, administrative support services are staffed by: 1 FTE Executive Director, 0.8 FTE Accountant, 0.4 FTE Administration Coordinator, 1.6 FTE Administrative Assistant, 0.5 FTE Maintenance Worker, and 0.8 FTE Janitor.

The FTE count of the staff roster tends to be stable from year to year, but just recently a 1.0 SLP, a 0.4 OT and a 0.3 PT were added to the EIP. This increase in staffing was made possible through new funding from MCFD in an effort to reduce waitlists for early intervention child development services across the province. This increase in staff, and its impact on the growing demand for service and waitlists will factor into later discussion.

In tallying up the COCDA's FTE roster, further attention needs to be drawn to the unique circumstance of the BI program. The FTE count for the BI program is constantly in flux, because of the funding mechanism the government has established for this program. All of the COCDA's early intervention child development programs have a fixed amount of government funding for delivering the service, regardless of the number of referrals. In the case of the BI program, however, every family qualifies for $20,000 per year if their child is under age six and diagnosed by a multidisciplinary team with an Autism Spectrum Disorder (ASD).

This method of funding has essentially allowed the BI program to grow with every new referral. The implication is that there is no funding cap to limit the size of the program. In a community where an increasing number of children are being diagnosed with ASD, the size of the COCDA's BI program has been growing in leaps and bounds. Since the BI program started in 2001, the number of staff has doubled and considering the growing list of children being identified as candidates for an assessment, every indication is that this program will continue to grow.

2.1.3 Referrals to COCDA Programs, 2004-2005

In the fiscal year 2004 to 2005, COCDA received a total of four hundred and twenty nine referrals from internal and external sources. The majority of these referrals, seventy four percent, were received from external partners. The COCDA's main external referral partners are physicians and public health nurses. The remaining twenty six percent of the referrals were generated from internal COCDA programs. Table 4 provides a further breakdown of the referral patterns by program.

Table 4: Number of Referrals Received by COCDA Programs, 2004-2005

Program	# of External Referrals	% of External Referrals	# of Internal Referrals	% of Internal Referrals	Total Referrals
IDP	86	27.2%	5	4.4%	91
SLP	128	40.5%	21	18.6%	149
OT	14	4.4%	30	26.5%	44
PT	46	14.6%	15	13.3%	61
SCD	32	10.1%	32	28.3%	64
ASD Assessments	10	3.2%	10	8.8%	20
Total	316	100.0%	113	100.0%	429

To correctly interpret this data, it is important to keep in mind that the number of referrals is not equivalent to the number of children referred for service. Some children are referred to several programs at one time. Taking this possibility into account, the three hundred and sixteen external referrals received in 2004-2005 represents two hundred and eighty nine unique children. For internal referrals the one hundred and thirteen referrals represents an additional thirty eight children. Combing these two statistics, in 2004-2005 three hundred and twenty seven children generated four hundred and twenty nine referrals.

2.2 Program Components

Each of the programs, EIP, IDP, SCD, BI, and ASD Assessments has a similar structure and set of components. Although the content may not be exactly the same and the style of the service provider creates some variation, all programs follow a similar mix of clinical or, procedural practices. These program practices, which are the core elements of every COCDA service option, are: intake, assessment, intervention, consultation and family support.

2.2.1 Intake

The first step in initiating services for a referral that is being picked up on the program caseload, is to complete an intake. If the referral is new to the agency, an extensive intake process is required. Detailed information is gathered about the family's history, the child's medical history, and the child's current activities, responses and abilities. At this point the family may be given a brief evaluation of their child's developmental challenges and opportunities, but this is done with caution given the preliminary nature of an intake. Parents are also informed about what to expect from the COCDA in terms of service, specifically the frequency and intensity of support. Due to the amount of information that needs to be exchanged, and depending on the child's health status, an intake may take two home visits to complete.

An agency intake focuses on the general status and history of the child and family. In addition to this general picture, each program completes its own intake. A program intake focuses on gathering information relevant to the involved discipline. The

purpose of an SLP intake, for example, is to get a good sense of the child's language and communication concerns and to confirm the family's goals for their child's language and communication development. For a new referral, both an agency and program intake must be completed. However, if the child and family are referred to another COCDA program after the initial referral, which is often the case, only a program intake needs to be completed for an internal referral. As a result, the intake process for secondary internal referrals is much shorter than for new referrals.

2.2.2 Assessment

Once the intake process is complete, the next step for each program is to assess the child's stage of development, including strengths, as well as needs, and to assess the parents' priorities for their child's growth and development. Depending on the child's stage of development and the clinician's style, an assessment may follow a formal, or informal format, or both. A formal assessment is based on a professionally recognized standardized tool with established validity and reliability standards. An informal assessment stems from the clinical observations of an experienced service provider. The fact an informal assessment is based on the practitioner's clinical judgment does not make it any less valuable in guiding client service plans.

Data for formal assessments is collected through direct observation by the service provider, while informal assessments tend to combine a mixture of the clinician's direct observation combined with the parent's report. The time to complete a formal assessment ranges from one to two hours working hands-on with the child and asking questions of the parent. In addition to the assessment itself, a portion of indirect time is needed for preparation, travel to and from the family's home, test scoring, and report writing.

The indirect time for an assessment averages two hours, but can run as high as four hours. Depending on the nature of the assessment, scoring and report writing can be quite extensive and require one to two hours in itself. If the child's health is fragile, or the child is an infant, he or she may tire easily. As a result, collecting the assessment data can take two home visits. Combining direct and indirect time, an assessment can take as little as four hours, but as much as eight hours to complete. Once completed,

the assessment report is placed on the central file with the Intake report and other vital information.

Assessments are crucial for two reasons. First, an assessment determines the starting point and the focus of future intervention. It provides a thorough evaluation of the child's health status and developmental stage, and it is the basis for developing the intervention plan. Secondly, assessments provide cues for initiating referrals to other services and supports within the agency, or the wider community. Planning the intervention strategy and activities is vital to the success of the service, and knowing when to make appropriate referrals to additional services is important to providing the family with the best possible support.

2.2.3 Intervention

Based on the assessment, the child's developmental stage and needs, and the family's priorities, are now well understood. Using this information, an intervention plan is developed consisting of the following major elements: (1) hands-on activities by the therapist to promote specific aspects of child development, and (2) strategies for transferring skills, techniques and information to parents for at home activities and exercises.

The first step in the intervention process is to gather all of the available information on the child's file. From this information an intervention plan is developed with the parent's goals and priorities providing the overall framework for the plan. With the intervention plan in place, sessions are scheduled and direct intervention commences.

The delivery of an intervention plan varies from program to program, both in terms of intensity, format, and location. For now, the discussion will be limited to the location of program interventions, while service format and intensity will be discussed in the following section.

Assessments usually take place in the family's home, but the location of the intervention is much more variable. Program intervention can be delivered on-site at the COCDA, at the family's home, or at a child care setting (i.e. daycare or preschool). To save on travel time and costs, SLP delivers the majority of its intervention sessions on-

site, whereas IDP goes into families' homes almost exclusively. PT and OT follow a mixed format with some services delivered at the COCDA's therapy gym, and other services delivered in the family's home, or a community child care setting. PT's and OT's mixed format is not evenly balanced, as about seventy percent of the service is delivered out in the community, with the remaining thirty percent delivered on site at the COCDA's facility.

2.2.4 Consultation

If intervention is not going according to plan and the child is showing little progress, service providers will typically consult with colleagues, either internally or externally. The intent of this consultation is to get a fresh perspective on why intervention might not be working and on what the best approach might be. If progress appears to be stalled, service providers also consult with parents and caregivers, tapping into the wealth of knowledge family and caregivers have of the child.

At various stages of the intake, assessment and intervention processes, service providers occasionally check-back with the original referral source, especially if the family continues to receive service from this partner. Depending on how the intervention plan evolves and on how the child progresses, additional referrals may also be made to other services. Once intervention is under way and the clinician spends more time with the child and family, the need for support from other services may become evident. With parent permission, referrals to other services are made.

Consultation is not just about trouble shooting and problem solving, it is also about integrating resources and ensuring service delivery is organized and cohesive. It is good practice to remain connected with other service providers working with the same family, so as to combine, or complement efforts. Disjointed service plans can be detrimental to the child's progress, as well as alienating parents from the whole experience.

2.2.5 Family Support

Family support is another distinct component of each COCDA program. Depending on the nature and severity of their child's delay, or disability and on the extent of their own network of support, some parents benefit from the emotional support

that is included with the COCDA's clinical activities. Parents sometimes experience a great deal of anxiety about their child's situation. They have pressing questions about the next steps, as well as the long term future, and they have a need to share their story and concerns. For these reasons, family support, in the form of listening, consoling, validating and advising, is an important component of all COCDA programs.

In addition to emotional support, parents are often keen to get further information about the nature of their child's delay, or disability. Families often have questions about the cause of the delay or disability, the underlying medical and physiological condition, and the possibilities surrounding rehabilitation. This information not only assists the family with becoming an educated consumer, but it also helps parents to come to terms with the challenge their family is facing.

If the need arises, family support also consists of encouraging parents to become advocates on behalf of their child. Children with special needs access many services and supports across the community. At times these supports may not be in-tune with the child's needs. Individual needs can vary a great deal from child to child, making it difficult to customize services and supports for everyone. When problems arise with services, parents must advocate on behalf of their child.

2.3 Delivering Programs as a Service

The COCDA's program offerings are bundled together, and offered in various combinations, as an individualized service mix for families. The objective of this section is to describe how COCDA programs are offered as a service to children with special needs and their families. As a preview to this discussion, Table 4 below illustrates how the COCDA's programs are delivered as a service.

Table 4: COCDA Programs by Service

Program	Needs-Based		Stand Alone		Group		Multi Disciplinary		Cluster		
	Rapid Resp.	Mon.	Reg.	Follow	Comm.	Parent	Intense	Reg.	Coord.	Serial	ST
IDP	■	■	■	■					■	■	
EIP: SLP	■	■	■	■					■	■	
OT	■	■	■	■					■	■	
PT	■	■	■	■					■	■	
SCD		■		■	■	■			■		
BI						■	■	■	■	■	
ASD Asses									■	■	■

Key:

■ Designates where a program delivers a service

Rapid Resp.	= Rapid Response	Mon.	= Monitoring
Reg.	= Regular	Follow	= Follow-up
Comm.	= Community Program	S.T.	= Short Term
Parent	= Parent Group		
Coord.	= Coordinated		

2.3.1 Needs-Based Services

2.3.1.1 Rapid Response

Given the growing demand for early intervention child development and the scarcity of resources, the option of providing a rapid response, sometimes intense stand alone service is not very feasible. There are certain conditions, however, where a rapid response service is warranted. For a rapid response to be initiated for a small number of children, but not others, some form of triaging must occur. An opportunity for triaging occurs when the referral is first received. Sometimes referral forms contain enough information to evaluate whether the child needs a rapid response or not. If the referral comes from B.C. Children's Hospital in the Lower Mainland, a referring professional might call to alert the Program Coordinator of the eminence of an urgent referral.

Another opportunity for triaging children occurs at the initial intake visit for new referrals. If on intake a rapid response is deemed appropriate, the child jumps other

children on the waitlist. An assessment is completed and the first stages of the intervention plan are then executed in short order.

In the case of SLP services, children who are deaf and hard of hearing jump the waitlist and receive service soon after the initial referral. For other children the wait for SLP services can be up to eight months, possibly more. The need for an intense, rapid response SLP service is minimal, as there may be one, perhaps two referrals of this nature every year. Once a referral for a deaf or hard of hearing child is made, an SLP schedules weekly visits with the family. Depending on the severity of the child's hearing loss and the family's timeline for making decisions, the schedule of weekly visits could last four to eight months. Given the importance of communication in promoting healthy child development, a lengthy, intense service is necessary.

Compared to SLP service, stand alone PT service faces a different situation. For PT a rapid and intense service is initiated for torta colis referrals, a condition where a child's head becomes misshaped because they have been lying on their back for too long. If this condition is not corrected in the early stages it becomes much more difficult to deal with as the child gets older. For PT an intense service consists of one visit every two weeks at best, but more likely once every three weeks. Generally children with this condition are on the caseload for four to eight months depending on the severity of their condition. Unfortunately referrals for this condition have been increasing recently. In 2005, the PT program received forty eight referrals for their rapid response service. The turn-around time for these referrals is listed in Table 5.

Table 5: The Number of Rapid Response Referrals to PT in 2005 and Turn-Around Time

| Quarter | No. of Referrals | Timeline for Intake Visit | | | |
		1 Month	2 Months	3 Months	Discharge
January - April	18	10	2	3	3
May - August	16	9	3	1	3
September - December	14	4	7	1	2
Total	48	23	12	5	8
Proportion	100%	48%	25%	10%	17%

This level of demand for PT's rapid response service is placing a strain on the program, leaving less staff time to invest in others forms of service. For the majority of other children not identified as a PT priority, the wait for other service options tends to be six to eight months.

For OT, children with feeding issues are given top priority. Children with feeding concerns tend to be infants or toddlers and the issue can involve positioning challenges related to feeding, tactile or sensory barriers, or matters related to a feeding tube. In the case of a feeding referral, an OT may visit the family on a weekly basis for several months. Only after the child is eating better, does the OT decrease the intensity of service. When child has a feeding tube, an intense service is initiated soon after the family returns from the hospital and will last until the child and family are comfortable using the tube. At this point, the intense service is discontinued, but starts again once the feeding tube is removed. After using a feeding tube for a period of time, it may take the child and family some time to establish regular feeding habits. Depending on the health of the child, a feeding tube could be in for several months, and occasionally over a year.

IDP, similar to SLP, PT and OT, tries to triage for priority cases, while contending with a growing waitlist and caseload. If a referral is received for a highly premature newborn infant with critical medical needs, this referral will jump the waitlist and receive an immediate response from IDP. While a rapid response is initiated, IDP is similar to PT in that the program is not in a position to deliver an intense service. For IDP, one visit every three weeks is the maximum available intensity given the level of staffing compared to the caseload demand.

2.3.1.2   Monitoring Caseload

Some programs offer a monitoring service to families who do not qualify for a rapid response, and who have not yet reached the caseload or stand alone or regular services. Some children and families are not ready to start services as soon as they can be picked-up on caseload. Sometimes the family is not ready to engage with service providers, or other times the child's developmental status warrants a wait-and-see approach. In these situations, families are placed on a monitoring caseload. A monitoring caseload consists of a check-in call from the assigned practitioner

approximately every six weeks. If questions or concerns arise between check-ins, the family has a standing invitation to contact their assigned practitioner.

In some cases, a child and family are assigned to a monitoring caseload for the appropriate reason. Unfortunately, in other cases, children and families are assigned to a monitoring service as a waitlist management strategy. In these instances, the service is no longer needs based and being provided as it is intended. Instead, it is a substitute for a service that is not available due to caseload pressures.

For EIP a large turnover in the caseload occurs every year at the end of August. It is this time of year that children who are age five, or will be age five prior to December, become eligible for school entry. Since thirty or more children are eligible for school entry every year, the waitlist for EIP drops drastically in September. As referrals are received in the winter and spring, waitlist and caseload pressures increase, and a monitoring service becomes a forced necessity. In other words, there is a seasonal cycle to the prevalence of monitoring services in EIP.

IDP does not experience such a seasonal swing in caseload, since this program has different criteria for age eligibility. In the case of IDP the prevalence of a monitoring service is related to the flow of incoming referrals.

Monitoring services do not provide a full-scale assessment or implement a highly involved intervention plan. If these elements are offered through a monitoring service it tends to be on a scaled down, reduced basis. Rather than the full package, monitoring services tend to be more consultative in nature. The family might be given a program to work on at home, but the practitioner provides little hands-on therapy, and sporadic family support. On this basis, monitoring services are more appropriate for less involved children than children with complex issues.

A family who is on IDP's monitoring caseload will receive a telephone call from an IDP Consultant once every three months. This call may lead to a home visit, if the IDP Consultant believes one is warranted. If a home visit is not warranted, the family waits another three months for the next monitoring telephone call, or if an opening comes up in the meantime, the family is brought onto the regular caseload under stand alone or cluster services.

SLP also offers a monitoring service, but the format is much more variable than IDP. If the child's delay is minor at intake, an SLP may prescribe a home program for parents to work on. The parent is asked to call if there are any concerns or difficulties. A call-back rarely happens, as home programs tend to be routine and the child's delay is of a minor variety. In some instances, children on a home program are often ready for discharge from SLP services once an opening becomes available on the regular caseload. In addition to home programs, the SLP Program Coordinator also has some availability to carry a few facility based sessions with children who can benefit from a more consultative approach. Between these visits and a home program, the child may be able to make a great deal of progress prior to being picked up on the regular caseload. If SLP monitoring proves to be insufficient for the family, one option is to seek a more timely or intense service from private practitioners. Unfortunately, there is typically a waitlist for private service and it can be an out-of-pocket cost to families.

The process for PT and OT monitoring services is similar to the description provided for SLP. Just as with other programs or disciplines, PT and OT use a monitoring service as an intermediate step between the waitlist and regular service. Under monitoring circumstances, a family may receive one to four consultative visits from a PT or OT with recommendations for activities in the home. If called for, another part of this monitoring service is to make a referral to other supports and services if one is needed. A referral to a private PT or OT could be one of the options considered at this point if the family wants to start therapy right away and has the financial means, or benefit plan coverage to pay for private services.

2.3.2 Stand Alone Service

Most new referrals to the agency start with a stand alone service, where the child and family's involvement is limited to one program, or in the case of EIP, one discipline. IDP and EIP, consisting of SLP, OT and PT, are the two programs that deliver a stand alone service.

2.3.2.1   Regular Caseload

If a child is not a candidate for a rapid response, and if a monitoring service does not fully address their needs, the family eventually qualifies for a regular service. Under

the auspices of a regular service, the child and family receive the full program package, including a full assessment, a fully developed intervention plan, and family support. Out of all the stand alone services, regular service is the longest in duration. It can last several months, sometimes close to two years, depending on the age of the child at the time of referral.

Compared to other programs and disciplines, SLP offers the most distinct form of regular service. Regular service for SLP is offered on a block therapy basis. A block consists of a one to two hour session every two weeks over a four month duration. If progress is slow or the child requires extensive involvement, regular service continues for a second block of treatment and on occasion a third block. Other children may receive one block of regular SLP and get moved to a follow-up caseload. Through this rotation, SLP resources are rationed and resources are stretched as far as possible for as many children as possible. In this sense, SLP is even triaging children on the regular caseload. To make the best use of time, many SLP sessions are conducted on site, which cuts down on travel for the practitioner.

For IDP, regular service amounts to an in-home visit once every three weeks. These visits focus on assessing the child's developmental stage and on providing parents with strategies and support. Based on provincial guidelines, IDP conducts a Gisell assessment every four months to ensure the child's development is adequately monitored. Since IDP sees children at a young age this program often refers families to other internal and external supports.

Compared to SLP and IDP, PT and OT use a much more varied approach to delivering a regular service. At the more intense end of the spectrum, PT and OT occasionally provide one visit every two weeks for children and families getting a regular service. This level of intensity is generally not sustainable, as PT and OT visits tend to be less frequent. More typically PT and OT's regular service visits range from one session every three weeks to one every five weeks.

2.3.2.2 Follow-Up Caseload

Follow-up service is very much like monitoring services. Follow-up is consultative in nature and is conducted over the telephone every six to eight weeks. Just as with monitoring, if there is a need for a visit and further contact, the practitioner

will use the follow-up call to schedule a visit. The main distinction between the two services is that follow-up happens after a child has received regular service, while monitoring occurs before a child reaches the regular service caseload.

2.3.2.3 Program and Discipline Caseloads Across Different Services

A survey taken was taken at the end of October 2005 of the various caseloads across IDP, EIP and SCD to get a sense of the caseload for monitoring, regular and follow-up services. In this particular instance the data is not referring to individual children. It is a snapshot of the number of cases each program or discipline has on its respective caseload. It is possible a child could be on the caseload of two or more programs or disciplines at one time. The purpose of this data is to provide a description of the distribution of monitoring, regular and follow-up services.

Table 6: Distribution of Monitoring, Regular and Follow-up Caseloads

Program	Monitor	% of Caseload	Regular	% of Caseload	Follow-up	% of Caseload	Total
IDP	13	16%	48	58%	22	27%	83
EIP: PT	34	45%	33	43%	9	12%	76
OT	23	34%	38	57%	6	9%	67
SLP	52	36%	91	62%	3	2%	146
SCD	11	15%	56	78%	5	7%	72
Total	133	30%	266	60%	45	10%	444

At the time of the survey thirty percent of the caseload for IDP, EIP and SCD received a monitoring service, sixty percent a regular service and ten per cent a follow-up service.

2.3.3 Group Services

Compared to the individualized, one-on-one format of stand alone, cluster and multidisciplinary services, group service provides a completely different approach to early intervention child development. In referring to group service, the COCDA provides two different program streams. One stream involves parent groups, either as a mutual support group, or as an educational group. The other stream is offered through the Supported Child Development (SCD) program and consists of supporting local preschool

and daycare centres to ensure children with special needs are included in the regular activities of these early learning programs.

2.3.3.1 Community Daycare and Preschool Programs

In terms of the early learning programs, the COCDA's role is to facilitate the connection between the child, the child's family and the community program. The SCD program does not actually design the group service, whether it is a preschool or daycare program. Instead, the SCD program follows the family's lead in the selection of a community program, and works with the community program to ensure the child is included in all activities. In this respect, the COCDA is not designing or even delivering the intervention. The SCD program is more of a bridge or a connector to a community program.

In a facilitation role, the group service format is not so hands-on in providing a direct intervention to children with special needs, as the other service options. In the group service format, the intervention is actually the community program itself. A community option provides an opportunity to socialize with, communicate with and move with, in terms of physical play, other children. Under these circumstances, group service is more about guiding and prompting than it is about hands-on therapy.

Every community preschool and daycare program has a schedule of activities, more or less, and it is the SCD program's role to ensure children with special needs are included in program activities. In the other service options provided by the COCDA, the main link is between the therapist and child or parent. For a community-based group service, the main connection is not between the child and a therapist or interventionist. Rather, group service is really about connecting children with special needs with other children to allow socialization and shared activities to stimulate growth and development.

2.3.3.2 Parent Groups

The COCDA also offers support to parents through groups. Sometimes parents are brought together for the purpose of nurturing the development of a mutual aid group. By meeting and building a relationship with other parents who are dealing with grief and loss issues, or behaviour management and regulation issues related to their child's disability, parents gain strength and hope. By identifying and sharing with others,

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parents can ease the discomfort they feel by being isolated and overwhelmed by the needs of their child.

Most often, parents are brought together for educational purposes. The SCD program offers a, "Meeting the Challenge" workshop designed for parents who are looking for support in managing their child's challenging behaviours. Over a series of six sessions, parents learn about behaviour management strategies and report back on their practice attempts at home. The BI program also offers a parent training seminar, entitled "Natural Teaching Strategies". In this workshop, parents learn how to prompt and reinforce their child during everyday learning opportunities.

Only when there is time, and when demand permits, the SLP program also offers the Hanen Program. Through Hanen sessions, parents are shown strategies for promoting communication with their child. Towards the end of the workshop, parents are asked to videotape an exchange between themselves and their child for review and feedback by the SLP instructor and other members of the parent group.

2.3.4 Multidisciplinary Service

Needs-based, stand alone and group services are available to all referred children under age six, regardless of their presenting issue or diagnosis. In contrast, the COCDA's multidisciplinary service has very specific eligibility criteria. The COCDA's multidisciplinary service is only available to children under age six, who are diagnosed with an Autism Spectrum Disorder (ASD). This criterion is set by the Provincial Government. Based on academic literature and best practices, the Provincial Government also mandated that services for children with ASD be delivered through a multidisciplinary model.

In some respects a multidisciplinary service model is similar to situation where a child with multiple needs is referred to several programs at once. Both multi-program service and multidisciplinary service rely on collaboration and team work to provide effective intervention and support. In the case of a multi-program service, one of functions of collaboration is to coordinate resources. For a multidisciplinary service, on the other hand, the purpose of collaboration is to integrate efforts.

In coordinating program delivery efficiencies are achieved, but practitioners stay within the boundaries of their discipline. With multidisciplinary service, these boundaries are blurred, as practices from various disciplines are incorporated into one service. When an OT is showing a Behaviour Assistant how to incorporate calming techniques into a program focused on behaviour modification, cross disciplinary practices are being mixed and integrated. This is qualitatively different from coordination, where collaboration does not cross-over such boundaries.

2.3.4.1 Intense Multidisciplinary Service

The intense version of the BI program's multidisciplinary service provides twenty hours of direct one-on-one intervention every week. This service can accommodate a maximum of eight children under age six, diagnosed with ASD. Since it started in August 2001, the intense multidisciplinary service has always been operating at full capacity.

The format of this service includes a mixture of applied behaviour analysis and natural teaching strategies. These two core elements of the program represent the behaviour intervention portion of the program. In round out behaviour intervention with a more general focus on learning various skills, SLP and OT contribute to, and further extend the curriculum based on the principles of applied behaviour analysis and natural teaching.

In structuring the content of the service, the Behaviour Coordinator (BC), SLP and OT build a curriculum based on information gathered through various assessments. Essential elements from the behaviour, speech-language and occupational therapy disciplines are individualized to fit the goals and priorities of the parents and the developmental strengths and challenges of the child.

Once a program plan has been assembled it is the responsibility of the Behaviour Assistant (BA) to deliver the service according to very specific instructions. Once a

month, the team meets to review the child's program and determine if any revisions are needed. During these team meetings, direction from the parents and feedback from the BAs allow the BC, SLP and OT to ensure the program curriculum remains current with the child's needs. At twenty hours of direct service per week, this is by far the most intensive service available to families through the COCDA. Considering the relatively high investment of resources, it is important to keep the program tuned to the child's needs and parent's goals.

2.3.4.2 Regular Multidisciplinary Service

The regular multidisciplinary service follows a similar format and curriculum as the intense service. Rather than providing twenty hours per week of intervention, the regular service delivers ten to twelve hours per week. The regular multidisciplinary service tends to act as an interim service until an opening becomes available on the intense twenty hour per week service. Currently there are thirteen children under age six, diagnosed with ASD, on the regular multidisciplinary service.

Just as the number of direct service hours is less for the regular service compared to the intense service, the emphasis on a multidisciplinary program delivery is not as strong. SLP and OT consult to the regular multidisciplinary service, but not as frequently as the intense service. In this service format, multidisciplinary collaboration tends to take the form of collegial consultation, instead occurring during team meetings. The level of funding available for regular multidisciplinary services dictates a reduced level of multidisciplinary involvement.

2.3.5 Cluster Service

Depending on a child's health and developmental status, a family may get referred to more than one COCDA program, or discipline at a time. The family's first referral to the agency, often initiated by a physician or public health nurse, may be a multiple referral and involve more than one COCDA program. This is a multiple referral from an external source; alternatively, a multiple referral may come from internal channels within the COCDA. For example, after receiving one or more visits from IDP, it may become apparent the child and family can benefit from other COCDA programs and disciplines, such as, SLP, OT, ASD Assessment, or SCD. In such instances, the IDP Consultant initiates a referral to one or more of these other programs and disciplines.

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Across the different COCDA programs and disciplines there are many possible permutations for a multiple referral. In some cases, a multiple referral may be limited to two programs or disciplines. Conversely, it might involve every possible discipline and program.

In the case of a multiple referral, where the family can benefit from the support of more than one program or discipline, the agency has a choice. On one hand, services for a multiple referral can be delivered separately, in a stand alone fashion as described in Section 2.3.2. The second option is for services to be delivered in a more coordinated manner, as a cluster of services. At present, the agency does not have any formal mechanism for coordinating cluster services. Coordination does happen, but it is dependent on the judgment of individual practitioners and it happens through informal mechanisms. If there are a small number of multiple referrals, an informal system may be adequate for coordinating a cluster service. On the other hand, if it turns out there is a high number of multiple referrals, an informal, unregulated system can limit or undermine the extent to which cluster services can be coordinated. At present, there are three forms of informal coordination mechanisms: joint visits, team meetings and collegial consultation.

One of the logistical complications in developing a coordinated cluster service is timing. Given the vagaries of the waitlist and different caseload pressures it is very unlikely a multiple referral will end up on the caseload for SLP, PT and OT at the same time. Although a multiple referral may qualify for a rapid response from one program or discipline, it may be on the waitlist or monitoring caseload for other programs. This does not mean that rapid response, monitoring and regular services cannot be coordinated as a cluster of services, but it does increase the challenge of getting various service providers coordinated. One practitioner may know the child and family very well. Other practitioners may not know the child and family at all, because the family is still on a waitlist.

2.3.5.1 Prevalence of Cluster Services

To determine the prevalence of cluster services a survey was conducted of the COCDA's caseload from January 1, 2005 to March 31, 2005. During this period, the COCDA had an average of two hundred and forty eight children per month on caseload.

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Out of this total caseload, fifty nine percent received a stand alone service, whereas the remaining forty one percent received a cluster service. Within the cluster service caseload twenty percent of the children were receiving service from two programs, or disciplines and fourteen percent were on the caseload of three programs, or disciplines. Five percent of the cluster service caseload involved four programs, or disciplines, and just one percent of the caseload accessed five programs, or disciplines.

Table 7: Prevalence of Cluster Services across Caseloads

Month	Stand Alone	2 Programs	3 Programs	4 Programs	5 Programs	Children on Caseload
January	56%	22%	14%	6%	1%	249
February	59%	21%	15%	4%	0%	248
March	63%	18%	12%	6%	1%	248
Average	59%	20%	14%	5%	1%	248

Note: Table 5 headings represent all programs.

2.3.5.2 Coordinated Cluster Services

On occasion, service providers from different programs conduct joint sessions together. Scheduling logistics, territorial issues across different professional disciplines, and interpersonal dynamics, make joint visits a challenge to arrange. As a result, joint visits are rare and tend to be limited to the intake and assessment phase. It is usually a one-time occurrence for the majority of referrals. During a joint visit, both practitioners take turns asking questions and sharing information with the family. One may work directly with the child, while the other observes. Throughout the entire process there is a high level of teamwork.

If it occurs, the joint visit plays a critical role in coordinating cluster services. This visit lays the ground work for coordinating which program and practitioner will take the lead in delivering service. Other programs or disciplines remain involved, but follow the pace set by the lead program. Thus, the joint visit is a pivotal process for working out a long term service delivery plan.

In other instances, cluster services are coordinated through a team meeting. Team meetings focus on service coordination and always emphasize the goals and priorities of parents and caregivers. Ideally, team meetings are primarily for the benefit

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of the family, with the needs of service providers coming a distant second. Due to the cost and difficult logistics associated with team meetings, these gatherings are infrequent and only occur when the child has multiple, complex needs. Similar to joint visits, team meetings are mostly limited to one per family. If a child has complex medical issues from an early age, more than one team meeting might be scheduled over two to three years of service provision. This is extremely rare, however.

To emphasize a family centered approach the team meeting is chaired by a parent, as long as they are comfortable with the coordinator's role. In cases that warrant a team meeting, there is usually other external service providers involved with the child and family. To ensure parent's priorities are put first, and to coordinate the efforts of different parties, team meetings are attended by all service providers connected to the family.

The last form of coordination for cluster services is more subtle and less visible compared to joint visits and team meetings. Many multiple referrals are coordinated through collegial consultation. Collegial consultation consists of informal discussions between colleagues at the COCDA office. Through collegial consultation, the next steps in terms of increasing or decreasing the intensity and cross-over of multiple program delivery are discussed. During these informal discussions the cohesiveness of multiple program delivery is assessed. Taking into account the family's readiness, a decision might be made to reduce the intensity of one program, while increasing the intensity of another program. Another possibility is the family might be ready to schedule appointments with two, sometimes, more programs simultaneously. To be respectful of the family's wishes, none of these informal discussions occur without the family's knowledge and permission.

2.3.5.3 Serial Cluster Services

Much of the time referrals to multiple programs are coordinated through some form of collaborative team work. There are occasions, however, when coordinated program delivery does not occur. In these cases, the agency's response to a multi-program referral looks very much like a series of stand alone services. There is no sense of a lead program and practitioner. There is no plan for throttling back on the

delivery of one program, while throttling up on the intensity of a second program, as the case with coordinated cluster services. From the family's point of view, it may appear as though the program service providers are from different agencies and competing for the family's time. Hopefully, this kind of fragmented service delivery is rare. However, given communication breakdowns, time pressures, differences in professional practices, organizational culture, and interpersonal conflicts, the possibility of a serial cluster service is real.

2.3.5.4   Short-Term Cluster Service

Every year, fifteen to thirty preschool children are identified as candidates for an ASD assessment. Most external referrals for this service come from physicians, while internal referrals are often initiated by SLPs or IDP Consultants. The ASD assessment is a short-term service, occurring over a relatively short time period. As well, once the assessment is complete, the child and family either return to their regular caseload, or if a diagnosis is confirmed the family starts with the BI program's regular multidisciplinary service.

Individual assessments are completed by a pediatrician, an SLP, a Child Psychologist, Child Psychiatrist, and sometimes an OT. Each practitioner prepares an assessment report, which may or may not consist of a formal assessment, depending on the child's testability. If time permits, these individual reports are shared amongst the team. While this initial process resembles a series of stand alone services, perhaps even a fragmented service, all this changes on the team assessment day.

The team assessment day consists of a three to four hour session, during which the family is interviewed by a Child Psychiatrist, followed by an interaction and observation session between the Psychiatrist and the child. During the interaction and observation session, other members of the team, usually the SLP and Child Psychologist will watch the session from behind a one-way mirror. Once this is complete, the Child Psychiatrist chairs a team meeting with the SLP, Child Psychologist and other involved service providers. The purpose of the team meeting is to decide on whether the child's characteristics fit an ASD diagnosis, or not. The sole diagnostician is the Child Psychiatrist, but his or her decision takes into account the opinion of individual

team members. After a decision has been reached, the Child Psychiatrist and other selected members of the team meet with the family to inform them of the decision.

Clearly the team meeting, as well as the shared assessment reports, are key processes for coordinating this short-term cluster service. The individual assessments may take two visits apiece and the final team assessment lasts one half-day. The ASD assessment is a relatively short process, but there are many players and lots of information to collate into a cohesive decision.

2.4   The COCDA's Client Base

According to protocols established by the Provincial Government, each of the programs has eligibility criteria for targeting a specific client base. IDP, for example, specifically targets children from birth to age three. IDP's guideline on age eligibility is very strict, as once a child turns three, she or he must be transitioned off the program. For the Early Intervention Program (EIP), children between birth and school entry, or age five are eligible for support. Those families who decide to delay kindergarten entry are no longer eligible for EIP services. The policy to not serve families who choose a kindergarten delay was recently set by the agency in response to growing caseload pressures.

While IDP and EIP focus exclusively on the infant and preschool age population, the SCD and BI programs work with a broader range of children. The SCD program serves children from birth to age twelve, although priority is given to families where both parents are working. In addition, the SCD caseload is managed in a way that the client base for school age children (i.e. children from age five to age twelve) is capped at twenty five percent of the caseload. This cap has created a longer waitlist for school age children, but it has allowed the SCD program to remain more closely aligned with an early intervention mandate.

In the Central Okanagan, the population base age birth to six is eight thousand six hundred and sixty seven (Statistics Canada, as reported by CATCH). Putting the COCDA's volume of referrals into context, the two hundred and eighty nine children referred in 2004-2005 represented three point three percent of the Central Okanagan's under six population.

2.4.1 Age Distribution of Clients

In 2004-2005 the majority of referrals to the COCDA were young children. Of the two hundred and eighty nine children referred, forty percent were age two and under. This proportion is a good indicator of how the community is doing at early identification. Although early identification seems to be going reasonably well, seventeen percent of the children referred in 2004-2005 were age four and over.

Table 8: Age Distribution of 2004-2005 Referrals

Age Group	Percentage of Referrals
Birth to 11.9 Months	23%
1 Year to 1.9 Months	17%
Two Years to 2.9 Months	20%
Three Years to 3.9 Months	24%
Four Years to 4.9 Months	13%
Five Years and Over	4%

3   An Analysis of the Child Development Sector

3.1   Market Forces of Competition

Each industry has underlying market forces that give rise to a specific level and dynamic of competition (Porter, 1979, p.2). These market forces are not just limited to competition between rival organizations, but also stem from other forces in the environment. In Porter's words, "...competition in an industry is rooted in its underlying economics, and competitive forces exist that go well beyond the established combatants in a particularly industry" (1979, p.2). In essence, competition within an industry is shaped by a number of external forces, such as, suppliers, clients, policymakers, collaborators, rival service providers, and sponsors (Porter, 1979, p.6, Vining, 2005, p. 4).

In forming strategy it is critical to have a sound understanding of these external forces. If an organization understands the forces of competition within its industry, the organization can position itself to take advantage of, or defend against these dynamics (Porter, 1979, p.3). Understanding the forces of competition opens up another possibility. Not only can organizations develop a strategic position to counter or complement external forces, knowledge of these dynamics makes it possible for organizations to influence the external environment in their favour (Porter, 1979, p.3).

In the private sector, competitive forces in the external environment dictate whether the industry is lucrative or not (Porter, 1979, p.2). In some industries the competition from various external forces is so intense it is difficult to earn a healthy profit. In other industries, where the competitive forces in the external environment are weak, the profit potential is high (Porter, 1979, p.2).

In the non-profit sector, organizations obviously have a different focus. By developing a strong position with respect to external forces of competition, non-profits can increase the value of the service delivered to the client (Porter and Teisberg, 2004, p. 67). In the case of the child development sector, the goal is to maximize the growth and development of young children who have developmental delays. Putting this in

more economic terms, the goal for this sector is to maximize the quality of child development outcomes per dollar expended (Porter and Teisberg, 2004, p.67). An analysis of the external environment is important, because it provides insights and opportunity for improving the performance of a non-profit in delivering better outcomes for the client.

3.1.1 The Different Segments of the Child Development Sector

The child development sector in the Central Okanagan[3] can be categorized across three segments of program delivery. The largest contingency in the sector is represented by child minding and early learning programs. Licensed and unlicensed daycares and preschools are run on both a non-profit and for-profit basis. In the Central Okanagan there are currently twenty seven licensed daycares and twenty preschools listed in the local telephone directory. Since unlicensed daycares do not have to register with the Child Care Licensing Branch, it is difficult to estimate the number of these operations. Licensed programs must follow a stringent set of regulations related to risk management and program delivery. These licensing requirements are under the jurisdiction of the Provincial Government and are prescriptive to the point of setting staff ratios based on the number and age of the children in the program.

The second largest segment of child development services is a range of prevention and intervention programs. In this category the Interior Health Authority (IHA) and its immunization and well child clinics is the biggest service provider. IHA also offers SLP services for preschool age children. To ensure there is minimal overlap with the COCDA'S SLP service, IHA tends to limit its SLP caseload to children who have minor communication delays, which is a large, clearly defined caseload. The COCDA SLP program, on the other hand, largely serves children with moderate to severe developmental delays and disorders.

Kelowna Community Resources (KCR) offers two child development intervention programs. KCR's "Kids Count" targets overburdened families who are expecting or parenting a young child for the first time. The other initiative offered by KCR is the

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[3] The Central Okanagan includes the following jurisdictions: District of Lake Country, Duck Lake Reserve, City of Kelowna, Central Okanagan Regional District, Westbank, Westbank First Nations, and the Corporation of the District of Peachland (Success by Six Information Brochure, 2005).

"Special Needs Adoption Program" (SNAP). SNAP helps young children in the care of the Ministry of Children and Family Development (MCFD) prepare for placement with adoptive families.

The Ki-Low-Na Friendship Society has a family support program similar to the COCDA's IDP service. The distinction between the COCDA's program and the Friendship Society's program is the target group. The Friendship Society serves on-reserve and off-reserve aboriginal families, while the COCDA largely serves non-aboriginal families.

In some specific areas of child development, intervention services can also be purchased from a private practitioner. These private practitioners tend to be scarce and seem to favour securing block service contracts with school districts rather than offering an individualized service on a family by family basis. Another qualifier worth noting is that if a family chooses to access private services, this cost must be covered out of their own pockets.

A third category of services promotes child development through parenting programs. Okanagan Families offers resources, support groups and educational sessions on parenting, mainly through an initiative known as "Parenting with Purpose". The Kelowna Child Care Society (KCSS) operates as a support for parents on a number of fronts. In one of its roles KCSS acts as a referral resource for parents in search of child care. This referral program also offers parents advice and tools for evaluating child care options. Another stream of KCSS programming offers support through parent support groups, similar to Okanagan Families.

If the child development sector has any overlap in services, it is in the area of parenting programs. Even this overlap is limited, as each parenting program is based on a different philosophy and approach.

Since the COCDA largely operates in the realm of intervention and prevention programs, the following analysis of the external environment will largely focus on this sub-sector. For ease of reference, this chapter equates the child development sector with intervention and prevention programs.

3.1.2 An Overview of the Sector's Dynamics

Traditionally, the child development sector has been an area of slow growth. Program funding has been essentially stagnant for ten years. The knowledge base and definition of best practices continues to evolve, but at a relatively modest pace. This sector is not driven by technological improvements; it is largely based on accumulating practical knowledge through applied practice and research. Overall, the child development sector is at a mature stage of its life cycle. It is perhaps somewhat too premature to tell, but the sector does appear to be on the cusp of a growth period. More details will be provided about this development later in the chapter.

All forms of child development programming are delivered entirely, or partially as a public good. There is an element of private enterprise, but the private provision of a service is largely limited to the early learning and child care segment. Since the sector has a long standing history as a public service, government funding has been relatively secure. For non-profits specializing in child development, this sector has provided a secure, viable existence.

Overall, the level of competition and rivalry in the child development sector is low. The early learning, child care segment experiences the most competition. In this sub-sector the number of rivals is significant and there is limited differentiation between programs. Even in this segment, however, the level of jockeying amongst service providers is lower than expected. The reason for this is that the demand from the community is much higher than the available resources.

In the program intervention and parent support segments, rivals are relatively scarce and there is a high degree of differentiation between programs. Economies of scale receive little attention in the sector, but the ability to subsidize costs is important to government sponsors. In these two segments, competition is quite low. Given these dynamics it is not surprising that turnover in this sector is virtually non-existent. For existing agencies, the child development sector has been highly stable and benign. This is not to suggest the sector is completely dormant. There are some existing and emerging forces of competition worth further analysis.

3.2 The Most Competitive Forces in the Sector

3.2.1 A Changing Labour Market

For many years employers in the Central Okanagan enjoyed what local residents refer to as a "sunshine tax". The climate and lifestyle in the Central Okanagan allows employers to attract a skilled labour force at less than a competitive wage. Many people are willing to work in the Okanagan at a wage lower than industry standard in order to live in one of Canada's more desirable , affordable locations. The attractiveness of the Central Okanagan gives employers the upper hand in competing for local, regional and national talent. This competitive advantage for local employers has changed dramatically in the past year. In the new labour market, the Central Okangan's "sunshine tax" now puts employers at a disadvantage.

The province of British Columbia's, and in particular the Central Okanagan's economic boom, has dramatically changed the local labour market. In October 2004 the unemployment rate for the Thompson-Okanagan region was six point three percent (MacNaull, 2005, p.A1). A year later in 2005 the unemployment rate dropped to four point eight percent (MacNaull, 2005, p.A1). Not only is this a significant drop in the unemployment rate over the course of one year, it also signifies a labour shortage. An unemployment rate below five percent indicates a labour shortage, because it is considered, "...the point at which everyone who wants to work is working" (MacNaull, 2005, p.A1).

A much tighter local labour market has made recruitment and retention in the Central Okanagan highly competitive. In August and September 2005 the COCDA lost four personnel to various School Districts, at least one person to a local daycare, and a therapist to IHA. In almost all these cases the new employer offered a higher hourly wage. The daycare, which lured away a COCDA employee, went so far as to waive the probation period and the wait period for the employee benefit plan. This is particularly noteworthy, since daycares tend to be known as frugal operations.

Even in the face of significant budgetary pressures, firms in the child development sector are now upping the ante by offering financial incentives to recruit prospective employees. The COCDA, for the first time, is now offering a one thousand

dollar retention bonus to the one classification, Behaviour Assistant, which has the highest turnover. This retention bonus arrangement may also be extended to other classifications.

Similarly, the COCDA is now seriously considering how a reinvestment of existing funds can be used to increase hourly wages. It is quite possible COCDA staff will receive a wage increase outside of the collective bargaining process. Instead of arising from labour relation negotiations, this wage increase will be due to labour market pressures.

Even if agencies are not investing more in employee wages and benefits, they are certainly incurring more overhead costs related to recruitment and training. For instance, when the Early Childhood Education Diploma program recently held an open house, agencies in the child development sector jumped at the opportunity to meet new graduates. When trying to fill a vacancy, agencies must now advertise in the local newspaper rather than drawing from a bank of resumes on reserve. These advertisements often run over several days instead of limiting it to one day of circulation.

The doubling of recruitment efforts has added to agency's overhead costs. With more opportunities now available in the local employment market, employees are now more mobile. A higher level of staff turnover means managers are spending more time recruiting, orientating and training new staff.

A more competitive local labour market impacts on the value non-profits can deliver. By investing more financial resources in recruitment and retention practices and by increasing hourly wages, funds are being diverted away from the expansion, or enhancement of children's services. As a result of local labour market pressures it now costs more to provide a unit of service than in the past. In other words, the value of service delivered to children and families has decreased. Competition stemming from a power shift between employees and employers is now diverting value from frontline services in the child development sector.

3.2.2 Community Sponsors

Much of the public sector, not just the child development sector, is reliant on some form of community sponsorship. For some non-profits, their entire operating

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revenue is based on donations from the local community. Other non-profits are at the opposite end of the continuum, where community sponsorship is a smaller portion of the agency's overall revenue. In the case of the COCDA, community sponsorship represents close to ten percent of the agency's revenue.

Regardless of the proportion of fundraised dollars to the total annual revenue, funding from community sponsorship is essential to every non-profit. Government funding agents rarely analyze non-profit costs. Rather than focus on costs, government funding agents are interested in the non-profit's capacity to subsidize operational costs with alternative sources of revenue. To some extent, a non-profit's reputation with government agents is dependent on the agency's ability to find subsidies to top-up government funding. If community sponsorship is used to offset overhead operating costs, government funds can go into direct service for the client

In the Central Okanagan fundraising is dominated by two major organizations. IHA's recent "180 Degree" campaign raised one million, eight hundred thousand dollars towards the construction of an adolescent psychiatric unit at Kelowna General Hospital. This campaign proved to be highly successful, as the original "180 Degree" goal was to raise one million dollars in eighteen months. Not only did the campaign exceed its fundraising target, it was accomplished in nine months. Another organization that pursues a great deal of community sponsorship is the United Way of the South and Central Okanagan. Through corporate sponsorship and community events, the United Way manages to raise approximately one million dollars every year in the Central Okanagan.

In addition to IHA's and the United Way's two big campaigns, several other non-profits run medium-scale community fundraising campaigns every year. The Boys and Girls Club works to raise at least a quarter of a million dollars every year, and Big Brothers, Big Sisters relies on a great deal of sponsorship from the community. Outside of health and social service programs, a number of non-profit groups from the arts and culture sector, and the recreation sector also compete for community sponsorship. Given the number of non-profit organizations engaged in local fundraising campaigns, the fight for community sponsorship is highly competitive.

The intensity of this competition does detract from the value non-profits can deliver to the community. A significant amount of resources go into supporting drives for community sponsorship. Although a number of these initiatives have been successful, not all fundraising efforts generate a profit.

There is a strong first mover advantage in securing community sponsorship. Since it takes dedicated resources to pursue community sponsorship, there is also an economies of scale effect related to fundraising efforts. Large organizations are in a much better position to leverage economies of scale for fundraising initiatives than smaller organizations. This is a barrier for many non-profits. In terms of maximizing the returns from community fundraising initiatives, a small non-profit is at a disadvantage compared to a large non-profit. A small non-profit may have to divert some of its operating revenue to cover the cost of a community fundraising campaign. When the diverted revenue is refunded to the agency's regular operations, this reduces the profit of the fundraising campaign. Due to economies of scale, a large non-profit does not have to be as concerned with cost recovery. This allows most of the profit from community fundraising can be recognized as new revenue.

3.3   Potential or Emerging Competitive Forces

3.3.1 MCFD's Involvement with the Sector

In 2004-2005 MCFD provided the portfolio of "Early Child Development and Special Needs Children and Youth" with over one hundred and thirty million dollars in funding (MCFD Service Plan, 2002). This figure makes MCFD the biggest sponsor, government or non-government, of child development programs. Within the MCFD portfolio of children's services, only the category of "Child Protection and Family Development" received more funding than the child development sector (MCFD Service Plan, 2002).

Historically, MCFD treated the funds it transfers to non-profits as a grant, rather than a service contract. This philosophy had far reaching implications for MCFD's approach towards contract management and MCFD's expectations of non-profit service providers.

3.3.1.1 MCFD's Historical Contract Management Practices

In the child development sector contract tendering did not happen through a competitive, open process. Instead, contracts were awarded through a closed, non-transparent process. Once contracts were in place and funds provided, service deliverables were not closely monitored by MCFD. Little attention was also paid to an agency's financial performance. MCFD often gave organizations a lot leeway to carry-over surplus funds from the end of one fiscal year to the following fiscal year, without adjusting subsequent payments. This leeway worked both ways; just as agencies were permitted to absorb surpluses, agencies were also responsible for handling deficits. If an agency budgeted conservatively enough, the prospect of a year-end deficit was minimized.

In managing service contracts, MCFD also paid little attention to unit costs. Although the same programs are housed by different non-profits in different communities, no comparative analysis of unit cost has been done. MCFD looks to agencies to subsidize some of the operating costs, but even this expectation is not well defined. In managing service contracts, MCFD has not set performance standards for unit costs, or contract subsidization. Taking all of these contract management practices into account, it is clear MCFD exercised little control over the child development sector in the past.

3.3.1.2 MCFD's Move towards Increased Accountability

At various times over the past three years the Provincial Government has considered putting public sector service contracts out to tender using a competitive bid process. Although a competitive process has not been fully implemented, steps have been taken towards creating a more open, transparent market for awarding government contracts. The Provincial Government's website, B.C. Bid, has been specifically established as a vehicle for tendering government contracts.

In the child development service sector, B.C. Bid is used to post details about service contracts the government intends to award to existing non-profits. Open bids are not invited, but the dollar value of the service contract is listed. It isn't happening at this point, but B.C. Bid clearly signals to non-profits that a competitive bidding process for service contracts can be implemented. Regardless if this threat is real or perceived, it

does have an impact on non-profits. The threat of competitive bidding encourages non-profits to keep operating margins as low as possible and to invest the maximum amount of funds in front line program delivery.

In another change, MCFD is now asking for bi-annual program reports. Data on the number of clients served, the utilization of staff, and up to date financial reports must be provided in the bi-annual report for each service contract.

Not only is MCFD now interested in monitoring contract outputs, but measures are also being taken to establish a framework for monitoring contract outcomes. Starting in the 2006-2007 fiscal year, the SCD contract will contain targets for program outcomes. For example, two of the proposed program outcomes are: (1) "eighty percent of children in SCD will attain their developmental goals identified in their own individual service plans", and (2) "eighty percent of primary caregivers will self-report an increased understanding of child development and growth processes, and an increased awareness of the available supports" (MCFD, SCD Service Contract, 2005, pp. 5-6).

These two changes clearly signal an end to the era where MCFD funding was viewed as a government grant. An entirely new level of accountability is being implemented. MCFD now intends to monitor and manage service contracts by tracking outputs and outcomes delivered by non-profits. A new relationship is being established between MCFD, as the main supplier of operating revenue, and non-profits in the child development sector.

In addition to implementing a new level of accountability in relation to program performance, MCFD is changing its standards for financial performance, as well. MCFD has notified non-profits that financial surpluses will not be left with the agency and carried forward as retained earnings. Instead, year-end surpluses will be deducted from the funding allocated to the following fiscal year. Once the audited financial statements are submitted to MCFD for the prior fiscal year, an adjustment to account for this surplus will be made through MCFD's monthly deposit. This level of financial accountability now applies to all service contracts.

MCFD's change in contract management practices, which are being implemented in the following fiscal year 2006-2007, greatly increase the accountability of non-profits. This new level of accountability may lead to an overall improvement in the

services provided by the child development sector. Increased accountability forces organizations to give serious consideration to the efficiency and effectiveness of delivered services.

On the other hand, depending on how far MCFD goes with its reform, new contract management practices can also lead to a greater level of competition within the sector. Through contract reform, the child development sector can be dramatically restructured. MCFD's reform could lead to a major re-tendering of service contracts. Such re-tendering could put many agencies out of existence, while a few agencies could thrive and expand. In supplying most of the operating revenue, MCFD has the power to transform the child development a sector. It could become a sector where the emphasis is on competition rather than delivering high standard client outcomes.

3.3.2 Labour Unions: Passive or Antagonistic?

From an employer's point of view, Labour Unions can be tacit supporters, or aggressive antagonists. At times the Union is less interested and less active in representing an employee facing disciplinary action than at other times. Two variables seem to influence the Union's response to an employer's attempt to discipline employees.

First, the style and manner of the Chief Steward, an employee of the agency and the Union's main representative at the local site, sets the tone in how the Union responds to labour matters. A second influence is the opinion the local membership holds of their employer. If employees generally view the employer as being unfair, the Union retaliates by being more aggressive in pursuing labour relation matters. If employees have a positive relationship with the employer, the Union is more passive in dealing with labour relation issues.

If the Union assumes an antagonist role, it forces the employer to dedicate a lot of time and effort to managing grievances and militant employees. The distraction of an uncooperative collaborator, such as a Labour Union, puts a non-profit agency at a disadvantage. A demanding relationship with militant employees and labour representatives pulls time and resources away from client services. On the other hand,

if this relationship is not demanding, non-profits have a better chance of focusing on client service.

Much of British Columbia's public sector is heading into collective bargaining, when existing agreements expire in March 2006. The Provincial Government is exercising a new ploy with Labour Unions for the pending collective bargaining. To encourage a speedy process and to exercise some leverage over Labour Unions, the Provincial Government has promised bonuses and wage increases for sectors in exchange for settling in an expeditious manner. For those who do not settle expeditiously, wage increases may be pulled from the bargaining table.

It is too early to determine the impact of this ploy on labour relations in the child development sector. With the government taking the lead in setting the agenda for collective bargaining, it is quite likely Labour Unions will react in an aggressive, antagonistic manner. If Labour Unions shift from a passive to aggressive collaborator, it changes the dynamics within the child development sector. Agencies will have to divert time and resources from service delivery to handle labour management issues. An aggressive, uncooperative collaborator is a roadblock for achieving superior performance

3.3.3 Can the COCDA's Monopoly be Contested?

There is little rivalry between non-profits in the child development sector. The COCDA is the only agency in the Central Okanagan to offer IDP, SCD, EIP and BI programs to preschool age children with special needs and their families. There is a larger continuum of services for families with young children in the community, but these services complement, rather than compete with the COCDA.

For instance, KCR provides support to young children whose families are at risk due to socioeconomic barriers and parenting challenges. Okanagan Families (OF) offer several programs directed at parents of young children. Of course, there are dozens of preschools and daycares for toddlers and preschoolers in the Central Okanagan area, but these programs focus exclusively on early learning. IHA, as part of its population health mandate, delivers immunizations and monitors children's development. MCFD also provides direct service to young children. One of MCFD's mandates is to provide

safety and support to young children suffering from abuse and neglect. MCFD's other, often related, mandate is to provide adoption services to young children, who are in the guardianship of the Ministry.

Some of the children who receive support and intervention from the COCDA may access services from one, or more of these complementary programs. Although other agencies in the sector share some of the same clients, the COCDA is the only service provider to specialize in developmental delays and disorders. Specifically, the COCDA specialize in addressing the global development of the child, including motor skills, cognitive abilities, communication, and social development in an integrated holistic manner. The focus on the child, and on both their physical and neuro-psychological development, is a service niche filled exclusively by the COCDA. This niche ensures the COCDA holds a monopoly in serving young children with special needs.

Vining (2005, p. 98) recognizes that although a non-profit sector might not be based on overt competition, tensions and strains may lie below the surface. These tensions stem from the potential contestability between agencies. Contestability is, "...the potential for an organization to step in and replace [another non-profit] (Vining, 2005, p. 98). Although the COCDA currently fills the niche for young children with special needs, there is an element of contestability to this monopoly.

If COCDA programs were to be taken over by rivals, IDP could be picked up by KCR. SCD would be a natural fit with the Okanagan Boys and Girls Club (B&G Club), or the Kelowna Child Care Society (KCCS), while the EIP would best be housed with IHA. The uniqueness of the BI program makes it hard to relocate, but it could be taken on by either IHA, or OF.

If a competitive take-over was to happen on a program-by-program basis, the end-result would be a much more fragmented sector of community service. Each of the COCDA's programs carry out related work, as demonstrated by the high number of referrals across internal programs. Dispensing even one COCDA program to a different agency creates a barrier to multidisciplinary collaboration. The continuity, quality and efficiency of service would suffer, because of fragmentation.

There is also some doubt as to whether competing agencies have sufficient economies of scale and subsidization to replace the COCDA's arrangement. It is also

not clear whether competitors have sufficient cost advantages to justify the transfer of COCDA programs. For these reasons, contestability at the level of individual programs seems a minor threat.

In addition to contestability at the program level, the status of the COCDA as an agency can be contested. The one competitor, where all of the COCDA's programs are a reasonable fit, is IHA. IHA is more than big enough to absorb the COCDA with ease. IHA is a huge organization with multi-layers of management. The depth and versatility of IHA makes a take-over of the COCDA logistically feasible. While the logistics are manageable, it is doubtful IHA could operate the COCDA's programs at the same cost. The COCDA pays lower wages and carries lower overhead costs than the mammoth IHA. It is difficult to determine if IHA has sufficient economies of scale to off-set higher costs.

In weighing the threat of a take-over by a rival agency, cost considerations are just one of the factors. An agency take-over is a dramatic change. For a change of this magnitude to happen, MCFD would have to at least endorse, if not initiate the process. In allowing IHA to take over an agency in the child development sector, MCFD would be turning-over a portion of its portfolio to the Ministry of Health. In other words, an IHA take-over equates to MCFD capitulating to one of its own chief rivals, the Ministry of Health.

The politics of such a move are enough to deter MCFD from permitting an IHA take-over. This political reality, more than a cost advantage, is the main factor preserving the COCDA's monopoly. In other words, contestability from competing rivals, in particular IHA, is kept at a low level due to other political pressures in the environment.

3.4 Forces Keeping Competition In-Check within the Sector

3.4.1 Clients are Disempowered and Disconnected

Although non-profits in the child development sector purport to be family-centered, this claim is somewhat over-stated. Families set priorities for their child's support and intervention, but these priorities must fit within the parameters of a regular work day, available resources, risk management precautions and professional paradigms and schools of thought. Families are given a small area of autonomy, but on

the whole families have little leverage to influence the sector. Poor accessibility and a disconnected client base are two key factors that limit the leverage families can exert over the child development sector.

3.4.1.1 Poor Accessibility of Services

The accessibility of child development services across the Central Okanagan is very limited, as it is in most communities. Families must book several weeks in advance for even the well-funded health protection program, "Well-Child Clinic", under the IHA's umbrella. In other cases the wait for service can be anywhere from two to ten months. The waitlist the COCDA struggles with is documented in Table 2, p. 22.

Given the poor accessibility of services across the child development sector, clients have very little bargaining power. If the wait for service at one non-profit is too long, the option to jump to another service provider in hope of a quicker response does not exist. There is simply not an abundance of services. In the case of service accessibility, the balance of power is clearly in the hands of the service provider. When this kind of power is wielded by a sector, intentionally or unintentionally, there is little leverage for clients to exert.

3.4.1.2 Fragmented Client Base

Developmental delays and disorders occur across all walks of society; it does not single out one population group. This fact, plus the dispersed geography of the Central Okanagan, means the client base for the child development sector is highly fragmented. In addition to social diversity and geographic dispersion, parents often have a hectic schedule between family and work commitments, especially in cases where their child needs a high level of care. All of these factors combine to make for a highly fragmented client base. This fragmentation tips the balance of power towards non-profit agencies. In this sense, a fragmented client base minimizes the influence clients can exert over the sector.

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3.4.2 Little Opportunity for New Entrants

3.4.2.1 Referral Partners

The vast majority of referrals for children's developmental delays and disorders are received from a referral partner in the community. Every time a referral is made, the referring agency and agent puts their reputation at stake. Clients trust their caregivers to make good decisions. One of the more important decisions a service provider makes is the timing and selection of a referral to another program. Clients trust their caregiver to select a qualified, first-rate referral partner, who will take responsibility for the next steps in the client's care . If a partner performs badly and the client is dissatisfied, it reflects poorly on the referring agency and agent.

The interdependency between referral partners puts new entrants at a disadvantage. Referral partners not only need to know each other, and know what service each offers, there also has to be a high level of trust between referring agents. Referring agencies and agents are not willing to risk their own reputation by referring clients to a new entrant. New entrants are simply too much of an unknown for service providers to jeopardize their own reputations in making a risky referral. Unless the COCDA and other child development services lose credibility with referral partners, it is extremely difficult for new agencies to break into the circle of interdependence between service partners.

3.4.2.2 Service Differentiation

Government is wary of sponsoring duplicate services and the child development sector is no exception. Child development is a relatively specialized area of service. To effectively work with children, service providers need to be familiar with all of the nuances of developmental milestones and the indicators of a child's status. Much of this expertise is developed through applied experience in the paediatric field. To duplicate this expertise, by endorsing a new entrant to replicate some, or all of the existing programs, does not seem like a good use of scarce tax dollars.

Not only is paediatric expertise an important ingredient for quality services, it is a feature that allows agencies to differentiate their service. Service differentiation that is largely based on a learning curve clearly puts new entrants at a disadvantage to

established agencies. Poaching staff from an established service provider is extremely difficult for an unknown, untried entrant.

Established agencies, such as the COCDA, are in the position to offer unique bundles of service by combining different programs. Offering a roster of programs allows agencies to assemble a mixture of individual programs into a unique service bundle for each individual client. Acquiring more than one service contract at a time is difficult, if not impossible, for new entrants. In other words, established agencies have a competitive advantage over new entrants in terms of offering a differentiated service by mixing and combining elements from a range of programs.

3.4.2.3 Community Development

In some communities informal grass-root movements may be a negligible or small factor in shaping the non-profit public sector. In the Central Okanagan, however, community development work is happening on a large scale.

In the past, community development was a rather informal, ad hoc process, but in recent years more structure and resources have been added. Approximately five years ago, community development in the Central Okanagan started to take shape with the formation of CATCH (Community Action toward Children's' Health). Originally supported by leadership from IHA and MCFD, CATCH has grown from a humble beginning into a well organized, government funded community force.

CATCH serves as a catalyst to get all agencies working with infants and preschool age children together to discuss common issues and challenges. The hope is these discussions will generate joint problem solving and shared solutions. In promoting children's health through community development, CATCH emphasizes the importance of coordinating existing resources. Improving children's health is not always about funding new initiatives, or boosting existing services. Gains can also be achieved through better coordination and deployment of existing resources.

Even if community development work identifies gaps in existing services, which can not be addressed through better coordination, the problem solving that takes place always involves existing service providers. It would not be community-based, grass-roots development, if key community partners were not invited to be part of the solution.

CATCH does not overtly exclude new entrants to the public sector, but the process inherent to community development restricts the opportunity for new entrants to establish a footing in the child development sector.

3.4.3 A Deep Pool of Volunteers

Volunteers are an important resource in the non-profit sector. In some instances volunteers assist with service delivery. For example, the organization, Big Brothers and Big Sisters, relies extensively on recruiting volunteers to match with children and youth in need of mentoring. In this case the agency's program delivery is entirely dependent on volunteer participation. In other instances, particularly in unionized environments, volunteer participation in service delivery is more limited. At the COCDA, volunteers participate in the therapeutic horse back riding program. In this program volunteers serve as side-walkers beside the horseback rider, while a PT directs the riding activities.

In addition to program delivery, volunteers serve other functions. All non-profits are governed by a volunteer Board of Directors. A non-profit's governing body can range from four to fifteen members, and meetings can be as infrequent as every quarter, or as frequent as bi-weekly. The governing body can also be a working group with active committees, or it can serve as an advisory group to management. Another function of volunteers is to assist non-profits with fundraising. The Kelowna General Hospital Foundation is staffed by a few paid staff, but much of the canvassing and organizational work is carried out by volunteers.

While volunteers are a valued commodity, there appears to be relatively little competition for this resource. KCR, another local non-profit, maintains a data base of both volunteer opportunities and interested volunteers. This community directory makes volunteerism and volunteer recruitment a cooperative venture.

The number of retired and semi-retired people in the Central Okanagan also reduces competition between agencies. The demand for volunteers by non-profits is moderate, while at the same time a large pool of potential volunteers exists in the community. These dynamics create a non-competitive environment for volunteers. For the last several years the COCDA has always been able to find sufficient supply of

committed volunteers to meet organizational needs. The ample supply of volunteers in the Central Okanagan helps boost the performance of agencies in this sector.

3.4.4 Latest Trend in Government Policy

Recently the federal and provincial governments have been paying a great deal of attention to the area of child development. Under the Liberals, the Federal Government committed five billion dollars to child development programs over the next five years. As a result of this commitment from the Federal Government, child development programs at the provincial level are entering a tremendous period of growth. It is just a small microcosm of the sector's growth, but to illustrate the impact of this new funding, the COCDA is receiving the following increase in the 2006-2007 fiscal year: SCD increases by three hundred twenty five thousand dollars, EIP increases by one hundred and twenty six thousand dollars, and IDP increase by sixty thousand dollars.

The magnitude of this new funding, if not unprecedented, is at least the largest injection of new money the COCDA has received in over ten years. Besides the COCDA, many child care and early learning programs in the Central Okanagan are receiving more funding. Included among these are the Ki-Low-Na Friendship Centre, and the Kelowna Child Care Society.

Not only is the funding base for the child development sector expanding, the breadth of program coverage is also growing. Historically the sector has been slow to expand the breadth of programs. After years of little or no program expansion, in 2001 the Provincial Government added an intensive behaviour intervention program for children with Autism Spectrum Disorder to its offering of contract services. A year later this area of service was further expanded, when the option of individualized funding was created for preschool age children, and school age children. Under this new funding, families are permitted to use a monthly government allowance to purchase service from a private or public service provider.

The scope of the child development sector is again going through an expansion phase. In late 2005 MCFD announced plans to fund assessment and case management services for preschool and school age children with Fetal Alcohol Spectrum Disorder

(FASD). Plans are still preliminary, but it looks certain the case management part of the service will be housed with an agency in the child development sector.

This period of substantial growth reduces rivalry within the child development sector. Significant sector growth eliminates the need for competing non-profits to jockey for position. Government funding is the major source of supply for non-profits. When this supply base expands, non-profits can take a break from aggressively advocating for increased funding. An increased share of government funding allows non-profits to focus on client service. Rather than lobbying government for increased funding, during a period of sector growth non-profits can focus on delivering the best possible service to the client.

If new entrants could set-up in the child development sector, the growth in government funding could attract rivals. However, since new entrants are essentially shut-out of the sector, the growth in government revenue decreases rivalry.

3.5   Summary of the External Analysis

Based on the key forces at work in the external environment, it is clear the COCDA needs to have a sound strategy to deal with a highly competitive labour market and a highly competitive market for community sponsorship.

The child development sector, like many sectors that rely extensively on human resources, is currently experiencing a labour shortage. One of the key ingredients in delivering a quality service focused on promoting healthy child development is a qualified, dedicated staff. In order to attract and retain staff with the right skill set and expertise, it is imperative the COCDA have a competitive human resource plan. The local and provincial labour force has more employment options than before. If the COCDA is to recruit and retain a strong workforce, new strategies for managing human resources are needed.

The pursuit of community sponsorship is another area where there is fierce competition in the non-profit sector. A few organizations rely completely on fundraising in the community to secure their operating budget. The majority of non-profits rely on community sponsorship to subsidize the cost of delivering programs.

Given the wide range of non-profits from various sector involved in community fundraising, perhaps it is worth considering whether community sponsorship is a worthwhile market to be in. Community sponsorship is used as a method for off-setting costs. In securing a sufficient supply of sponsorship from the community, one option is to develop a high powered marketing campaign. A successful marketing campaign, however, requires financial backing and marketing personnel with the right skill-set. In the non-profit sector, both these resources are scarce. Rather than subsidizing costs through community sponsorship, perhaps a better strategy is to maximize operational efficiencies, or economies of scale. In developing a strategic plan for the COCDA, the advantages between cost containment and economies of scale, versus cost subsidization will be given further consideration.

In addition to the two competitive forces that currently dominate the external environment of the child development sector, several other competing forces are emerging. MCFD's involvement with the child development sector is changing dramatically. Under pressure from the Provincial Government to run a tighter Ministry, MCFD is implementing new accountability measures around contract management. Better contract management on MCFD's part might spur-on improvements in client related outcomes. If the child development sector has drifted from a client-centered focus, a more accountable relationship with MCFD will help to re-focus the sector on the top priority – the promotion of healthy child development.

If on the other hand, MCFD takes the reform of its contract management practices too far, it could result in a major restructuring within the sector. Increased accountability is a priority no non-profit would argue with. However, an environment where the primary supply source, namely government funding, exerts a lot of competitive pressure is a very different sector from the one that presently exists.

Non-profits do not have the resources to cope with an aggressive, disruptive collaborator. For this reason, the collective bargaining, which is just under way and tentatively scheduled to conclude at the end of March 2006, is an important process to follow. Presently, Labour Unions play a relatively passive role in the child development sector. Depending on the outcome of the collective bargaining process, Labour Unions in the child development sector may become more aggressive and hostile. If this

occurs, Labour Unions in the child development sector may become more of a competitive force in the external environment.

The level of rivalry in the child development sector is low. There is some potential for this to change, however. Increased contestability, including a complete take-over by a larger non-profit, is a possibility. The main variable that is presently keeping contestability in-check, is MCFD's strategy to maintain some diversity in service providers. If MCFD decides to abandon this strategy, or if a non-profit shows poor performance, contestability from competing rivals will increase substantially. Until this kind of change happens, contestability remains a latent force in the child development sector.

Overall, the child development sector is not a very competitive environment. A fragmented client base with little service options, a closed market for new entrants, and a recent trend towards growth in this sector, keeps competitive forces from building. Given the demographics of the Central Okanagan, there is also little competition over a key resource base for non-profits. Non-profits in the Central Okanagan are fortunate enough to have easy access to a wealth of volunteers. In addition to these variables, the main contract manager and source of funds, MCFD, discourages rivalry amongst non-profits, while encouraging differentiation across service providers.

A relatively non-competitive sector, such as the child development sector, offers non-profits the room and freedom to concentrate on client outcomes. There are relatively few competitive forces in the sector to distract service providers from delivering a high value service to clients. While this makes the child development sector a favourable environment to be in, it does not guarantee success. To ensure success, the organization needs to be guided by a strategic plan built around careful consideration of the key competitive forces in the external environment, and the key internal competencies of the organization.

4 The COCDA's Resources, Primary Value Chain and Organizational Culture

The focus of this chapter is to describe and analyze the COCDA's internal activities and attributes. After reviewing the external environment in the previous chapter, it is important to develop a profile and analysis of the organization's internal attributes. The connection between the external environment and internal resources is integral to strategy. This connection between an organization's environment and resources is critical, because, "...managers should build their strategies around exploiting and leveraging company capabilities – its most valuable resources – and avoid strategies that place heavy demands on areas where the company is weakest or has unproven ability" (Thompson and Strickland, 1998, p. 111). Knowledge of the organization's internal resources and processes are just as important to successful strategy formation, as external market forces.

The first step in analyzing the COCDA's internal attributes is to provide an overview of the COCDA's resource capabilities and deficiencies. The purpose of this resource inventory is to construct a description similar to, "...a strategic balance sheet where resource strengths represent competitive assets and resource [deficiencies] represent competitive liabilities" (Thompson and Strickland, 1995, p. 107). In assembling this resource inventory, the focus is on the following seven key areas: human resources, service quality, information management, infrastructure, governance and management, reputation, and financial status. Each of these seven resources is critical to the COCDA's mission to serve children with special needs and their families.

To take the analysis of the COCDA's internal characteristics one step further, the second part of this chapter focuses on the primary activities of the COCDA's value chain. The goal of this section is to review, in detail, the flow of primary activities that create value for COCDA clients. Chapter Two defined COCDA services according to the following five categories: needs-based service, stand alone service, group service multidisciplinary service, and cluster service. In analyzing the COCDA's value chain, the most prominent and resource-intensive of these five services will be broken down according to inbound logistics, operational processes and outbound logistics. The focus

of this analysis will be to describe the COCDA's case management practices for coordinating the delivery of a cohesive, effective service.

4.1 The COCDA's Resource Inventory

4.1.1 COCDA's Critical Resource: Front-Line Practitioners

In serving children and families the COCDA relies extensively on frontline staff. The quality of the COCDA's services is largely dependent on the skills and attributes of staff. Fortunately, the COCDA excels in this area. Human resources are the agency's strongest asset.

COCDA staff remain committed to a family centered approach. Staff ensure parents are informed about their options and take leadership in setting the priorities and goals for their child's intervention. The vast majority of COCDA staff are excellent ambassadors for the agency and treat families in a respectful, enlightened manner. Over the years, very few parents have complained about staff performance. In fact, the opposite occurs; compliments and accolades are often received about practitioner's skills and support. There is much anecdotal evidence to suggest COCDA staff provide a quality customer service to families.

The COCDA has also managed to assemble an experienced, well qualified group of practitioners. The organization has ten employees with a Master's Degree, and twelve employees with a Bachelor's level of education. Practitioners have an obligation to remain current with best practices. This obligation is taken seriously, as staff are diligent about pursuing professional development opportunities.

The COCDA also has a good portion of staff who are highly experienced in pediatrics and child development. Pediatrics is a specialized field, where applied experience is an important factor. Again, the COCDA does well in this area. Eleven practitioners have ten or more years of service with the agency. Even those how have been with the agency less than ten years tend to have several years of experience in pediatrics from previous employment. Overall, the COCDA has an experienced, skilled staff that are tightly aligned with a client service focus.

Although some of the programs offered by the COCDA require hard-to-recruit staff, such as OT's, SLP's, and PT's, the agency has a done well in recruiting for these

positions. The draw of living in the Okanagan is certainly helps in recruiting qualified candidates. Another factor in recruitment is the strength of the existing team. The opportunity to learn from and to collaborate with strong colleges is a major attraction for many professionals in the community service sector. The COCDA's existing base of practitioners is a major advantage in recruiting strong candidates.

Recently, one COCDA program, the BI program, experienced a high rate of turnover at the Behaviour Assistant (BA) position. To address this problem the format of the program was revised to give staff more opportunity to work together as a team rather than in isolation. As well, a retention bonus was created for this one classification. BA's who now stay with the agency for a year receive a one thousand dollar bonus. In taking an open, flexible and responsive approach to human resource management, the COCDA has been able to address a serious retention problem. This was a significant human resource issue, as it was highly detrimental to the continuity and quality of the BI program.

The discussion so far has focused on the COCDA's strong human resources and sound human resource management practices. There is one area related to human resource management, where the COCDA is weak. For most of the job classifications in the organization, the COCDA is currently paying a wage rate below market.

In a recent survey conducted by the Community Social Service Employer's Association (CSSEA) it was estimated that wages in the social service sector are twenty four to forty four percent below wages in the health sector (CSSEA, 2006). A recent recruitment effort highlights the gap in wages between the two sectors. In trying to recruit an experienced SLP, the COCDA found itself in competition with the local IHA Health Unit. The Health Unit was able to successfully compete for this promising recruit by offering a wage that was five dollars per hour more than the wage the COCDA could offer. Even though the COCDA had more hours per week to offer, the wage differential between the two competing employers wiped out this advantage.

Clearly, uncompetitive wages are significant disadvantage. Uncompetitive wages contribute to turnover, as experienced by the BI program and therapy positions. Uncompetitive wages have also hurt recruitment efforts. Although there is no evidence to substantiate this claim, there is a risk uncompetitive wages are negatively impacting

on productivity and morale. A competitive compensation system is needed to protect the quality and continuity of services, and to ensure the sustainability of the agency. For these reasons, competitive wages are a key issue for the COCDA.

4.1.2 Does the Agency Deliver Quality Service?

The COCDA's services can be assessed across the following four key dimensions: accessibility, effectiveness, efficiency, and integration. The first dimension refers to the timeliness of service, an important attribute in the field of early intervention. The effectiveness of services relates to the impact of assessment and intervention on client outcomes. Efficiency is defined in terms of staff utilization, which is the amount of staff time invested in direct services to children and families compared to the total paid time. Lastly, the dimension integration relates to the amount of coordination and collaboration between different programs and disciplines.

4.1.2.1 Accessibility

The front end of COCDA services, namely the initial contact and intake visit, provide a high level of accessibility to children and families. All initial contacts for newly referred children are completed within one month, or sooner, of receiving the referral. The intake visit, a critical first-step in initiating services is typically completed within three months, or less of the initial referral. The timeliness of the initial contact and intake connects new referrals to the agency in an expedient manner. If families are apprehensive about their child's development, the timeliness of the initial contact and intake process helps to put parents at ease, knowing there is some action being taken in response to their child's referral, and that support and assistance is available.

Although the front end of service delivery provides a high level of accessibility, the waitlists for many programs equate to a significant delay of assessment and intervention work. In a survey completed of the Early Intervention Program in January 2005, twenty five percent of the children referred to SLP, PT, and OT had been waiting a minimum of six months, or longer for service. In the six months between the referral and the time of the survey these children had not been assessed, or received any intervention. During this wait period families, who might have been in need, did not

receive family support. From an early intervention perspective, this length of delay is detrimental to healthy child development.

4.1.2.2 Effectiveness

The COCDA has very few indicators to assess the effectiveness of its services. This in itself is a weakness for an agency purporting to be a quality service provider. It is important for public service agencies to gather input from clients. A non-profit can not rely completely on self-evaluation if it is to be a truly conscientious service provider.

The COCDA does gather some feedback from parents, but the effort put into collecting this data is minimal. Only one program, IDP, makes an effort to conduct an exit interview with parents. The methodology of these exit interviews has some shortcomings, but based on the information collected during the interview, IDP is providing an effective service. Of those parents who participate in an exit interview, approximately eighty five percent are satisfied or very satisfied with the service they receive. Outside of IDP's exit interviews, the COCDA periodically receives unsolicited comments from parents. The vast majority of these unsolicited comments are positive reports. Only a very small number of parents report a complaint or concern with the COCDA's service. Again, this should be treated with caution, as parents who are not satisfied with the service may feel uncomfortable about voicing their concerns without an invitation or platform to do so. Although the COCDA has collected some feedback from parents, the generalizability of this data is too limited to draw conclusions about the effectiveness of COCDA services.

Parent input is just one indicator to measure the effectiveness of service. The intensity of service can be used as another more objective, clinical indicator of effectiveness. Over the years, the intensity of COCDA services has declined. For example, as little as four years ago, a child on IDP's regular caseload usually received a home visit once every two weeks. Today, children on IDP's regular caseload receive a maximum of one home visit every three weeks. Even if a child and family can clearly benefit from a more intense service, the program is not resourced well enough to increase intensity. If the intensity of regular service increases, either the length of the waitlist, or the size of the monitoring caseload will increase. In other words, without

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increasing staffing, an increase in the intensity of service will increase the wait-time leading up to the regular caseload. When the focus is on early intervention, this is a difficult trade-off to make.

The dilution of service is not just a concern with IDP. Two years ago SLP moved to a block therapy format described in Chapter Two. By shifting to a block therapy model, SLP was able to increase the program's annual through-put, while using the same amount of staff. In this way, block therapy is a method for managing the waitlist for the SLP program. There is a downside, however. Using a block model reduces the intensity of service. Previously, children on the regular caseload received one session every two weeks over an extended period of time, often one year or more. Under block therapy, sessions are still scheduled once every two weeks, but the duration of this intensity is limited. Currently, the maximum period for a block session is eight months. In cases where the child's delay is mild, only one block of service (i.e. four months) is delivered before the child is moved to the monitoring caseload.

Service intensity has also declined for PT and OT. There is no question some OT and PT referrals now receive a less intense service than the child requires. Just as the case with the other programs and disciplines, children on the regular caseload for PT and OT do not receive the same intensity of service as delivered in the past. Although the parent report data needs to be treated with caution, the recent trends around the intensity of service suggest the effectiveness of COCDA services is declining.

4.1.2.3 Efficiency

One of the key measures of efficiency is staff utilization. The agency does not track this measure on a regular basis, because the existing information system is not up to the task. To fill in the holes in the existing information system, a great deal of manual counting and calculation is required. As a result, staff utilization is tracked on an annual basis, which is not a very frequent measurement. Whenever staff utilization is measured, however, the results have been positive.

In a recent review of the BI program, staff utilization amongst the Behaviour Assistant (BA) group was extremely high. If direct intervention time with the child, time

for team meetings, and indirect time for program preparation are taken into account, these activities explain ninety percent of the total paid time allocated to BAs.

Across the therapy disciplines (i.e. OT, PT and SLP), sixty to seventy percent staff utilization is the accepted benchmark. For therapy staff at the COCDA, the utilization rate from the 2004 sample was seventy eight percent, while in 2005 it was seventy three percent. In other words, for the last two years utilization of therapy staff at the COCDA exceeded sector standards.

There is no benchmark for the utilization of staff time in IDP, but when data for 2005 was analyzed for this program, just over seventy five percent of staff time was going to direct and indirect client services. Based on the standard set by the therapies, IDP's utilization rate is satisfactory. Considering IDP's staff utilization and the utilization rate for BI and EIP, the COCDA is currently showing strong performance in the area of program efficiency.

The COCDA also fairs well with regards to administrative efficiency. The total overhead operating cost for the entire agency accounts for only thirteen percent of the agency's program revenue. If all revenue is taken into account, the COCDA's overhead administrative rate drops to just over nine percent. In calculating the proportion of administrative costs, all facility costs, utility costs, and program administration costs were included in the calculation. In setting a benchmark for program administration, the Provincial Government proposes a target of ten percent. Not only are the COCDA's program administration costs within this target, the agency's total overhead costs also meet the target of ten percent.

In fact, an argument can be made that the agency is too efficient administratively. The push for accreditation and MCFD's move towards more involved contract management monitoring and reporting is increasing the amount of administrative demands placed on the agency. In this new, emerging operating environment, the COCDA's lean administrative structure is proving to be a limitation. In the past, the agency's lean administration was an asset.

4.1.2.4 Integration

As outlined in Chapter Two, roughly forty one percent of the approximately two hundred and fifty children on caseload at any given time receive a cluster service. In other words, at any given time, approximately one hundred children and families receive service from more than one COCDA program. The size of the caseload for cluster services presents a challenge. In order to deliver a quality program, cluster services need to be integrated in a seamless fashion. If cluster services are not integrated, families become confused and uneasy. When different practitioners from different programs schedule separate appointments with families, it is easy for service to become disjointed. A high level of fragmentation does not fit with the goals of a quality, family-centered service. From a family's point of view, fragmented services paint the picture of an agency in chaos.

In some instances, the COCDA's cluster services are integrated and in-sync. In many other instances, however, cluster services are at best disconnected, and at worst disjointed, and counter-productive. This hit-and-miss nature of the COCDA's cluster services stems from an informal, piece-meal system of integration. As noted in the earlier discussion on the case management of monitoring, regular and follow-up services, integration relies extensively on the practice and judgment of a wide range of individual practitioners. Integration relies far too much on unstructured processes, such as, informal collegial discussions and haphazard team work. The problem with using an informal, unregulated system for coordinating multiple efforts is that it relies too much on interpersonal dynamics and self discipline. Informal integration mechanisms reduce organizational bureaucracy, but the existing system is too susceptible to personality conflicts, breakdown in communication and lax work habits.

Given the prevalence of cluster services and the importance of maximizing the impact of scarce resources on client outcomes, a checkered track record on service integration is a major concern for the organization. Redesigning cluster services has to be a top priority for the COCDA.

4.1.3 Information Management

The COCDA has three information management systems that are critical to the operation of the agency. The three areas of information management pertain to: financial performance, client files, and staff activity.

4.1.3.1 Financial Management

Although no effort has been made to carry out a comparative analysis, it appears the COCDA has a solid financial management system. The Board of Directors and management receive a monthly financial statement, which includes a detailed breakdown of compensation and operating costs across numerous cost centres. In addition to the budget analysis, a monthly cash flow statement is prepared every month. Finally, as per the Provincial Government's contract requirements, audited financial statements are prepared for each fiscal year.

The budget development process is relatively straight forward, since the majority of the agency's operating costs are allocated to staff compensation. Since there is little change in full-time equivalents and compensation costs from year to year, the COCDA's annual budgeting process follows a very similar format from year-to-year. Nonetheless, a consultative process, incorporating input from all the Program Coordinators, is used every year to develop program budgets.

4.1.3.2 The Central File

Another critical data base is the client file system, or in more common terms, the central file. If used properly the central file ensures service delivery is in-sync, effective and well-informed. In the case of the COCDA the central file system is a weak link. Policies and procedures are being developed to standardize the information contained within the central file and staff's use of this data base. Up until now, however, central file management and use has been haphazard. Staff are clear about filing intake and assessment reports on the central file, but beyond this, practitioners are uncertain about the requirements for filing other client-related information. For example, there is uncertainty about how to categorize information that is suitable as a practitioner's

working notes, versus information that should go to the central file. In this sense, the COCDA's central file system is a significant gap in the information management system.

4.1.3.3 Service Statistics

The third key component of the COCDA's information system is the data base for tracking staff activity. For close to ten years the COCDA has been using one software system, Developmental and Rehabilitation Information System (DRIS), to track the amount of time practitioners put into travel, assessment, intervention, documentation and consultation for each child. Unfortunately the reports provided through DRIS have proved to be highly unreliable. A common complaint is that children, who are actually on a waitlist, are often listed on as receiving service on the active caseload. Also, in using DRIS the coding of activities is never clear across individual practitioners. As a result these inconsistencies, the statistics provided through DRIS reports contribute little to the operation of the agency. Not only is DRIS unreliable, but the system is outdated to the point that tech support is no longer available. DRIS, which runs better off of Windows 98, is not as compatible with Microsoft's more current operating system, Windows XP. In addition, almost one year ago the Provincial Government disbanded the help desk for this system.

Out of the COCDA's three information systems, DRIS is the weakest link. An internal committee is looking for a suitable software package to replace DRIS. Until the existing system is replaced, the COCDA's information system puts the agency at a disadvantage in managing internal process, including such key items as staff utilization and caseload management.

4.1.4 Infrastructure

The COCDA's information technology has traditionally been a weak spot for the organization. In the past two to three years the agency has targeted its information technology system as a priority, and some important gains have been made in this area. Three years ago the computer network's entire cable system was replaced, which greatly improved reliability and performance. The network server is scheduled to get replaced this year, and each year three to four computer work stations are replaced. By

the end of this fiscal year in March 2006, only six of the agency's twenty-six work stations will be older Pentium computers running Microsoft Windows 98. All other work stations are current enough to operate the XP version of Windows. Not long ago, the organization's information technology could have been sited as a significant deficit. However, upgrades in recent years, and planned purchases in the near future largely address the organization's weakness in this area.

The COCDA has been at the same site for twenty years. The facility has served the organization well, but the interior is dated and worn, and the availability of space for program growth is limited. The facility was originally built with grants from the Provincial Government and the Variety Club and with the support of a local fundraising campaign. Due to the success in raising funds for the building, the COCDA has been able to operate the past twenty years without mortgage or lease payments.

Since the building's initial construction very little has been done to maintain the facility. A new elevator was installed in 2002 and four of the original air conditioning units were replaced. Outside of these upgrades, the facility is essentially the same as it was when originally built. Carpet is getting thread bare, window coverings are faded and paint schemes are dated. Rather than periodically upgrading the facility, the COCDA has made a conscious effort to invest in services to children and families. This has been a successful short-term strategy, but as a long term approach it has left the organization with a badly worn out and dated facility.

Not only does the facility need to be refreshed, organizational growth has tapped-out the existing space. Recent expansion has required staff to double-up in offices. Although the existing space is now being better utilized, there is little room to accommodate further growth. No more therapy space is available within the building and meeting space is now at a premium. A few offices have room to add a second occupant, but this capacity will be absorbed very fast when expansion happens.

The new provincial budget indicates more money will be invested in children's services, but should this happen, the COCDA's facility has very little room for growth. If the COCDA is to keep pace with competitors, and to be positioned to take advantage of increased funding for children's services, the organization must upgrade and expand its

existing facility. The current facility is a serious impediment to the organization's growth and development.

4.1.5 Governance and Management

The leadership provided by the COCDA's Board of Directors is a source of strength for the organization. As committed volunteers, the Board of Directors takes their responsibility as the agency's stewards very seriously. The Board's current composition of parents, community members and corporate professionals provides a good mix of experience and specialized knowledge. This breadth of experience and background is a tremendous advantage in weighing governance matters. The Board's diversity of membership, as well as a familiarity with the COCDA's programs is an asset to the organization.

In providing stewardship, the Board works well as a backstop and sounding board for management. The agency has a lean management structure, but the Board helps to make up for this lack of depth by providing feedback, guidance and check points to assist management. While the Board excels at handling the day-to-day governance issues, it has not done much to develop a strategic plan. The lack of a long range, forward-thinking plan is proving to be a detriment as the organization faces new challenges and opportunities. When the external environment was stagnate, the lack of a strategic plan was somewhat inconsequential. In the current environment, where new funding and opportunities abounding, a sketchy strategic plan is now a liability.

The management group, which consists of the Executive Director and five Program Coordinators, is very lean and efficient. The group has produced some strong results in terms of recruitment, even for positions where there is a shortage, and in terms of staff performance and utilization. While there have been several successes and a few failures, the management team clearly functions with some limitations. The most noticeable shortfall related to the management team is the extent to which decision making is centralized. Since Program Coordinators are occupied with heavy caseloads, too much responsibility and decision-making is left to the Executive Director. As the organization continues to grow, a centralized management structure is simply not going to be able to keep up with the demand. To keep up with growth opportunities, the

COCDA needs to look at restructuring the organization, or at the very least, shifting current management practices to a more decentralized model.

4.1.6 Reputation

The COCDA has a good track record of collaboration with community partners and other Child Development Centres in the Interior of B.C. The COCDA's positive reputation has worked in the agency's favour. As a respected community partner the COCDA has been invited to some of MCFD's internal discussions and consultations. In turn this has allowed the agency to be one of the leaders in making policy decisions and contributing to the development of new community services. Being part of the inside track has also created some opportunities for the COCDA. When CATCH (Community Action towards Children's Health), a community development initiative, was looking for office and meeting space, MCFD approached the COCDA as a possible location. CATCH has now shared space at the COCDA for two years, and having CATCH's presence on site has brought more traffic into the building. Co-locating CATCH in the same building has increased the community's exposure to children with special needs and the services they access.

A strong, positive reputation also pays-off in terms of the agency's relationship with its main funding agent, MCFD. Recently, a special request was submitted to MCFD for assistance with facility upgrades. The request was substantial, involving twenty two thousand dollars of upgrades. This request was immediately endorsed, to a great extent because of the COCDA's reputation and profile with MCFD and the community.

4.1.7 Financial Status

Based on evidence provided in the annual financial audits, the COCDA has a healthy financial status. According to the income statement, in 2004 the agency finished with a net revenue of just over twenty five thousand dollars. The following year, 2005, the agency finished with a net loss of close to twenty eight thousand dollars. On an annual revenue base of $2.6 and $2.7 million respectively, these are very small financial variances. Not only are the variances small, the net income across these two years is essentially at break-even. These results fit well with the non-profit's goal of operating at, or just slightly above, the break-even point.

From a balance sheet perspective, the COCDA is again in a healthy position. Over the COCDA's forty year history, the agency has built up retained earnings of three hundred and sixty five thousand dollars. In the private sector, this may seem like a meager total. In the public sector, where the goal is to invest in service, rather than invest in the company, this is a respectable level of retained earnings. The agency has enough reserves to cover most unforeseen liabilities, or to make a significant contribution to a major capital campaign. At the same time, this reserve is not so big it attracts unwanted attention from government funding agents.

In terms of both the statement of operation and the statement of financial position, the COCDA is well positioned as a non-profit organization.

4.1.8 A Summary of the COCDA's Resource Inventory

Table 7 summarizes the agency's strengths, recent areas of improvement, and weaknesses.

Table 9: Summarizing the COCDA's Capabilities and Deficiencies

Critical Resources: Capabilities and Deficiencies	Rating
Human Resources:	
a. Staff Skill & Knowledge	3
b. Recruitment	2
c. Retention	2
d. Competitive Wages	1
Quality of Service:	
a. Accessibility...........................intake	3
...........................waitlist	1
b. Effectiveness...........................parent feedback	2
...........................intensity of service	1
c. Efficiency...........................staff utilization	2
...........................low overhead	2
d. Integration...........................accelerated response	3
...........................monitoring, regular, follow-up	1
...........................discharge	2
Information Management:	
a. Financial Management	3
b. Central File	1
c. DRIS	1
Infrastructure:	
a. Computer Network & Stations	2
b. Facility Condition	1
c. Space for Growth	1
Governance & Management:	
a. Board Involvement	3
b. Strategic Plan	1
c. Ability to Manage Growth	2
Reputation:	
a. Collaboration	3
b. Credibility	2
Financial Status:	
a. Break Even on Annual Income	3
b. Retained Earnings	3

Key:
> Rating 3 = Good
> Rating 2 = Average
> Rating 1 = Poor

The COCDA is well resourced and demonstrates a highly level of capacity in the following areas: staff expertise, an accessible intake service, financial management, involvement from the Board of Directors, a reputation for collaboration, and a healthy

financial status, both in terms retained earnings and annual statement of operations. Used strategically, these resources and capacity can be an asset for the COCDA as the organization strives to provide the best possible outcomes for children with special needs and their families.

The areas where the COCDA has significant deficiencies are: non-competitive wages, inaccessible services after intake, fragmented group and cluster services, poor information management related to client files, and stating practitioner activities, an inadequate facility, and the absence of a strategic plan. All of these deficiencies, in some manner, significantly detract from the COCDA's mission to provide quality early intervention services to children with special needs and their families.

4.2   The COCDA's Primary Value Chain

The COCDA's value chain is highlighted in this section in order to develop a more detailed description and analysis of the operation's main activities and the way these activities coordinated.   Porter's value chain is typically used to diagram the sequence of steps non-profits follow in delivering a service (Vining, 2005, p.4).

Porter's value chain divides activities into two categories.   Primary activities transform inputs into services, while support activities provide the infrastructure for primary activities (Porter, 1985, p. 34).   A schematic of the COCDA's primary and secondary value chain is provided in Figure 2.

Figure 2: COCDA's Value Chain

Support Activities	**Human Resource Management** • Recruitment & Retention • Training & Professional Development	• Orientation • Performance Management	
	Information Management • Information System • Central File	• Financial Services • Quality Improvement	
	Firm Infrastructure • Legal Services • Maintenance • Labour Relations • Janitorial	• Administrative Assist. • General Management	
	Governance • Policy Development Monitoring		
	Case Management • RIT Program Team		

Intake	Assessment	Intervention & Support	Coordination
• Initial Contact • Intake Visit • Info Sharing • Report • Parent Support	• Preparation • Formal Assess. • Informal Assess. • Scoring • Report • Parent Support	• Info Gathering • Planning • Preparation • Delivery • Monitor • Document Notes • Parent Support	• Consultation • Transition Planning • Change Management • Discharge Report

Primary Activities

INBOUND LOGISTICS   OPERATIONS   OUTBOUND LOGISTICS

None of the COCDA's primary and few of its secondary operations are outsourced. The agency requires little legal counsel, but if a need arises, a well established local law firm provides service. On labour relation issues, support is provided free of charge by a government funded agency, Community Social Service Employer's Association (CSSEA). CSSEA provides labour relations counsel to all unionized operations in the social service, community living sector. Each agency is assigned a CSSEA consultant who is available for telephone consultations. One prevalent internal resource, which is outsourced, is the maintenance of the agency's information system. A local firm, Computer Techs, is contracted to provide on-call and regularly scheduled maintenance of the COCDA's information system. This support also extends to the purchase of new computer equipment.

Since the resource inventory in Section 4.1 largely describes the COCDA's main support functions, this section focuses on the COCDA's primary operation. These

functions are at the heart of the organization; it is these processes that impact on client outcomes.

4.2.1 Recognizing the COCDA's Economies of Scope

In Chapter Two the COCDA's five different services were described. To recap, these services are: needs-based, stand alone, group, multidisciplinary, and cluster.

Since the COCDA's service delivery relies extensively on economies of scope, the activities across the value chain of these five different services are similar. Regardless of whether it is a stand alone service, group service, multidisciplinary service, or cluster service, practitioners use the same assessment tools and similar intervention techniques. An OT, for example, may use the same formalized assessment tool across all the different service groups. Since there are major economies of scope across the operation, the present value chain analysis will be limited to the most prevalent service and the most resource intensive (Vining, 2005, p.9). Based on caseload statistics, stand alone service is the most prevalent, while both the multidisciplinary and cluster service require the most resources.

4.2.2 Stand Alone Service: Primary Value Chain, Coordination and Control

The primary value chain for a stand alone service is provided in Figure 3. Stand alone is the most prevalent service at the COCDA, although almost half of the children and families in this program eventually move into a cluster service. Since a stand alone service involves only one program or discipline, case management is a relatively straightforward process.

Figure 3: The COCDA's Value Chain for Stand Alone Service

Inbound Logistics

Referral Reception:
- Referral received by Admin and logged in the RIT book.
- RIT meets every Wednesday to review and process referrals.

Initial Contact:
- New referrals are contacted within 1 month of RIT meeting.
- The family is informed of their status on the waitlist. An intake visit is discussed, and is possible, scheduled.

Intake Meeting:
- Every effort is made to schedule an intake meeting within 3 months of RIT meeting.
- At the intake visit information is gathered on the child's medical history, the child's current developmental status, and the family's history, concerns and priorities.
- The first steps in providing family support occur, if needed.
- A record of the intake meeting is record on a standard form.

Waitlist:
- Typically a child will wait three to eight months from the date of referral to the time a stand alone service starts.

Operations

Assessment Preparation:
- The child's chart is reviewed.
- Materials and standardized tools are gathered.

Assessment:
- An assessment is carried out over 1 or 2 sessions, working directly with the child.
- The assessment consists of informal and formal observations.
- Scoring for standardized tools is completed.
- Results are reported to the family. A report is prepared.
- Family support is provided as needed.

Intervention Planning:
- Information from working notes, client file and assessment report is reviewed.
- A plan is developed incorporating the family's priorities.
- Materials, equipment and activities are gathered and prepared.

Intervention Delivery:
- Intervention is delivered in the home, at a child care setting, or at the COCDA.
- Interventions sessions take place once every 2 to 3 weeks.
- Parents are encouraged to carry out activities between sessions.
- The impact of the intervention is assessed; the plan is adjusted as needed.
- Observations are documented in case notes.
- Parent support is provided, when possible, as needed.

Consultation :
- If intervention stalls, practitioners check with colleagues.

Outbound Logistics

Referral Planning:
- If needed, refer the child and family to over services and supports, with permission.

Discharge Planning:
- Prepare a discharge report.
- In some cases, schedule or attend a team meeting to discuss the transition process into School District #23.
- Support parents through the transition process.

When the child is referred to one program, RIT functions more like an administrative body than a case management process. The Program Coordinator simply receives the referral as it was made by the external referral partner. There may be some discussion by the team about the possibility of secondary referrals, if the accompanying information on the one-page referral form suggests the child may have multiple needs. For the most part, this type of discussion is rare. For a single-program referral, RIT tends to consist of data entry, not decision making.

Once a single-program referral is received through RIT, the Program Coordinator reviews the available information to triage whether the referral is urgent, or routine. If it requires a rapid response the Program Coordinator either takes on the referral herself, or assigns it to another practitioner on the team. The Program Coordinator for IDP tends to handle rapid response services, while SLP, PT, OT and SCD assign rapid response referrals to various practitioners. Rapid response referrals are assigned to practitioners according to caseload pressures and skill set..

If the referral does not require a rapid response, the Program Coordinator makes the initial contact with the family to provide information about the COCDA's services and to answer questions. After completing the initial contact, the referral is placed on a waitlist. Due to a significant turnover of the caseload in September, Program Coordinators tend to monitor the waitlist more closely in the late winter, spring and summer months. By the time spring arrives, significant waitlists have accumulated for most programs and disciplines.

From a Program Coordinator's perspective waitlist management is not straightforward. Decisions have to be made about moving families to a monitoring service, or leaving them on the waitlist. In some instances decisions are made to allow children to jump the waitlist cue. A referral for an ASD assessment is one condition for allowing a child to jump the cue. Health status is another factor taken into consideration. If a child's health status is critical or fragile enough, a Program Coordinator might decide to fast track the child onto a monitoring or regular caseload.

Once a child is off the waitlist and receiving service, decision making and coordination responsibilities shift to the individual practitioner. In other words, frontline practitioners take on the responsibility of a case manager. Within the parameters of

program standards, this involves making decisions about: selecting methods for identifying the child's strengths and needs, the duration of service, the extent of preparation needed for intervention, the content of the intervention plan, the nature and intensity of family support, the decision to recommend additional referrals, the style and content of documentation, and the decision to recommend discharge.

In the case of a single-program referral, all these decisions are handled by the assigned practitioner. Teammates within the program or discipline, and colleagues across the agency can be consulted, if a practitioner wishes to seek a second opinion. The decision to initiate collegial consultation is entirely with the individual practitioner. Due to personality differences, differences in practitioners' styles and professional paradigms, this highly autonomous system for managing single-program referrals can create friction within the organization from time-to-time.

At this point individual practitioners have a lot of autonomy in managing service delivery. If the intervention is not achieving the desired outcome, and the child's development is not progressing as expected, it is the responsibility of the individual practitioner to recognize this and to take action. This means the case management decision on how to coordinate a stand alone service is highly dependent on the clinical judgment of individual practitioners. If there is doubt or uncertainty, practitioners have the option of consulting with a colleague. A practitioner's case management decisions, or the decision to seek a second opinion are not monitored.

Similar to the assessment and intervention phase for stand alone service, individual practitioners also take responsibility for discharge planning. Occasionally a child is discharged, because their development reaches an age appropriate benchmark. More often, a child is discharged as a result of aging out of the service.

A child must be under age three, in the case of IDP, or age five in the case of OT, PT and SLP, to be eligible for service. In most cases little discharge planning is required for a child who has reached age appropriate development. For children who age out, but still have ongoing needs, discharge planning is more involved. If the child requires further support, COCDA practitioners ensure the family is connected with other resources and services. In addition to making further referrals, discharge planning also involves preparing a report detailing the child and family's service plan and the progress

towards obtaining goals. This report provides historical and baseline information for subsequent services and supports.

4.2.3 Cluster Service: Primary Value Chain, Coordination and Control

A cluster service tends to be resource-intensive, because it involves two or more practitioners working with the child and family at any given time. In some cases, there may be as many as five practitioners from different programs and disciplines working with the child and family. The prevalence of the different levels of cluster service are depicted in Table 4 on page 36.

Not only is cluster service resource-intensive, it is one of the most dynamic and complex services to coordinate. The inbound logistics of a cluster service are very similar to a stand alone service, as depicted in Figure 4. If coordinated correctly, the core operation of a cluster service can be different from the operation of a stand alone service. Unfortunately, this does not always happen.

Given the complexity of a cluster service, case management plays a pivotal role in program delivery. Depending on case management, cluster service can be highly coordinated and integrated. If case management is lax, it can also be highly fragmented. From a client's perspective, the service can be fragmented to the point where it appears to be a series of separate, distinct programs delivered independently from one another. In this respect, a poorly coordinated cluster service starts to look similar to a series of stand alone services.

Figure 4: The COCDA's Value Chain for Cluster Service

Inbound Logistics

Referral Reception:
- Very few external referrals arrive as a multiple-referral. Most arrive as a single-referral.
- Requests for cluster service mainly arrive through internal referrals.
- Internal referrals are processed every Wednesday at RIT.

Initial Contact:
- External referrals are contacted within one month of the RIT meeting.
- The family is informed of their status on the waitlist. An intake visit is discussed, or even scheduled.

Intake Meeting:
- In most cases an agency intake has already been completed.
- An abbreviated intake is completed for the program or discipline picking the child up on caseload.

Waitlist:
- To trigger an internal referral, the child is already on caseload with one or more programs or disciplines.
- A wait period will likely occur for the new internal referrals.
- Internal referrals go onto a program waitlist just as external referrals do.

Operations

Assessment Preparation:
- The child's chart is reviewed.
- Materials and standardized tools are gathered.

Assessment:
- An assessment is carried out over 1 or 2 sessions, working directly with the child.
- The assessment consists of informal and formal observations.
- Scoring for standardized tools is completed.
- Results are reported to the family. A report is prepared.
- Family support is provided as needed.
- Results may be discussed with colleagues.
-

Intervention Planning:
- Information from working notes, client file and assessment report is reviewed.
- A plan is developed incorporating the family's priorities.
- Other involved colleagues might be consulted in developing the intervention plan. Each practitioner tends to develop her own plan. Rarely is an integrated intervention plan developed in collaboration. At most there is consultation.
- Materials, equipment and activities are gathered and prepared.

Intervention Delivery:
- The intervention plan may be integrated, in sequence, or uncoordinated.
- If coordination occurs it is largely through documentation and collegial discussions. Occasionally team meetings are scheduled.
- Intervention is delivered in the home, at a child care setting, or at the COCDA.
- Interventions sessions take place once every 2 to 3 weeks.
- Parents are encouraged to carry out activities between sessions.
- The impact of the intervention is assessed; the plan is adjusted as needed.
- Observations are documented in case notes.
- Parent support is provided, when possible, as needed.

Consultation :

- If intervention stalls, practitioners check with colleagues.

When a multiple-program referral is received at RIT, case management decisions must start right away. The team must decide who is going to take the lead in contacting the family, setting up the first visit, and completing the intake. This decision is largely based on the availability of the referred programs or disciplines to respond to the referral. All programs and disciplines have a waitlist, but IDP's consultative caseload, and SLP's concentrated intake process typically establish these two as the frontrunners for responding to a multiple referral.

Once the lead program or discipline completes an intake and likely initiates service, the assigned practitioner becomes the informal case manager. This is not a well defined or recognized role within the agency. Expectations are unclear and decision making is based more on informal, ad hoc discussion than on a standardized process. Sometimes the case manager role is simply assumed without any discussion.

There are four mechanisms for coordinating a cluster service. The least intensive method is to coordinate services through documentation. This involves written correspondence between practitioners, and the review of goals and plans in the client file. This is a passive form of case management, and is more of a communication approach, then a method to coordinate service.

A more intensive case management method is collegial consultation. This method relies on practitioners connecting with one another at the office to discuss the family's status and the service path each respective practitioner is following. Occasionally, a joint visit may be scheduled, or arrangements made to stagger visits, so as to not overwhelm the family. Joint visits promote integration, but scheduling logistics, professional biases and family readiness make this difficult.

The fourth form of case management, team meetings, is the most intensive method of coordination. Team meetings consist of all the involved parties, including parents, sitting down to work out an integrated plan. In many cases a parent chairs the meeting, and the agreed upon plan is documented. At the very least, a method for coordinating visits is discussed, and on occasion joint visits are arranged. In the case of cluster service team meetings are rarely used as a case management tool.

While the four mechanisms for facilitating case management are clear, a framework for implementing these methods does not exist. For a stand alone service, case management is relatively simple. Individual practitioners must select from a limited range the most appropriate assessment tool, or the most appropriate intervention strategy. Coordinating a cluster service is quite a different matter. Not only must decisions be made by several practitioners about assessment and intervention options, but communication and decisions must also occur in relation to the sequence, direction and coordination of service. Without cohesiveness, it is easy for programs to be working at cross-purpose to each other. Parents can feel as though practitioners are providing conflicting goals and information. Another danger is that uncoordinated services can overwhelm parents with a barrage of information. For so many reasons, sound case management practices are critical for quality cluster services.

Even if these obstacles can be dealt with, another hurdle exists in the form of cumbersome operational logistics. A more coordinated case management format can be adopted, where a team meeting is scheduled once the lead program has completed intake and started service. With support now in place, the child and family may be ready for other practitioners to join the intervention plan. At this point, the coordination process is complicated by waitlist and caseload pressures.

The family and lead practitioner may be ready for other programs or disciplines to join in delivering a more comprehensive service. However, with full caseloads already in place, there is simply no room to bring the child with multiple-referrals on. For a child on an SLP, OT, PT, or SCD waitlist, it may be some time before there is sufficient room on the caseload to start service. A case manager and standardized case management process might be in place, but the required resources are not available.

No allowances have been made in the management of resources to permit children with multiple referrals to access the support of all programs and disciplines in a timely fashion. Outside of the cultural and professional factors working against the case management of cluster referrals, a large structural barrier exists, as well. Unless this structural issue gets resolved, the role of a case manager is severely limited. It is difficult to manage without available resources to coordinate and work with.

4.2.4 Multidisciplinary Service: Primary Value Chain, Coordination and Control

The one COCDA program that truly fits a multidisciplinary service model is the Behaviour Intervention (BI) program. At twenty hours of therapy each week per child, plus the multidisciplinary therapy team to back-up the hands-on interventionists, the intense stream of the BI program is extremely well resourced. Given this level of involvement it is not surprising this multidisciplinary service, which is illustrated in Figure 5, is coordinated through extensive case management.

Figure 5: The COCDA's Value Chain for Multidisciplinary Service

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Inbound Logistics

Referral Reception:
- Referral received by Admin and logged in the RIT book.
- RIT meets every Wednesday to review and process referrals.
- For this service, referrals can only be received from Community Living British Columbia.

Initial Contact:
- New referrals are contacted by the Behaviour Coordinator within 1 month of RIT meeting.
- The family is informed of the BI program's capacity to add their child to the service list. An intake visit is scheduled.

Intake Meeting:
- Every effort is made to schedule an intake meeting within 2 months of RIT meeting.
- At the intake visit information is gathered on the child's medical history, the child's current developmental status, and the family's history, concerns and priorities.
- The first steps in providing family support occur, if needed.
- A record of the intake meeting is record on a standard form.

Variable Waitlist:
- The waitlist for this service is dependent on the turn-around time to hire additional staff. Families who qualify for this service receive $20,000 per year from the Provincial Government. Since funding exists to open new program spots, children can start as soon as there is sufficient staffing.

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Operations

Assessment Preparation:
- The child's chart is reviewed.
- Materials and standardized tools are gathered.

Assessment:
- An assessment is carried out over 4 or 5 sessions, working directly with the child.
- The assessment consists of informal and formal observations using a specific curriculum guide.
- Results are reported to the family. A report is prepared.
- Family support is provided as needed.

Intervention Planning:
- Information from working notes, client file and assessment report is reviewed.
- A detailed program curriculum with activities is developed. The curriculum incorporates elements of applied behaviour analysis, incidental learning and natural teaching.
- Materials and visual schedules for the child are prepared.

Intervention Delivery:
- Intervention is delivered in the home and at the facility.
- The impact of the intervention is assessed and the plan is adjusted during team meetings every 4 to 6 weeks.
- SLP and OT consults with the behaviour team.
- The child's response to applied behaviour analysis discrete trials is documented during each session.
- Video-taped sessions are reviewed periodically for quality control in delivering the discrete trials.
- Parent support is provided on a limited basis.

Consultation :

If intervention stalls, the team gets together for an informal consult.

Outbound Logistics

Referral Planning:
- If needed, refer the child and family to over services and supports, with permission.

Discharge Planning:
- Prepare a discharge report.
- In some cases, schedule or attend a team meeting to discuss the transition process into School District #23.
- Support parents through the transition process.

Compared to a referral for cluster service, a referral for multidisciplinary service is handled quite differently. To qualify for a multidisciplinary referral, a child must first be diagnosed with ASD. Once a diagnosis is confirmed, Service Planners at the local Community Living British Columbia (CLBC) Branch make a referral to the COCDA. When such a referral is received at RIT, it is simply recorded in the log book and automatically passed onto the BI program.

The BI Program Coordinator plays a central role in processing multidisciplinary referrals. As a case manager, the BI Program Coordinator operates with a great deal of

autonomy and authority. The BI Program Coordinator sets the pace for doing an intake and for bringing the child onto active caseload. The BI Program Coordinator might complete an assessment of the child's developmental status, or this task might be delegated to a Senior Behaviour Assistant (SBA). Regardless, the Program Coordinator has a great deal of control over the process.

After an assessment is completed, the Program Coordinator plays a central role in developing the appropriate curriculum for the child and in scheduling a team of BAs to deliver the program. A regular multidisciplinary team meeting is part of the program's framework. It is already an established standard. The BI Program Coordinator cannot chair every team meeting; again some of this is delegated to the SBAs. Nonetheless, the BI Program Coordinator has significant influence in setting the agenda and tone for these meetings. Team meetings are intended to be highly participatory, and other members, such as, BAs, SLPs, SBAs and OTs contribute to and share throughout the meeting. Out of all these participants, however, the BI Program Coordinator has the most influence in shaping the service.

Considering the way case management works in relation to other referrals and services, it is not surprising the relatively centralized format of the multidisciplinary service creates some conflict. In the case of a single-program referral, practitioners have a high degree of autonomy. The same is also true for multiple-program referrals. The case management of cluster services is limited by a number of factors. As a result, individual practitioners again exercise a lot of autonomy over the case management process. In contrast, multidisciplinary referrals follow a relatively structured, centralized case management process. Under this model, individual practitioners do not have as much autonomy compared to other service models within the agency.

In addition to team meetings, case management within the multidisciplinary model is facilitated by data collection. Every service, to some extent, relies on documentation as a coordinating mechanism. This is especially true for an intensive multidisciplinary service. Within the BI program, log books are updated on a daily basis and extensive data is collected on the child's performance during each session. This data is entered into a daily log book, which serves as a communication tool for BAs who are scheduled to do the next session. The program plan is also mapped out in detail

and shared across the team. This level of documentation helps to keep all team members on the same page.

Team meetings occur much more frequently in the multidisciplinary model than in any other service. The inclusive nature of the team meetings consume significant staff time. At any given team meeting there can be as many as five or six COCDA staff sitting at the table with parents. This kind of frequent, inclusive case management practice translates into a high unit cost. At the same time, it is the best method for ensuring team work remains coordinated, which is extremely important for an intensive, dynamic service.

4.2.5 Key Elements in the Coordination and Case Management Process

The Referral and Intake Team (RIT) is the first point in the primary value chain, where decisions are made about coordinating service delivery. Overall, RIT plays a relatively minor role in coordinating services. The main coordination and case management functions rest with individual practitioners, either as Program Coordinators, or frontline service providers.

This informal system is very dependent on the attributes of individuals, rather than qualities of the organization. This means that training, acquired experience, and individual style factor quite heavily into the organization's case management processes.

In comparison to case management, the actual work hands-on work with children and families is relatively standardized. For example, all intakes are completed according to a standardized form. There is leeway for practitioners to inject their own manner, their own approach to information sharing, and their own style of building rapport. The completion of an intake leaves some room for autonomy, but compared to case management practices, the process is relatively standardized.

Other elements of child development work are relatively standardized, as well. Many assessment processes follow the method and format setout by a professionally recognized, standardized instrument. Intervention planning and implementation often follows best practice guidelines learned at workshops and conferences, or through collegial discussions. Although a specific process and format is prescribed by these assessment and intervention tools, there is some opportunity for practitioners to deviate

from the script. Compared to the templates used for assessment and intervention planning, case management practices are relatively loose and un-standardized.

The difference in standardization between core elements of service and service coordination is noteworthy. Practitioners refine and extend an assessment based on education and previous experience. In such cases the practitioner is looking for opportunities to enhance service. There is also a standard format to follow, which limits the amount a practitioner can stray.

Case management practices are completely different. Under the COCDA's structure, case management is far more dependent on individual judgment and preference, than on industry guidelines. Clients and management hold practitioners accountable if service is shoddy. Faulty case management is not so obvious, as most of it occurs behind the scenes. The concept of good case management is somewhat vague and removed from direct client service. All the same, sloppy case management practices can undermine the effectiveness of service.

4.3 Decision Making and Coordination across Support Services

The COCDA's administrative structure is lean. There are two administrative assistants, one part-time accountant, one part-time janitor and maintenance worker position, and an Executive Director. While practitioners in the primary value chain work within a relatively open and flexible system, support services follow a relatively prescribed routine and list of assignments. For example, Administrative Assistants transcribe reports, file records, direct incoming telephone and walk-in traffic, enter caseload statistics, enter payroll data and compile billing information.

There is very little monitoring of administrative work. Instead, this work is managed by exception. If a routine assignment gets missed, this oversight is usually reported, or picked-up by management, and dealt with. In this way accountability is more self-imposed. If accountability slips, management gets involved.

The other positions in support services also have routine tasks and assignments and follow the same accountability format. If support service staff run into difficulties, the employee is expected to seek the council of their supervisor, which is the Executive Director (ED). In this sense, support staff have some latitude of autonomy.

Assignments must maintain a certain standard and be completed on time. Outside of these two criteria, there is some room for individual discretion in terms of the pace, and the methods for completing the work.

In addition to trouble shooting issues involving the delivery of support services, the ED has a wide ranging role. The ED plays a central role in managing relationships with external partners, and in making internal resource distribution decisions. The ED also monitors the organization's output, and financial performance. The ED handles most of management's labour relation responsibilities, and many of the human resource functions, especially in terms of recruitment, hiring, and performance management. The ED has a hands-on role in developing policies and procedures, and in maintaining quality assurance processes. All dispute resolutions, or case management and policy dilemmas tend to get referred to the ED for resolution. Outside of human resource management, a major function of the ED's role is troubleshooting critical operational and policy issues. The Board of Directors monitor the ED's performance based on the quality of work displayed at Board meetings, and on staff input acquired during an annual evaluation process.

4.4   High Level Monitoring of Case Management: A Noticeable Gap

There is a noticeable gap in the structure and coordination of the COCDA's services.   Case management responsibilities are largely held with individual practitioners, either with Program Coordinators or frontline staff. This in itself is not problematic.   What makes it problematic is the lack of a system, or assigned responsibility for ensuring this key operational function is carried out well.   In the previous discussion of the primary value chains, and the coordination of support services, it is clear a monitoring role to oversee case management practices is not centralized anywhere in the organization.

The case management system itself is informal, un-standardized, and open to negotiation, as individual practitioners try to navigate through personal conflicts and professional differences. This leaves the organization susceptible to a highly variable case management process. To keep this in-check, some form of monitoring is needed.

At present, the only time case management gets attention, is when a difficulty, or conflict is flagged. Since conflict is not well received or dealt with in the COCDA's

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culture, a crisis management approach to monitoring case management is not very effective. Case management responsibilities need to be designated to a position in the organization, and a clear framework for guiding case management practices needs to be established.

4.5   The COCDA's Organizational Culture

Based on the discussion of coordination processes, and positions of control and influence, it is readily apparent the COCDA is a decentralized, informal, highly flexible, and flat organization. For the most part, the organization is mission-driven, focused on serving children and families in the best way possible. In striving to fulfill this mission, the organization's primary resource, its skilled practitioners, is given a great deal of autonomy in organizing service delivery.

The COCDA's organizational culture emphasizes participation, dialogue and growth, both personally and professionally (Wexler, 2005, p.4). An organizational culture that stresses practitioner autonomy is very evident in service delivery and case management practices. As exemplified by the current case management practices, it is also an organization that relies on trust. Using Wexler's (2005, p.1) model for classifying organizational structure, the COCDA's culture embodies a communitarian world view. This frame of reference makes the COCDA distinct from a bureaucracy's regulatory world view, which is another common organizational structure in the public sector (Wexler, 2005, p. 4) Large health organizations like IHA tend to be highly bureaucratic. In a communitarian organization like the COCDA, bureaucracy is not a good fit.

A communitarian culture makes for a comfortable workplace, except in times of conflict. The egalitarian, inclusive nature of a communitarian culture, where meaningful, cooperative relationships are valued, does not handle internal conflict well (Wexler, 2005, p.5). Given this, it is not surprising there is a proclivity within the agency to avoid conflict.

As a commitment to serving children, the COCDA's culture also emphasizes a child-friendly environment. Several walls have floor to ceiling murals of children's cartoons, and a paper mache tree decorates the front lobby. The fish aquarium and well stocked play room are a big attraction for children as they enter the facility. Even the front reception desk has been lowered to a child-friendly height.

In classifying the organizational culture as inclusive, one caveat must be added. Although the COCDA's internal environment is highly inclusive for staff who work on site, it is a different matter for those working in community settings. Most SCD Program Assistants work a thirty-five hour work week without spending any of their time at the COCDA. These staff are completely immersed in the culture of the community daycare or preschool they are assigned to. Due to the nature of their assignment, these staff are quite unfamiliar with the COCDA's culture and atmosphere. The SCD Program Assistants represent a fairly large contingent of staff, but so far management has not seen the lack of participation by this group in the COCDA's culture as a limitation, or concern.

Along with the characteristics inherent to a communitarian organizational culture, other internal dynamics exist. The more prominent of these dynamics is the different schools of thought represented by the different disciplines. OT, PT and BI tend to be anchored in a medical model of practice and conduct. In this model, documentation is more formal, and although the family's priorities are respected, professional opinion is also highly valued. On the other hand, IDP and SCD tend to be more community-based. The family's priorities are paramount and documentation tends to be kept in working files rather the client's central file. SLP is somewhere in the middle between the medical and community model.

At times the diversity of these different orientations strengthen the COCDA's internal processes. If managed well, the diversity represented by the two different paradigms, a medical versus community model can strengthen decision making (Garvin and Roberto, 2001, p. 110). At other times the different professional orientations become battle lines for turf wars. On these occasions, staff can easily get side-tracked into debates that amount to struggles over the pecking order of the different professional standings. There is both an upside and a downside to this element of the COCDA's culture.

4.6 Summary of the COCDA's Case Management Practices, Primary Value Chain and Culture

The COCDA's most prominent service is the stand alone option, where one practitioner works with the child and family. This form of service requires few resources.

Assessment, intervention strategies and discharge planning are implemented by one practitioner. The coordination of this service is straightforward. The assigned practitioner makes all case management decisions with limited involvement from colleagues, or the practitioner's supervisor.

The COCDA's more resource-intensive services follow a different delivery model. In the case of cluster and multidisciplinary services, more than one practitioner is involved with the child and family. Assessment tools and intervention strategies used in the stand alone service are also used for cluster and multidisciplinary services. However, under cluster and multidisciplinary services, the coordination of assessments, intervention and family support is important. If these activities and processes are not properly coordinated, service to the child and family can become fragmented, overwhelming and counter-productive.

In the case of multidisciplinary services case management is coordinated through regular team meetings. The standard for cluster service is quite different. Under cluster service, responsibility for case management falls to individual practitioners. A single practitioner might be designated as the case manager, but no standard is in place to ensure this. There are also no standards around the method, or frequency with which team members coordinate their activities. An informal, unstructured process for the case management of cluster service is a significant gap in the agency. This gap is compounded by the fact that no position in the organization's structure is responsible for ensuring some form of coordination is achieved through case management. Practices, such as proper documentation, timely collegial consultation, coordinated visits, and team meetings, are needed to ensure assessment and intervention are as effective and client-focused as possible.

The organization's openness, flexibility and informality seems to be both a strength and a weakness. The COCDA's culture is well matched with the organization's mission to serve young children with special needs. Employees who are dedicated to making a lasting impact on a child's life, find the high value placed on an autonomous organizational culture a good match. On the other hand, a culture and structure that emphasizes a high level of autonomy is not a good fit with sound case management practices. Reliable case management practice cannot be based solely on trusting relationships. In large organization, the risk of communication breakdowns is too great.

To counter some of the disadvantages to a relationship-based case management system, some work needs to be done to establish more formal guidelines and lines of accountability.

5 The COCDA's Strategy and Performance

The first section of this strategic analysis categorized the COCDA's programs, services and clients across different segments. The second step of the analysis described the competitive and non-competitive market forces in the COCDA's external environment. In the previous section the COCDA's resources, deficiencies, primary value chain for key services, and organizational culture were examined. Building on these previous steps in the strategic analysis, the current section is focused on developing a succinct, well-rounded description of the COCDA's current strategy and performance. Based on this evaluation the COCDA's prognosis, given emerging trends and pressures, will be forecasted.

5.1 The COCDA's Current Organizational Status

Taking the past two years into account the COCDA has been experiencing a modest expansion phase. Out of the five services, the Behaviour Intervention program's multidisciplinary service has grown the most during the last two years. In April 2004 there were approximately a dozen children accessing the COCDA's multidisciplinary service. In March 2006 there are currently twenty eight children enrolled in the service.

Other programs and services have also experienced growth, but this expansion is more recent. In fact, much of this growth occurred in the last three quarters of 2006. In the second quarter of 2005-2006 the Early Intervention program's (i.e. SLP, PT and OT) specialized service, stand alone service and cluster service grew by one point six FTE. This recent growth permits these services to carry a bigger caseload of children and families than before. Similarly, in the third quarter of 2006 the SCD program added four new FTEs to the existing staff roster. To add some context, this amounted to approximately a twenty percent increase in staffing.

The organization's administrative structure also expanded in the past year, with the creation of a part-time Quality Improvement Coordinator position. This position was created in response to the government's requirement for community service non-profits to become accredited by the end of 2006.

During the past two years, the only program that has remained at status quo is IDP. Although the number of IDP referrals continues to climb, the staff roster for this program has remained stagnate over the past five years. The other organizational dimension that has remained static is the physical infrastructure. The recent increase in staff has been manageable within the current facility. However, the facility is quickly reaching its limits. This shortage of space needs to be addressed if further expansion is to occur.

While the COCDA's program capacity has grown in size, the organization's scope remains the same. The COCDA's mandate to serve preschool age children with special needs and their families is a clear, relatively narrow scope. No effort has been made to expand this scope by branching into other areas of child development, or at an even broader level, other areas of community service. The organization's program and service menu has not changed since 2001, when the BI program was added to the existing slate of programs.

The number of incoming referrals from external partners obviously has a tremendous impact on the organization. A high volume of referrals puts pressure on the agency's waitlist and caseload management. Despite the importance of external referral volumes relative to the organization's operation, the COCDA has not made a move towards vertical integration. In maintaining an open door policy for all referrals, the COCDA has not tried to influence any element of the referral supply chain. The COCDA has been content to allow the rate of external referrals to evolve at their own pace.

5.2   Cost Orientation versus Differentiation: What is the COCDA's Strategy?

To some extent the COCDA adds value to the service it provides to children and families by harnessing key drivers of cost (Vining, 2005. p.7). The application of the same assessment tools and intervention strategies across the five different services represents economies of scope. A high level of dexterity is developed as these tools and strategies are repeatedly used over the long term. This expertise represents economies of learning (Birkmeyer and Young, 2000, p. 284; Birkmeyer, Siewers, Finlayson, Stukel, Lucas, Batista, Welch, and Wennberg, 2002, p. 1129; Waldman, J.D.,

Yourstone, S.A. and Smith, H.L., 2003, p. 42). A lean administrative structure, in proportion to front-line services, indicates the organization is taking advantage of economies of scale. All of these advantages represent significant organizational efficiencies. These efficiencies suggest the organization might be focused on a cost orientation, but this evidence only tells part of the story.

In actuality the COCDA provides a differentiated service. The organization's effort to differentiate itself is evident by the investment made in developing and maintaining service quality. The organization is very serious about delivering a quality service on two fronts. First, the organization strives to deliver quality in order to ensure the optimum impact on a child's development and parent's satisfaction. There is little formal data to support this assertion. There is, however, a great deal of anecdotal information from parents about the positive impact of COCDA's services on their child's development.

In addition, the organization also strives to deliver a family centered service. In striving to be family centered, the goal is to make services highly customized to suit individual family needs. The best way to create an individualized service is to ensure parents and guardians are the case manager for their child's service. Any system that allows families to set the priorities for their child's service plan, and to make decisions about intervention options and equipment options is not a cost oriented service. A system where parents play a central role in how their child's service is designed and delivered is a differentiated service.

5.3 Assessing the COCDA's Performance as a Differentiator

The COCDA's current strategy is to deliver a quality service rather than focus on a cost orientation. While the COCDA is committed to delivering a differentiated service, it is not clear how successful the organization is in accomplishing this. As a result, the next step is to review evidence that indicates whether the COCDA has a strong, clear differentiation strategy, or a weak, muddled differentiation strategy. In evaluating the COCDA's strategy, the following four dimensions will be examined: inputs, processes, outputs and outcomes (Canadian Health Council on Health Services Accreditation, 1996, pp. 12-14).

5.3.1 Measures to Differentiate Inputs

In terms of inputs, the organization's most critical resource is the practitioners who deliver the service. High recruitment standards, and retention strategies associated with a flexible work environment and superior vacation benefits ensure COCDA services are staffed by highly qualified and motivated practitioners. The promotion of ongoing professional development ensures practitioner's skills remain current with new developments in the field. To support professional development, the COCDA allocates over twenty five thousand dollars to staff every year to sponsor travel costs and conference or workshop registration fees.

Another input where the COCDA exercises quality control relates to the tools practitioners use. Standardized tools are used to assess children's strengths and needs, when appropriate. The reliability and validity of these assessment tools have been measured and recognized by university programs and professional councils. In other words, staff are using industry standard tools to carry out a vital component of their work.

5.3.2 A Mixed Report on Quality Processes

Staff are committed to following best practices in their respective fields. The standards around best practices are constantly evolving as research findings and trial programs expand the existing base of knowledge. A commitment to professional development helps practitioners to remain current with the best practices in their respective disciplines.

Keeping abreast of best practices works well at the individual practitioner level. It ensures practitioners are using the best assessment tools and implementing the best intervention strategies. Best practices not only apply to individual practitioner techniques; best practices also apply to team-based case management strategies.

One service in particular, the multidisciplinary service, follows a strong case management process. The monthly team meetings between parents, behaviour specialists, OTs, and SLPs is an ideal process for ensuring service remains coordinated, responsive and focused.

The same cannot be said for the COCDA's cluster service. With several practitioners involved, cluster services also require a great deal of coordination, but unfortunately this is an extremely weak aspect of the service.

There is no organizational standard for the case management of cluster services. Individual practitioners have a great deal of leeway in setting case management processes for each cluster service. Due to different professional paradigms and personality clashes, this informal system of case management tends to be highly susceptible to breakdowns. This is weakness is clearly illustrated by the fact that some cluster services are offered in a serial, fragmented fashion. Serial cluster services are not an intentional goal of the organization. Instead, serial cluster services are the by-product of weak case management practices.

5.3.3 Shifting Outputs Away from Quality

In the past, the organization's goal was to produce quality outputs. By focusing on quality outputs the COCDA tried to maximize the amount of service delivered to each child. The quantity of outputs, namely the number of children and families served, was not an issue. Rather, the agency's focus was on the quality of the output, which meant every effort was made to maximize the number of sessions and visits provided to a child. In focusing on maximizing the number of intervention sessions per child, the COCDA was clearly providing a differentiated output.

Steady, significant increases in the number of referrals on an annual basis, without a complementary increase in staff, caused the organization to re-evaluate its output. Over the past three years the COCDA has shifted away from quality outputs. For example, three years ago the SLP program moved to a block therapy model, where children receive a limited amount of regular service before moving to a monitoring service. Rationing some forms of regular service, while increasing monitoring services, allows more children to be served in a year. This does come at the expense of lowering the number of intervention sessions per child. By increasing the volume of clients, the trade-off is that clients receive a less intense service. Fewer intervention sessions per child equate to a lower quality output of service.

SLP services are not the only instance where quality has been compromised in order to carry larger caseloads. IDP has decreased the intensity of its regular service from one visit every two weeks to one visit every three weeks. PT and OT are also delivering a less intense service. Children on the regular PT and OT caseload are now receiving fewer visits per child than delivered in the past.

All this evidence clearly suggests the COCDA has pulled back on many of its outputs by shifting to a less intense service. With specific reference to the quality of outputs, the COCDA has shifted away from being a strong differentiator, to a more moderate position where quality is still given some consideration, but is no longer top priority.

5.3.4 Inconclusive Evidence on Differentiated Outcomes

Delivering quality outcomes is a priority for a community service agency serving a special population. All COCDA services are oriented towards supporting parents and towards improving children's development. If COCDA services are successful, parents should report a high level of satisfaction with the organization's service, reduced stress levels and a sense of empowerment in relation to their child's delay or disability. In terms of child-related outcomes, a successful service leads to the majority of children making significant gains in terms of their language and communication development, motor skill development, internal regulation, and social skill development.

Target outcomes exist, but unfortunately the organization does not measure its performance along this dimension. A parent survey was conducted in 2002, at which time eighty two percent of the forty respondents were satisfied or very satisfied with COCDA services. This survey took place prior to the COCDA's shift towards a less intense service. It is only speculation, but given the organization's move away from high quality outputs, it is possible a decrease in the intensity of service also impacted on service outcomes.

If the COCDA is delivering fewer visits and less support to children and families, it is possible children are also making less developmental gains. With less support, parents might also experience higher levels of stress, and less empowerment around

their family's situation. It should be emphasized this is merely speculation, and as such, needs to be treated with caution.

It is not entirely clear a less intense service automatically translates into reduced outcomes. A direct one-to-one relationship between outputs and outcomes may not exist. The intensity of services may have to drop-off dramatically before outcomes are affected. Taking all this into account, there is not sufficient evidence to determine if the COCDA is a strong differentiator in terms of quality outcomes, or if it has shifted to a less differentiated position. One conclusion can still be drawn, however. If the COCDA claims it provides quality outcomes to the population it serves, the organization needs to do a much better job at measuring its performance on this dimension.

5.3.5   Is the COCDA a Strong or Weak Differentiator?

In looking across each of the four dimensions, the evidence suggests the COCDA has a weak strategy when it comes to delivering service. The organization's inputs and some of its operational practices emphasize a quality approach to delivering service. On the other hand, case management practices and many service outputs de-emphasize quality. For example, the organization takes an undisciplined approach to the case management of cluster services. Although it was done in a more conscious manner, the organization has also reduced the quality of output for its stand alone and cluster services. Decreasing the intensity of the service makes it a less differentiated service.

The COCDA's variable strategy towards the delivery of quality service makes it a mixed differentiator. Previously, the organization's strategy was much more consolidated and fixed on delivering quality. It was a focused strategy (Campbell-Hunt, 2000, p. 127). Largely in response to an increasing demand for service, the organization has abandoned its position as a strong differentiator, to adopt a less-focused, weaker strategy.

The aim on the next section is to determine if the shift to a less differentiated service is a good strategy for the COCDA. Considering the challenges and opportunities currently facing the organization, is the COCDA's weak differentiation strategy a good

course to follow? Looking further into the future is a weak differentiation strategy a good fit with the emerging challenges and opportunities in the child development sector?

5.4 The Fit between a Mixed Strategy and the Current Situation

The main pressure currently facing the COCDA is the upward trend in referrals documented in Chapter One. As the population in the Central Okanagan continues to grow, and as community services continue to improve early identification strategies, the number of children and families referred to the COCDA will remain on an upward trend.

The additional funding the agency received in 2005-2006, which was only partially used to increase the number of staff, helped to temporarily reduce waitlists. Nonetheless, a sizable gap still exists between available resources and community demand.

Waitlist and caseload pressures are closely linked with output. Given the pressures created by increasing referrals, adopting a mixed differentiation approach, particularly in terms of outputs, is a sound operational strategy. In the face of an overwhelming demand, holding fast to high quality service outputs is challenging. If service demand does not subside, a strong differentiation strategy eventually leads to an enormous backlog on waitlists. In turn, the more waitlists grow, the more the organization is pulled away from delivering an early intervention service.

If service can be delivered in a way that still adequately meets family's demands, but at the same time allows more children to be served, the COCDA would be foolish to not adopt such a strategy. In this way, the current mixed differentiation strategy in relation to organizational outputs and processes is a practical approach for trying to manage over-subscribed services.

Although a mixed differentiation strategy is a practical solution in attempting to address increased demands, an argument can be made that it is not a sound service strategy. In the context of the two generic strategies the, "...failure to choose between one of cost – or differentiation orientation – leadership will result in inferior performance, the so-called 'stuck in the middle' [conundrum]" (Campbell-Hunt, 2000, p. 127). By combining an emphasis on quality with an emphasis on through-put in one single service

strategy, the COCDA runs the risk of being muddled. In trying to do both, there is a risk neither priority will be served well. In fact, evidence suggests that firms focused on a focused, cohesive strategy outperform firms that are trying to balance differentiation and efficiency (Ebben, J. J. and Johnson, A. C., 2005, p. 1249).

5.5 Does a Mixed Strategy fit with the COCDA's Short-term Future?

Over the next three to five years, the COCDA's ability to handle three factors in the external environment will determine the organization's future. One of these external factors, an upwards trend in the demand for service, has already been discussed. Two additional factors, a highly competitive labour market, and MCFD's commitment to increased accountability were identified in Chapter Three.

The main government funding agent in the child development sector, MCFD, is increasing the amount of accountability demanded of contractors. Previous contracts, which were essentially unconditional grants, are being replaced by more business oriented contracts. As contractor service providers, operations like the COCDA are now being held accountable for the inputs, outputs, and outcomes associated with each MCFD contract. For a sector that is unaccustomed to this level of accountability, and to this style of operation, MCFD's change in contracting practices is a significant shift. To ensure the COCDA remains a service provider of choice with the Provincial Government, the organization's strategy needs to be in-sync with MCFD's new direction.

Another emerging factor in the external environment is a highly competitive labour market. The recruitment and retention of highly qualified staff is emerging as a significant challenge. There is every indication this trend will continue for some time.

If the COCDA is not able to recruit and retain skilled and knowledgeable practitioners, the quality of service will suffer. This is not the only concern. If turnover and staff vacancies become a problem, the organization will not be able to serve as many children and families. As soon as a staff vacancy occurs for any length of time, referrals back-up and the waitlist grows. If a staff vacancy persists, or if a number of staff vacancies occur, the waitlist can grow to a point where it is extremely hard to recover from the backlog. Once service delivery falls behind, it is hard to regain the lost ground. If the organization's strategy is not sensitive to a competitive labour market, the

COCDA's viability could be threatened. Without the required staffing, the organization will not be responsive to community demand, nor will it be in a position to deliver MCFD's deliverables around inputs, outputs and outcomes.

Given the pressure created by increased referrals and the move to a more accountable system, the COCDA's mixed differentiation strategy has some advantages. When referrals surpass the organization's resources, maintaining service delivery that focuses on nothing but quality is a problematic strategy. To keep pace with referrals in a way that makes early intervention obtainable, and that keeps waitlists in check, some service quality has to be traded for higher output. The COCDA's reduction in service intensity to increase caseload numbers, is a prime example of such a trade-off. Children are still progressing and families remain satisfied, but the number of children served increases.

As a contract administrator with limited funds, and a strong sense of obligation to the community, MCFD will find such a trade-off to be not only acceptable, but also desirable. From MCFD's point of view, the COCDA's increased through-put is a positive accomplishment. If this means the COCDA delivers a lower quality service, but one that is still adequate, MCFD is willing to accept this trade-off. As the COCDA becomes more accountable to MCFD in the future, it is important for the organization to demonstrate it can manage community demand.

A less differentiated strategy works well for outputs, but not for core operational processes. Increased accountability to MCFD means government funding agents will be looking at the organization in very different terms. For the first time, government agents will be concerned about the COCDA's main facets of operation. A case management process, where standards are lacking, raises concerns about the quality of service. If quality outcomes are to be achieved and if a satisfactory balance between quality and quantity is to be achieved, a strong case management process needs to be in place. Good case management ensures quality inputs are converted into the desired outputs and outcomes. A weak case management process will prove to be a major liability in the near future, as community demand and accountability continues to increase.

In the case of an increasingly competitive labour market, a mixed differentiation strategy offers both advantages and disadvantages. Encouraging professional

development and offering superior vacation benefits, boosts recruitment and retention. On the other hand, a shift to less differentiated outputs deters recruitment and retention. Practitioners find the opportunity to make a significant difference in a child's life intrinsically rewarding. However, if practitioners are required to roll children through their caseload, to keep pace with referrals, job satisfaction suffers.

An emphasis on higher outputs provides less opportunity for practitioners to form a bond with their clients, and less opportunity to directly impact on a child's development. As long as parents and caregivers remain committed to improving the child's development, the service outcome might not change. In a competitive labour market, however, increased through-put can negatively impact on recruitment and retention.

In addition to external challenges, the COCDA also faces a significant internal obstacle. Opportunities for further program growth could arise in the near future. Children's services are riding a wave of political and public popularity that could last for several more years. If opportunities for expansion occur in the next few years, the COCDA does not have the physical space to accommodate further growth. The COCDA needs to plan the next phase of its facility expansion if the organization is to be poised to handle growth opportunities. If a plan is not in place, significant opportunities could be lost.

5.6 Summarizing the COCDA's Strategic Fit: Current and Future

The COCDA's current strategy as a mixed differentiator fits reasonably well with the current environment. De-emphasizing the quality of outputs allows the organization to keep pace, to some degree, with increasing referrals. The extent to which case management practices have been allowed to drift from quality standards does not fit the commitment to provide a differentiated service. It also a mismatch for the complexity of coordination associated with multi-program services Since MCFD requires little accountability at the moment, and families tend to be appreciative of any service that is offered, the current gaps in case management are not a significant liability. This may not always be the case.

In the next three to five years, the child development sector is expected to change. A tighter labour market, greater accountability, and higher referral rates are emerging trends. The COCDA's mixed differentiated strategy is not up to the task of meeting these new challenges. A mixed strategy sends a confusing message to staff, as it is not clear whether the organization is striving towards quality service, or adequate service, but at higher volumes. It is hard to do both. A muddled, confusing service strategy can leave staff confused, even disenfranchised. In a tight labour market the possible negative impact of a mixed strategy is a concern. Similarly, as accountability increases, funding agents will be looking for service providers with clear, deliberate, sophisticated strategies. A mixed strategy, where the most prevalent services are compromised is not going to win high marks with government.

6 Selecting the COCDA's Future Strategy

Based on the evaluation of the COCDA's strategy in the previous chapter, the organization is not facing a crisis, or at a crossroads. The COCDA is financially healthy, it has a strong team of skilled practitioners, and service delivery is based on a somewhat cohesive strategy.

The COCDA, similar to many public sector enterprises, is struggling to keep pace with increasing community demand. The Provincial Government's ability to expand existing programs is limited. In response to the pressure from increasing community demand, the COCDA has started to de-emphasize quality. In an attempt to keep up with referrals, the intensity of stand alone and cluster services have been decreased. This shift, combined with the COCDA's historical gap in case management for cluster services, means the organization has a mixed strategy. Some services emphasize quality, while others have lowered quality standards in order to boost output.

A mixed differentiation strategy does have benefits. There is a danger, however. If the organization moves too far away from a strong differentiation position, its overall strategy becomes confused and muddled. As a result, performance suffers (Ebben, J. J. and Johnson, A. C., 2005, p. 1249). Staff become unsure of how to deal with a mixed message; is their assignment to provide quality, or adequacy?

Not only is the COCDA in danger of losing its identity as a quality service provider, there are also some new developments the organization needs to adapt to. The COCDA's major funding agent, MCFD, is requiring much more accountability than in the past. Every indication is that the government is moving to a business model, after years of operating like a charitable foundation. If the organization is held more accountable, a cohesive, deliberate strategy is needed. A muddled strategy does not build confidence and credibility with funding agents.

Another dynamic in the external environment is a changing labour market. The unemployment rate is the lowest it has ever been. Competition for hard to recruit positions, such as, SLP, PT and OT, is increasing. Recruitment and retention problems are a new concern for the COCDA.

After a recent round of modest expansion, the organization is now facing a significant shortage of space. The facility no longer has capacity for further growth. Some storage space has been converted to office space, which is far from ideal. Booking treatment space within the facility is a challenge, at times. A shortage of space needs to be addressed if the COCDA is to have room to grow and remain a service provider of choice in the community.

Given the risk of falling into a muddled strategy, and some of the emerging challenges, the COCDA needs to consider alternative options.

6.1 What are the Strategic Alternatives?

In developing and selecting a strategy, several factors must be taken into account. An organization's strategy needs to be responsive to external factors, including market opportunities that offer avenues for growth (Thompson and Strickland, 1998, p. 113). Strategy also has to take into account the organization's resource capabilities, either the resources already in existence, or the resources that can be acquired (Thompson and Strickland, 1998, p. 113). Lastly, strategy must also fit with the organization's financial status and corporate goals. Taking all these factors into account, strategy development is about, "…capturing a company's best growth opportunities and creating defences against external threats to its competitive position and future performance" (Thompson and Strickland, 1998, p. 113).

In weighing all these factors there are several alternative strategies to consider. In point form, these alternative strategies are:

1. Maintain status quo
2. Increase service intensity and integration
   a. by narrowing the scope
   b. by limiting eligibility
   c. by increasing revenue
3. Change service design to a mass delivery format
4. Combine mass delivery services with quality-based services

The following sections will provide further explanation and elaboration on each of these options. Once the strategic alternatives are outlined, the COCDA's primary goals

will be identified. These goals will guide the evaluation and selection of the best strategy for the COCDA.

6.1.1 Alternative #1: Maintain Status Quo

One option is for the COCDA to maintain its current strategy. Status quo consists of delivering a quality-based service across the following caseloads: multidisciplinary, group, and needs-based. In contrast to these caseloads, the two most utilized services are less committed to delivering quality. Specifically, stand alone and cluster services are delivered with less intensity. The difference in intensity between these two tiers of services is quite noticeable.

Another key element of the COCDA's service delivery model is case management. Under the status quo strategy, case management practices are also inconsistent. The multidisciplinary service model is built on strong case management practices, while cluster service has a loose, informal set of guidelines. Given the dynamics and complexity of a cluster service, the discrepancy between cluster service and other services is striking.

This mixture of high quality and moderate quality services and processes leads to a muddled, confusing strategy. Under these conditions the COCDA is not a strong differentiator; it is somewhere in the middle.

6.1.2 Alternative #2: Increase Service Intensity and Integration

This scenario involves adopting a strategy where quality outputs and processes are top priorities. To improve the organization's outputs, the intensity of stand alone and cluster services can be increased. Increasing the intensity of service, in terms of the number of sessions or visits per child, increases the quality of output. For example, in this scenario children on the SLP caseload would get block therapy for as long as they need it. At present, stand alone and cluster services associated with the SLP program are rationed. Each child accesses a maximum of eight months of service, after which they are placed on a monitoring caseload. Similarly, children on the IDP, PT and OT caseloads would receive one session or visit every two weeks, rather than the current standard of one visit every three weeks.

A stronger focus on quality also carries implications for case management. To enhance the organization's core operation, gaps in the case management practices for cluster service need to be addressed. The implementation of periodic team meetings, where the agenda focuses on integrating the efforts of involved practitioners, is the best method for improving case management. To support the implementation of team meetings, a case manager needs to be appointed. The primary role of a case manager is to recognize the need for a team meeting, to facilitate the team discussion and agenda, and to monitor the team's performance.

The emphasis on improving the quality of outputs and the quality of operational processes puts this strategy in the category of a strong differentiator. Increasing service intensity and case management integration differentiates the COCDA from other child development services in the community.

There is a possible downside to a strong differentiation strategy. If the intensity of service increases without increasing staff resources, waitlists are bound to increase. It is difficult to estimate the impact of a strong differentiation strategy on waitlists, but it is quite conceivable wait-times could double. Where wait-times are now six months, under a differentiation model wait-times could increase to twelve months. Prior to the introduction of block therapy, children referred to the SLP program waited eighteen months before being picked-up on caseload. This was also at a time when the annual referral rate was below two hundred children. Considering the continual upward trend in referrals, a doubling of the wait-time under a strong differentiation strategy is very conceivable.

If the intensity and integration of services is increased, the negative side-effect on wait-times could be counter-balanced by one of three options. One option is to narrow the scope of the services. Another option is to narrow the eligibility criteria for accepting referrals, and a third option is to increase revenue.

6.1.2.1 Narrowing the Scope of Service

If the decision is to narrow the scope of services, the COCDA's needs-based service could be eliminated. Children in need of a rapid response, or monitoring support could be redirected to practitioners in private practice. Families would have to pay for

private service out-of pocket, but the COCDA could reinvest resources from needs-based services into boosting the intensity of stand alone and cluster services.

6.1.2.2 Narrowing the Eligibility of Referrals

Another option is for the COCDA to limit the number of referrals accepted for service. Criteria could be developed for screening out children with minor delays. Again, these referrals could be redirected to the private sector, and only those children with significant delays and disorders get support. Limiting eligibility criteria is a way to manage inbound logistics. By placing higher control on inbound logistics, the size of the population deemed eligible for service can be restricted. Limiting the number of eligible clients makes the caseload much more manageable, if intensity and integration is increased.

6.1.2.3 Increasing Revenue

An investment in more intense, integrated services can also be supported through an increase in operating revenue. Since all of MCFD's financial resources are fully allocated, the most viable option for increasing revenue is to enter into a major fundraising campaign. A fundraising campaign of this nature involves garnering donations from community supporters. Additional revenue can also be obtained through grants and foundations, but this revenue is usually conditional on increasing the scope of services. In this case, the new funding goes into adding new services, and not into enhancing the current service offering. Under these circumstances grant or foundation funding is not a viable method for increasing the intensity and integration of services.

6.1.3 Alternative #3: Change Service Design to Mass-Delivery

At the opposite end of the continuum from an emphasis on quality, the COCDA has the option to switch to a cost orientation. Switching to a cost orientation requires a complete redesign of the service. One model of service which fits a cost orientation is the adoption of a mass-delivery process. Rather than offering a differentiated service through individual sessions, several children and families can be seen en-masse at the COCDA's facility.

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Children and families can be assembled in small groups according to the level and nature of need. Information and suggested activities can be delivered to parents in a lecture style format. For this type of service, the agenda is largely on delivering information. There is little opportunity for interaction and delving into family support, or parent's questions. The session is strictly focused on transferring knowledge from the practitioner to the group. In this scenario children and parents are viewed more as a category than as individuals.

A cost oriented group service is quite different from the group service currently offered. In the SCD program's group service, children with special needs participate in preschool and daycare programs with several other children. Depending on the program, children follow a tight or loosely scheduled curriculum. Regardless, a great deal of attention is paid to each child in assisting them with each activity throughout the day. Each child has their own individual service plan, and a team of designated service providers.

Under a cost orientation scheme, individualization disappears. Information is imparted in an impersonal way. Children and families do not receive a specialized service. It is a pre-packaged service that provides basic support and a generic response to a range of common child development issues. A mass-delivery format is far more about coaching parents, than intervening directly with the child. In this format it is largely up to parents to make a difference in their child's development. A mass-delivery service is completely consultative. While there are elements of a consultative approach in the COCDA's current service offerings, the vast majority of current service delivery focuses on working directly with the child. Current services are delivered through a hands-on format.

Although a mass-delivery service does not deliver individualized support, it does increase the COCDA's through-put capacity. It is quite possible this format might wipe-out existing waitlists. For an agency always plagued by waitlists, this is an enticing possibility. At the very least, it is bound to significantly reduce wait-times.

6.1.4 Alternative #4: A Focused Hybrid Strategy

The COCDA's current strategy attempts to rationalize resources as much as possible without compromising the quality of service too much. This is a difficult balancing act, especially when the strategy is more reactionary than strategically planned. It is not surprising the COCDA's current response has lead to a mixed, somewhat muddled strategy. The COCDA's mixed strategy currently achieves rationalization through a reduction in the quality of services, and not through concerted cost-based strategies.

In adopting a more focused strategy, the COCDA can shift to a targeted approach, where some services are cost-oriented, while others emphasize quality. The COCDA's needs-based service, both the rapid response and monitoring caseloads, can be shifted to a cost orientation. Rather than making individual calls, monitoring services can be offered through a mass-delivery process. Every six weeks parents who have concerns, or are interested in checking-in with their consultant, can have the option of attending a two hour group session. Practitioners do not prepare for the session. The intent is limited to checking-in with families and reacting to any questions or concerns. If needed, parents can be pulled out from the group on an individual basis to ensure discussions remain private and parents feel free to talk.

The follow-up caseload under the COCDA's stand alone service can also be delivered in a mass-delivery fashion. Rather than contacting families individually and providing a relatively high quality of family support, families can be invited to a group session. Again, a quick check-up can be carried out by the practitioner and if there are any concerns from the family, a subsequent one-on-one session can be arranged.

The rapid response caseload can be delivered as a cost-based service, as well. In these circumstances families largely need a highly focused, timely response to their child's developmental concern. Once the immediacy of the developmental concern is addressed, the child is either discharged or transferred to a stand alone or cluster service caseload. Often a full-scale intake and assessment process is not needed. Skilled practitioners can get a quick read on the child's status and design an intervention plan. If the family does need service beyond the rapid response caseload, a detailed intake and full assessment can be done at a later time.

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In addition to targeting a cost-based approach for some services, quality outputs and processes can be targeted for other services. As described in the second alternative, the intensity of stand alone and cluster services can be increased. In addition, the integration of cluster services can be enhanced and standardized by implementing team meetings as a case management tool.

Service intensity does not have to be as high as it was in the past, but the option to provide children with complex needs a more intense block of SLP therapy, or more frequent IDP home visits, would be a great benefit. As mentioned earlier, for cluster service to be truly effective, the serial caseload should be eliminated. The entire cluster service option would benefit from a more integrated case management process. If some services are offered through a cost-based model, the savings can be reinvested in boosting the intensity and integrity of other services.

6.2   Establishing Criteria to Evaluate Strategic Alternatives

Without a strategic plan in place the COCDA does not have formal goals for guiding the agency. Nonetheless, the organization's mission statement and method of operation can be used as guides for identifying several goals. These goals will provide a framework for evaluating the strategic alternatives. Table 11 lists an overview of these goals. All of these goals are not at the same priority level. To distinguish the more important goals, Table 11 assigns a weight to each goal. This ranking will be taken into consideration in evaluating each strategic alternative.

Table 10: An Overview of the COCDA's Goals

Goal	Weight	Description	Relevance
Early Intervention	4.0	Provide support and intervention as soon as a delay or disorder is identified.	Children's physical, emotional and cognitive systems are more malleable in the early years. Significant developmental gains can be achieved.
Family Centered	2.5	Families set priorities and make the final decision on intervention plans.	Families know their child and family situation the best.
Optimum Child Development	4.0	Support and intervention aim to promote the greatest possible developmental gains.	The organization and staff place a high priority on making a difference in a child's life.
Maximum Utilization of Human Resources	3.5	The organization has highly skilled practitioners who have a great deal of knowledge and techniques to share with families.	Practitioners who specialize in child development are scarce. This resource needs to be managed well.
Responsive to all Referrals	2.0	Referrals are accepted from all sources. As long as the child is under age 6, the family will receive service.	All concerns related to developmental delays or disorders are treated as credible. Eligibility for service remains high.
Fits the Culture of Autonomous Service Delivery	1.5	The COCDA's culture emphasizes autonomous practice.	The selected strategy needs to fit with the existing culture to garner employee "buy-in".
Feasible and Low Risk	1.5	The implementation of a strategy often involves more financial investment, more resources than others.	The COCDA has limited capacity to invest additional funds and human resources into new initiatives. Risk tolerance is low.
Incremental	1.0	Organization is not in crisis, or at a crossroads. Fine tuning is needed, but not radical change.	The selected strategy needs to fit the organization's status and need.
Total Weight	20.0		

6.2.1 Early Intervention

In serving young children, one of the primary goals is to get service and support to a child soon after a delay or disorder is identified. Young children are at an impressionable, malleable stage of their life cycle. As a result, support and intervention during the early years can have a significant impact. This window of opportunity is limited, which puts pressure on service providers to get to children in a timely fashion. If a child development service is not good at managing the turn-around between the date of referral and the initiation of service, the opportunity to make a difference can be lost, or reduced.

6.2.2 Family Centered

Providing a family centered service is a priority for the COCDA. Not only is it part of the mission statement, it is also part of everyday practice. A strong belief in this goal is espoused by staff.

A family centered service denotes families as the chief decision maker in setting priorities for their child's service plan. Parents know what is best for them and their child. Parents have the option to chair team meetings and to make the ultimate decision on accepting or rejecting a referral to another service. Practitioners might identify different priorities for a child's development, but these opinions take a backseat to parent's wishes in a family centered service.

Of course, parent's priorities do not completely rule the decision-making process. There are constraints within which service is delivered, such as scheduling logistics, resource availability and efficiency considerations. Due to practical demands, family centered service is delivered within the context of several organizational constraints. This is different, however, from practitioners exerting full control over the child's intervention plan.

6.2.3 Striving for Optimum Development

The promotion of optimum child development is another goal captured in the COCDA's mission statement. In stating this goal, the organization's intention is to

optimize the impact of services on a child's development. Regardless of the severity of a delay or disorder the COCDA is intent on making a difference with respect to the child's development and the family's quality of life. In some instances this is an enormous challenge. In these situations the COCDA is still intent to do more than maintain the child's present level of functioning and quality of life. The ultimate goal is to make a difference, no matter how small.

6.2.4 Maximum Utilization of Skilled Practitioners

Skilled practitioners in the field of child development are a scarce resource. For example, university and college programs produce a limited number of OTs and Early Childhood Educators (i.e. SCD Program Assistants) every year. Not only does the COCDA have a scarce resource, the organization invests a great deal in the recruitment and development of its human resources. Given the scarcity and value of the COCDA's practitioners it is imperative this resource is used effectively. The use of staff time must be organized in a way to ensure the greatest number of children and families get the most benefit. In short, the COCDA's service model needs to deploy practitioners effectively.

6.2.5 Remain Responsive to Every Referral

It is not an element of the mission statement, but in practice the COCDA accepts every referral. Other than age limits imposed by government, there is no criteria for limiting referrals. Every referral, regardless of the source, is deemed an appropriate referral. The organization's culture has always emphasized a universal, equitable approach to delivering service. Concerns about a child's development, regardless of the nature or source, have always been treated seriously.

6.2.6 Fits the COCDA's Culture

Implementing a strategy that does not take into account the organization's existing culture could prove disastrous. Current service delivery is based on a culture of individual autonomy. Practitioners have a great deal of influence over the content, pace, and quality of service delivered to each family. Some of this autonomy needs to be reigned in, particularly with respect to case management practices. In most cases, this

high level of practitioner autonomy works to enhance service. It enriches practitioner's work and instills a high level of ownership, which motivates staff to deliver quality results. Since organizational culture is a key component to the COCDA's success, the selected strategy needs to mesh with the current culture.

6.2.7 Feasibility and Level of Risk

Most of the COCDA's resources are committed to service delivery, and resources at the management level are relatively lean. The agency simply does not have the capacity to undertake massive change. The level of change needs to fit the organization's capacity, both in terms of financial resources and human resources.

The agency also has a low tolerance towards risk. Ventures that involve a modest to high element of financial risk are not tolerated by the Board of Directors. Government funding levels are not adequate for the level of community need. The scarcity of funds creates a high level of risk aversion in the Board of Directors. Instead of risking funds, Directors are more interested in finding ways to maximize resources without compromising service.

6.2.8 Incremental

Since the COCDA is doing relatively well, and not struggling, preference is given to alternatives that involve an incremental level of change. Not only does the agency lack the capacity to implement radical change, it is also at a point where radical change is not needed.

6.3 Evaluation of the Strategic Alternatives

Each of the strategic alternatives, including the variations associated with increased service intensity and integration, can be evaluated against the COCDA's eight goals. The results of this evaluation are summarized in Table 12.

Table 11: Evaluating the Strategic Alternatives against the COCDA's Priorities

Goal	Goal Weight	Status Quo	Intensify & Integrate Service			Mass Delivery	Targeted Cost and Quality
			Limit Scope	Limit Eligibility	Increase Revenue		
Early Intervention	4.0	3	3	3	4	5	4
Family Centered	2.5	3	3	2	4	1	3
Optimum Child Development	4.0	3	3	3	5	2	5
Maximum Utilization of Human Resources	3.5	3	4	4	3	1	4
Responsive to all Referrals	2.0	4	1	1	4	5	4
Fits the Culture	1.5	4	2	2	5	1	4
Feasible and Low Risk	1.5	5	3	1	1	1	4
Incremental	1.0	5	5	4	2	1	2
Total Score	**20.0**	**68.5**	**60**	**53.5**	**75.5**	**48**	**79.5**

Note: 1 = low score; 5 = high score

6.3.1 The Status Quo

The status quo option fits moderately well with the COCDA's priorities. In fact, this mixed differentiation strategy achieved the third highest ranking out of the six strategic options. The main drawback to this strategy is its modest performance on several key outcomes. The status quo strategy delivers mediocre results in several key areas, such as, early intervention, family centered service, optimum child development, and the maximization of human resources.

On the positive side, this strategy is easy to implement and fits the description of an incremental change. The status quo carries extremely low risk and is obviously very feasible to implement. The status quo strategy is also a reasonable fit with the COCDA's autonomous, communitarian culture.

6.3.2 Intensifying and Integrating Service by Limiting the Scope

Although this differentiation strategy coincides with the COCDA's emphasis on quality service, it does have several elements that are not a good fit. Limiting the scope of service directly opposes the organization's desire to serve all referrals. This option narrows the range of the COCDA's responsiveness to the overall community demand, which is a severe limitation.

This limitation impacts on several other priorities. An intense, integrated service is only family centered for those families whose needs fit the scope of services. It is not a family centered service for children with a developmental delay or disorder that is outside the scope of service. To some extent an intense, integrated service also promotes early intervention and optimum child development. However, for those children and families who do not fit the scope of service, finding a different high quality, timely option is extremely difficult. For these families the COCDA certainly does not promote early intervention, or optimum child development. A limited scope strategy works for the majority of referrals, but for some families it does not work at all. The lack of inclusiveness limits the rating of this strategy across the early intervention, family centered and optimum child development priorities.

An intensification and integration strategy made possible by limiting the organization's scope does maximize the use of the COCDA's human resources. Under this model, practitioners have enough contact with families to maximize the impact of their skills and expertise. In this way, a limited scope strategy is an improvement over the status quo. Once again, this strategic advantage is somewhat limited by the fact that not all children will have the opportunity to benefit from the COCDA's expertise.

A limited scope strategy is feasible to implement, but it does carry some risk. For families who are denied service, but previously would have qualified, this alternative is

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unacceptable. There is some risk these excluded families will protest the COCDA's restructuring of service.

A limited scope strategy involves an incremental change, which fits the agency's need, but it does have a questionable fit with the organization's culture. Practitioners, who are used to exercising autonomy over their work, and who welcome challenges and opportunities for growth, will not approve of a restriction in the scope of their work. In this way, getting buy-in from staff is a challenge for a strategy that limits the scope of work.

After delivering services to a broad range of child development referrals, narrowing the scope of services will not be easy. For an organization whose identity is intent on serving the community, narrowing the scope of service is not an appealing option.

6.3.3 Intensifying and Integrating Service by Limiting Eligibility

For the most part, a strategy where service is differentiated by limiting children's eligibility has a similar fit, as a strategy where the scope of service is limited. There are a few notable exceptions, however.

Limiting the eligibility of service according to a child's age, or the severity of the reported delay or disorder is difficult to accomplish. It involves a complex screening system in order to sort referrals and to identify children who are ineligible. Even developing criteria to determine eligibility is extremely difficult. For these reasons the feasibility of this strategy is low.

Age is a clear standard to impose for eligibility criteria. The difficulty is determining where to draw the line. There is no clear rationale as to why younger children, or older children should be identified as a priority. A strong case can be made for both. Even if a specific age criterion is set, if a child is within one or two months of the cut-off, it is extremely difficult to deny service.

The severity of the delay or disorder is also a difficult criterion to use. There are a number of variables connected to child development. Determining which of these

variables can be used to weigh the eligibility of each referral is a difficult task. At some point, drawing the line between an eligible and ineligible referral becomes arbitrary. If a family or caregiver sees their child's development as a priority, it is difficult to classify the referral as inappropriate. This is especially the case when the selection criteria are somewhat arbitrary.

The difficulty in defining and implementing a screening system that determines the eligibility of all incoming referrals is a daunting and somewhat arbitrary task. Given the complexity of developing such criteria and their susceptibility to challenges and appeals, there is a high level of risk associated with this strategy. If eligibility criteria were implemented, this strategy runs a high risk of coming under attack by families who are denied service. For this reason, a strategy which limits eligibility is also not seen as being family centered.

6.3.4 Intensifying and Integrating Service by Increasing Revenue

The strategy of increasing service intensity and integration by increasing revenue largely relies on expanding the number of practitioners. If the staff roster is expanded sufficiently, the resulting impact on service is likely to fit well with a number of COCDA priorities. A sufficient number of practitioners makes it possible to increase intensity. If handled correctly, an increase staff also creates an opportunity to improve service integration. From a quality perspective this strategy ranks high. In delivering quality this strategy promotes early intervention and optimum child development, while also remaining family centered.

One of the questions associated with an increased revenue strategy is the amount of funding needed to increase staffing. There is a limit to the amount of new revenue that can be found, but this strategy certainly increases the probability that the COCDA will have enough resources to at least come close to meeting the community's demand. The ability to increase the agency's available resources makes this strategy relatively responsive.

A strategy to increase the number of staff is also a good fit with the COCDA's organizational culture. Increasing the available staff allows the organization to improve

service quality without infringing on the autonomy of staff. If anything, this strategy might increase the autonomy of staff.

Considering all the advantages associated with an increased stream of revenue, this alternative is a strong candidate for selection as the best strategy. Although there are a lot of advantages to this strategy, there is a very significant downside.

An increased revenue strategy is highly unfeasible, on a number of fronts. For one thing, community fundraising is a competitive market, and given an agreement with the local United Way, the COCDA has a narrow window to this market. Several large organizations, such as, IHA, the Central Okanagan Foundation and the University of British Columbia – Okanagan are major players in the local fundraising market. Not only do each of these organizations already own a large share of the Central Okanagan market, efforts are underway for each competitor to increase their existing market share.

In addition to it being a competitive market, the COCDA's fundraising efforts are also restricted by an agreement with one of its main contributors, the local United Way. In return for the United Way's support, the COCDA is not permitted to launch any of its own fundraising initiatives between the beginning of September and the end of January each year. This timeframe marks the length of the United Way's fundraising campaign. If this agreement is violated, the COCDA stands to loose the thirty five thousand dollars contributed by the United Way each year. This agreement with the United Way benefits the COCDA, but it does restrict the advantage associated with an increased revenue strategy.

A number of other factors also limit the feasibility of an increased revenue strategy. Generally, successful fundraising initiatives take several years of development before significant profits are realized. Similar to many new ventures, it takes time for an initiative to blossom and achieve sufficient market share. The waitlist and caseload pressures facing the COCDA are already high and increasing every year. The agency simply does not have the luxury of waiting for a successful fundraising initiative to mature. Waitlist and caseload pressures need to be addressed now, not in several years.

To successively launch a fundraising initiative, the COCDA will have to divert some of its investment in frontline services. The agency does not have the capacity to

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operate a fundraising campaign that is successful enough to bring in over fifty thousand dollars in additional revenue on an annual basis. As a new activity, fundraising will have to be outsourced at a cost. With mounting waitlist and caseload pressures, diverting funds away from core operations to invest in fundraising does not coincide with the agency's goals. Staff will rebel against such a reinvestment, plus the lost opportunity cost for service delivery is enormous.

Good fundraising campaigns can cost tens of thousands of dollars. In comparison, the cost associated with one FTE in an SCD Program Assistant position is approximately thirty five thousand dollars. Given the rising demand for service, a strategy based on some financial reinvestment is far from appealing. Transforming itself into a fundraising force is a huge challenge considering the COCDA's lack of capacity in this area.

Lastly, a fundraising campaign also seems unfeasible, because of the internal and external marketing challenges associated with it. Fundraising certainly places demands on administrative staff, but to be successful, frontline staff must also lend support. With full caseloads, frontline staff do not have the time, or more importantly, the inclination to assist with community fundraising. From past experience, staff are reluctant to assist with fundraising, because it is perceived as a conflict of interest. Staff are uncomfortable in holding out their hand to the community, essentially asking for contributions to fund their own wages. Internally, fundraising campaigns for increased staffing are a tough sell.

Many fundraising campaigns focus on raising money for capital purchases. IHA's recently completed fundraising campaign to build a new adolescent psychiatric unit is a prime example of a successful capital campaign. For its next fundraising initiative, IHA is planning to target another capital project: an expanded neo-natal unit. Even the COCDA has a similar experience. The COCDA's last major fundraising campaign involved raising sufficient funds to cover the cost of installing a new elevator in the facility.

Major fundraising campaigns are appealing to donors for two reasons. The first is that building expansions and upgrades become long term monuments of community generosity and good will. As the Kelowna hospital expands one wing or unit at a time,

its stature as a community monument continues to grow. Corporate sponsors and community donors can point to a tangible outcome made possible by their contribution. Not only is it a highly visible monument, it is also sustainable, at least from a fundraising perspective. Once constructed, the ongoing operating costs are absorbed by the organization, or picked-up by government. Fund-raised dollars are no longer needed to back it.

In contrast, fundraising for service expansion is not so appealing, or easy. Service expansion produces more intangible results. Children and families who benefit from enhanced or expanded service fade into the fabric of everyday life; they are not visible monuments to community fundraising. Fundraising for services is also not sustainable. Every year, the same amount of money needs to be raised, or the service is reduced or lost. It is an ongoing commitment for donors. It is not only the sustainability that deters community donors. The idea of funding what is sometimes perceived as "high price" union wages, or funding a top-up for insufficient government funding is difficult to market to corporate and community donors.

The alternative of increasing the COCDA's revenue base through community fundraising has many advantages related to it, especially in terms of protecting service quality. The challenges associated with successful fundraising, however, significantly detract from the feasibility of this option for the COCDA.

6.3.5 Mass-Delivery as a Cost-Based Strategy

Overall, a cost orientation does not fit well with the COCDA. The restrictive, impersonal, mass delivered format of a group service leaves no room for a family centered orientation. The emphasis on through-put and turnover does not optimize children's development. It provides the family and caregivers with planned activities, but the execution of this plan is dependent on many variables. As a result, this strategy does not consistently deliver strong results in relation to children's developmental gains.

On the other hand, a high through-put does allow service delivery to keep pace with referrals. For this reason, a cost orientation fits well with the COCDA's emphasis on early intervention. A high level of through-put carries another advantage. It allows the

organization to serve all referrals, regardless of age, severity, or any other criterion. It is one of the better methods for ensuring the agency remains responsive to all referrals.

From an implementation perspective, a mass-delivery format presents challenges. Practitioners do not consider mass-delivery to be enriching, rewarding work. Mass-delivery provides little opportunity for practitioners to connect with families, or to see the impact of their efforts. A mass delivery strategy greatly restricts the autonomy of service providers. This strategy completely contradicts the current culture, which is a significant drawback. Without buy-in from practitioners, a mass-delivery service model is difficult to implement.

The COCDA has a long history of delivering quality. In this context, adopting a cost orientation is a radical concept. Not only is it a significant shift, the COCDA has little expertise in designing cost-based services. All of these factors makes the adoption of a full-scale mass-delivery system seem like a stretch for the agency. It is a highly unfeasible strategy.

6.3.6 A Focused Hybrid Strategy

Overall, a strategy that combines elements of quality service with proper consideration for high volumes and through-put, is the best option for the COCDA. Due to the balance between quality and quantity, this strategy scores relatively high on the majority of the COCDA's goals. Its attention to quality, while carefully selecting appropriate referrals for mass-delivery, allows the COCDA to optimize the organization's impact on children's developmental gains.

A carefully constructed hybrid strategy also achieves a balance between serving all referrals, while simultaneously remaining responsive enough to make early intervention logistically possible. A combination of mass-delivery with better integrated and more intense services is a rationale utilization of skilled practitioners, the COCDA's most valuable resource. Through this strategy, practitioner's skills and expertise are focused on delivering intense, integrated service where it is needed the most, while backing off on these qualities where a lower, just adequate level of quality is justified. It is a delicate, but appropriate balance. In a recent analysis, organizations with well-

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designed hybrid strategies were found to outperform those with a weak or muddled strategy (Reklitis, P. and Trivellas, P., 2002, p. 319).

Some elements of a hybrid strategy, namely the emphasis on quality and practitioner's practices, fit well with the agency's culture. To some extent, however, the nature of the work involved with mass-delivery is at odds with the culture. This clash is not too concerning. There is a mitigating factor, which helps to cushion the loss of autonomy associated with mass-delivery.

The strain associated with overwhelming service demands are starting to show in the COCDA's workplace. Occasionally staff talk openly about feelings of helplessness, as there seems to be no relief in sight from a steadily increasing volume of referrals. There is a large forced turnover in the caseload each year, and occasionally new funds are available for hiring additional staff. Regardless of these events, waitlist and caseload pressures persist. Although a targeted mass-delivery approach conflicts with the current culture, its ability to ease the demand on staff off-sets much of this disadvantage. The overwhelming demands for service are creating a morale problem. The introduction of mass-delivery methods in a contained, focused manner, will help to alleviate the crush of referrals that is starting to overwhelm staff.

The mass-delivery element of a hybrid strategy does detract from a family centered service. Mass-delivery is not an individualized form of service. Since a hybrid strategy also emphasizes the quality of service intensity and integration, the overall negative impact on delivering family centered service is small, but noticeable.

The nuances and specificity of a combination strategy does add some complexity to its implementation. A cost orientation needs to be highly focused and backed by sound rationale. The mass-delivery aspect of this strategy does reduce its feasibility to some extent. The complexity of mass-delivery also adds to the degree of change needed in implementing a hybrid strategy. Again, the balanced nature of this strategy ensures that it does not fall into the radical category. The scope of change is small enough to still keep this strategy within the COCDA's capacity.

Like most strategies, a hybrid mass-delivery and quality service strategy has some disadvantages. These detractions are relatively minor and compared to the advantages associated with a hybrid strategy, it is clearly the best direction for the

COCDA. A hybrid strategy is the best way to deal with the COCDA's rising service demands without compromising quality. At the same time, it remains a feasible option .

6.4 Summary

Six different strategies were identified as viable options for addressing both the COCDA's internal concerns, and emerging developments in the external environment. Each of the strategic alternatives was evaluated against eight priorities for the organization. Based on this analysis, mass-delivery methods for rapid response, monitoring and follow-up service, combined with more intense and integrated stand alone and cluster services, are the best strategy for the COCDA to pursue. A hybrid strategy receives a high rating in terms of delivering optimum child development services in a timely matter. These are two key priorities for the COCDA. In terms of a key external partner, the focused nature of this strategy fits well with MCFD's new requirements around accountability.

7 Recommendations for Implementing the Selected Strategy

The COCDA's current strategy, a weak differentiation strategy, is an attempt to balance a commitment to quality with the need to achieve a high through-put of clients. In attempting to achieve this balance, the COCDA elected to lower quality standards for the two services in most demand, stand alone and cluster services. By lowering the quality of output, as measured by the frequency of visits and sessions, the COCDA increased the volume of clients served. At the same time the COCDA allowed another measure of quality service to lag. Although cluster services represent the most complex service delivery model in the organization, the case management system for coordinating this service is loose, informal and problematic.

The Provincial Government, the COCDA's main source of revenue, is starting to impose more stringent reporting and accountability requirements on all service contracts. MCFD is now more concerned about the amount and manner in which services are being delivered. At the same time another element in the COCDA's environment is changing. The labour market in the Central Okanagan is becoming more competitive than ever. Considering the COCDA's drift into a mixed differentiation strategy, MCFD's new demands for accountability, and an increasingly competitive labour market, the timing is right for the COCDA to review the performance and fit of its current service strategy.

7.1 The Results of the Analysis

Based on the analysis of the COCDA's service offerings, client groups, external environment, internal resources, and organizational culture, several different service delivery strategies were developed. Using key goals and priorities at the heart of the organization, these strategic alternatives were evaluated.

Out of this analysis a strategy was selected, where mass-delivery methods are combined with targeted quality standards. Specifically, this strategy proposes that rapid response and monitoring caseloads in the needs-based service category, and the follow-up caseload in the stand alone service be mass delivered. A mass-delivery model is clearly a cost-based service orientation. This cost orientation is only part of the overall strategy. The other part of the strategy emphasizes a quality approach to service standards. For a different part of the operation, the intention is to deliver stand alone, group, multidisciplinary and cluster services according to best practices.

In selecting a strategy where mass-delivery is thoughtfully combined with targeted quality standards, a better balance can be achieved between increasing demands for service and maintaining quality standards. As demand for service increases, and the organization becomes more accountable to government, it is critical for the COCDA to have a strategy for balancing client through-put and quality service delivery.

7.2 Recommendations for the Implementation of a Combined Strategy

The shift from a mixed differentiation strategy to a combined strategy is not a radical change. Nonetheless, any change initiative, no matter how incremental, needs to be handled appropriately. In other words, proposed changes must be implemented in a way that coincides with the COCDA's communitarian organizational culture. To ensure the adoption of a new strategy goes as smoothly as possible, and to increase the probability of success, the following actions are recommended.

7.2.1 Ensure the Governance Structure and Operation Stay in Step

One of the first steps is to seek approval from the Board of Directors before initiating the shift to a combination strategy. The case for shifting to a combination strategy is sound, but the Board of Directors needs to be in agreement with the recommendation. If the shift to a combination strategy is approved, policy statements need to be developed for the Board's monitoring purposes (Carver and Carver, 1997, p. 153).

7.2.2 Developing a Mass-Delivery Service Model

The idea of a mass-delivery system is a relatively new concept for the COCDA. The organization does not have much direct experience with this method of service. To guide the process, a team of practitioners needs to be assembled. This design and implementation team should be made up of practitioners with previous experience in delivering mass services. One of the first assignments of the team is to review the list of services selected for mass delivery. The team must feel comfortable with the suggested short-list of services. If not, other options can be given further consideration before making a final decision.

Once the design and implementation team is confident in the selection of services and caseloads, a value chain for mass-delivery must be designed. The goal is to develop a detailed description of all the methods involved with the operation of a mass-delivery model. Once this is complete, the team can turn to developing an implementation plan for training staff and phasing in the new system.

In order to ensure the integrity of both a mass-delivery and best practice hybrid strategy are maintained, some consideration needs to be given to the organization's structure. If the co-existence of a mass-delivery system, and a best practice system are a concern, it may be prudent to establish distinct service delivery units. A clearly delineated organizational structure helps keep organizational strategy from becoming muddled. The issue of organizational structure needs to be given serious consideration by the design and implementation team.

7.2.3 Revisiting Quality Service Delivery

In contrast to a mass delivery model, the COCDA already has significant experience with quality service standards. Nevertheless, assumptions should not be made about the COCDA's expertise in this area. To be thorough, a review of the literature and professional guidelines around quality service standards and best practices should be conducted. Again, a design and implementation team will be assembled to carry out these tasks and to help garner buy-in from the larger group.

Since the concept of quality service standards is open to some interpretation, it is best to conduct focus group discussions with several groups of practitioners from across the organization. The goal of the entire design process is to develop standards for governing the intensity of service and the integration of case management practices. Once guidelines for service intensity and case management practices are developed, staff will be oriented and trained in the new program and case management practices. A timeline for implementing new quality service standards and practices will also de communicated to staff.

7.3 Tending to the Organization's Infrastructure

In addition to refining the COCDA's service strategy, attention must also be paid to several critical infrastructure issues. If management is to track the performance of a more calculated, rational service delivery model, a sound tracking system needs to be in place. Similarly, if greater accountability is to be delivered to the COCDA's main funding agent, a reliable information system is needed. Along with shifting to a combined service strategy, the COCDA also needs to address the existing gap in its information management system. This gap was identified in Chapter Four.

The COCDA's physical plant is another issue needing attention. The capacity of the current facility has reached its limit. At present there is little room for the expansion of existing services. For the more immediate future the possibility of a satellite site needs to be explored. The community of Westbank is growing significantly. Given this demographic trend, the possibility of leasing or renting a satellite site in the Westbank area is worth considering. Considering the traffic delays on the bridge between Kelowna and Westbank, a satellite site on the other side of the lake could also improve staff utilization. Instead of spending time stuck in traffic delays, staff could have the option to catch-up on phone calls and documentation at a satellite location in the Westbank area.

Opening a satellite site relieves the immediate pressure on the COCDA's existing facility. For long term purposes, and depending on the costs associated with a satellite site, the possibility of expanding the current facility also needs to be examined. To plan for the future, the COCDA needs to commission architectural plans for expansion, along with a cost estimate for construction. Once this information is available, the COCDA can weigh its options for expanding its physical plant.

Switching to a more refined service strategy is an important step for the organization. To ensure this strategic move pays dividends, it is important the organization cares for its most important resource: skilled practitioners. Concerns have been raised about the competitiveness of the COCDA's wage grids. The main concern is at the top end of the classification scheme, which is occupied by hard to recruit positions, such as OT, PT and SLP. Besides a sound service strategy, if the COCDA is to be successful at delivering service, a strong base of practitioners must be maintained. One element for ensuring this is the implementation of a balanced, rational service delivery model. Another element is a competitive wage grid.

7.4 Conclusion

The COCDA owes it to the children and families it serves to find the best strategy for allocating scarce resources in a way that maintains optimum service quality. A strategy where some services are delivered through a cost-based mass-delivery system, while others are delivered according to best practices, is the best method for achieving this balance. To ensure the success of this strategy, attention also needs to be directed towards the organization's information system, facility capacity, organizational structure, and compensation system. The status of these support systems is just as crucial as the content and implementation of a shift in the COCDA's service strategy.

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