Clinical Managers: Ignored Yet Critical to Innovation Success
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Introduction

Everyone knows we need to re-invent hospitals and care delivery quickly. To adopt new “app” ideas for population treatment and improved quality, existing organizations and their people have to innovate. Yet there’s confusion about how to innovate in entrenched, hierarchical organizations. And silence on how to lead innovation.

The call for better healthcare leadership comes from many quarters – academic and leadership development educators. They list vague, highly variable leadership capabilities unrelated to goals or roles [35]. These vary little from what’s been said for twenty years. Medical school curricula have changed little despite upheavals in hospitals [21]. No one addresses leading innovation. Innovating new models for healthcare differs dramatically from leading established operations or incremental quality improvement (QI).

Innovation as complex adaptive challenge

QI is a “technical challenge” [20] – creating process improvements using existing knowledge and experience. The project to re-create hospitals to deliver less expensive patient-centered care for increasing complex situations is an “adaptive challenge.” Any solution must be newly invented because the knowledge and engineering of the past are not sufficient. What got you here won’t get you there [18]. The situation is ambiguous, and the path uncharted. While the many “fixers” in healthcare have knowledge and ideas that can contribute to a solution, solo or easy fixes will not solve today’s complex systems issues because “fixes” rely on what they knew and what worked before 3, 22, 5.

Leading innovation balances on a central dilemma - Innovating unavoidably requires unleashing individuals’ talents to create new options and to think differently than they have previously. At the same time leaders create the conditions for expansive thinking and experimenting, they must harness people to ensure they achieve a viable, valuable outcome [22]. This requires creating a culture to foster values, beliefs and behaviors that will create very different services and organizations [30]. Leaders create the conditions for adventurous thinking, experiments where failures are expected, and respect for all individuals’ contribution and sets rules and norms for performance, deadlines, and collaboration (21, 30).

Capabilities to lead innovation

Hill, Brandeau, Truelove uniquely ask what’s it take to lead innovation. They pinpoint capacities for leading creations that succeed:

(1) Collaborative problem-solving: Successful leaders of innovation convene a range of diverse people to solve problems together. The diversity of experience creates new, better and wiser solutions – key to “inventing” population health successes [31, 36, 37, 40]. Leaders must manage the messy process of generating true, honest ideas, fostering respectful, thorough discussions, supporting disagreement, adjudicating conflict and persuading people to support solutions and continued participation when their ideas are discarded. Leaders create successes when they enable themselves and others cope with uncertainty, complexity and the hard, critical limits of the situation [28].
(2) Discovery-driven learning: New solutions derive from iterative experiments, as complex adaptive change has no clear, straight path and no well-defined destination. Most ideas fail, so organizations willing to fail fast learn what needs to be done next and get closer to something better faster [14, 39]. Leaders build the container for this - more time, energy, and resources, clear goals, metrics and limits, conditions and support for experimenting, including people’s safety in speaking up [12, 28, 31, 37, 44].

(3) Integrative decision-making: Innovation and continual improvement demand new ways to make decisions. (a) Success comes from “both-and” integrative thinking that requires patience despite the volatile world of care delivery screaming urgency. (b) New valuable opportunities come from the bottom up while most run healthcare organizations from the top down [5, 22, 31].

These challenge traditional medical and nursing practice of experts acting autonomously. These capabilities don’t fit easily with clinical education’s norms. Leaders must inhibit leaping to solutions, truly collaborate across an increasing number of boundaries, value and integrate others’ ideas, and, crucially, be comfortable not knowing. The many current healthcare leadership courses, even those aiming for “transformational leaders,” fail to address these critical capabilities for successful innovation except marginally.

Despite widespread embracing of QI, healthcare’s efforts at performance improvement – a much more limited project than innovation - have so far been “dismal” [6]. Less than 50% of QI projects become consistent, successful practices, and failures derive from ineffective leadership, lack of trust of involvement among other more technical problems [29]. QI is essentially incremental, engineering change. Hospitals and providers must re-invent care which involves much more risk, organizational trauma and uncertainty.

Objective

Neither the medical literature nor leadership practice identifies clearly the capacities needed for real innovation. Moreover organizations have singularly focused attention and resources on “top” decision-makers and “high potentials." This overlooks middle managers: their innovation willingness and capacities to implement new processes and roles prove critical to success. This article identifies why and how managers’ vital contributions turn innovations into consistent practice that improve patient outcomes.

Methods

This review considered literature published about US hospitals and clinical care in US-based journals published since the year of Affordable Care Act passage, 2010. Regulations and cultures in other countries fundamentally influence innovation culture and clinician readiness. The search focused on Pubmed using the keywords that follow plus the author’s familiarity with the management literature on innovation and leadership in other sectors as well as healthcare. The search also included the bibliographies of key articles.

Keywords: Leading innovation, transformational leadership, leadership and system change, physician leadership, middle manager, frontline manager

Results

Middle managers implement innovations that produce positive results. At the same time they must ensure on-going patient care remains safe and high quality. They perform multiple, varied roles simultaneously. Healthcare’s definitions of middle managers vary, and often extend to Chief Medical Residents and other frontline supervisors. Key innovation roles for middle and to a lesser extent frontline managers include:
Bridge. Middle managers work with senior management to understand innovation strategies and to influence the shape and resourcing of innovations. Then they bring that vision and information to the frontline and use their knowledge of the work, clinicians and patients to suggest opportunities and influence expectations to leadership [8, 9, 15, 16]. They translate strategy into action and make sure everyone remains "in the loop," but go much further to promote systems thinking and linking [5, 6, 7, 23, 25]. They clarify intent, influence implementation plans, communicate real resource needs, and identify new opportunities for improvement. They advocate for their staff, soliciting resources to support them. Then skillfully transform restrictions from above into creative opportunities for their staff.

- Design reality-tester. Middle managers validate designs and shape the details to implement them. Their involvement from early stage can speed success by providing crucial contextual details of patient care, including arguing why a concept won't work [2, 23]. They themselves innovate by aiming for something bigger than a small implementation. Then they work to satisfy executives' goals in ways that accommodate the needs of their staff [5, 25, 43]. In this they are problem-sensors, as they identify secondary design or resources needed to make the primary effort successful [25]. Their success depends on applying the knowledge and ideas of diverse specialists and patients that can only be achieved by skill and commitment to collaboration [42].

- Enabler. Middle managers must create whatever is needed to enable their people to be capable, ready and willing to engage fully in using and improving the innovation [23, 27, 33]:

  ~ Culture creator – Middle managers create and clearly represent the values and features of the work environment that will guide staff and support success. This work includes enhanced communication and real teamwork [9, 15, 26]; continual and honest feedback and reflection on performance [1, 42, 44]; guarantees of safety in contributing without retaliation [12, 17, 38, 42]. They do this by codifying behavioral expectations, consistent communication, creating new opportunities and structures to foster exchange and trust (e.g., regular discussions to involve everyone in the innovating), and modeling the behaviors key to dealing with the many boundaries, complexities and stresses. Demonstrating their commitment to the innovation significantly improves outcomes [7, 8].

  ~ Motivator – Middle managers find ways to engage their junior managers and frontline people by, at the very least, explaining why the changes are important [8] and, more powerfully, showing individuals how they will truly benefit [15]. This involves soliciting people’s ideas with follow-through; recognizing people’s contributions; acknowledging effective teamwork; really answering clinicians’ questions; fostering relationships so that people know one another and their strengths [7, 33]. Successful managers actively promote individuals' professional aspirations and development. Managers also counsel and mediate interpersonal challenges to reduce resistance, stress and unproductive conflict because these dramatically limit innovation success [4, 7, 25, 35].

  ~ Opportunity creator – Freeing time for people to learn and try the new work and reflect on performance frequently is crucial to gaining commitment and implementation success [10]. Increasing the demands on already busy clinicians in complex care – the history of QI and information technology (IT) interventions - creates workarounds and blockages, frustration, fatigue, burnout and resistance to improvement efforts and failure [19].

- Improvement monitor – Managers monitor and report system performance and resource use. They also devote time to learn from mistakes without blame and to reflect with their staff on how to improve better or further [9, 35].

In other industries, the skills of the middle managers in these roles accounted for almost 23% of the variation in organizational performance while all other company-specific factors together accounted for less than 21% [33].

Conclusion
What is needed from leaders in these extraordinary times “runs counter to current practice” [9]. The times demand something other than solitary “heroes.” IT capabilities enlarge the opportunities for hospital and care re-invention, yet survival and success rely on much more than a selection of a tech product. IT investment always shakes up the workflow and roles. One-quarter of sentinel events derive from communication, teamwork and workflow [24].

The demands of population health and care across the continuum, along with the opportunities of connected health, magnify the necessity to understand deeply the processes and relationships involved. Leaders will find solutions that can succeed only if they involve and facilitate cross-boundary thinking and creative problem-solving, cede control to those who best know what is needed, and get comfortable with asking questions because no one knows exactly where to go or what to do.

Middle managers need these capabilities too as they do similar and critical work with their staff – that is, where the innovation implementation works, fails, improves and becomes accepted…or not. They create the conditions that allow and support the people to perform the new uncertain work. They must create an innovation climate where people feel comfortable asking, claiming mistakes and learning to appreciate rather than resist the changes. The more “proactive” middle managers are to implementing innovation, the more likely they will find creative, effective solutions to their challenges [7].

Yet exactly what local leaders must do and how remain poorly understood. Local leaders report they feel “unprepared” or disempowered by rank and hierarchical boundaries [9, 11]. They claim they have little or no support from top management to understand and fully engage in innovation and its implementation. Moreover they are accountable for the quality of daily operations and reap no rewards and plenty of problems from committing to innovation [6, 13].

What might organizations do to enable middle managers to better shape and support essential innovations? A few ideas include:

- Integrate middle managers into innovation thinking early and ensure they have significant discretion over how they implement it. Middle managers who believe they are engaged and have control prove more committed to the changes [10].
- Structure innovation plans so that managers benefit and know how they’ll benefit [10]. Without this middle managers will resist the encroachment on their territory as conventional wisdom suggest.
- Resourcing middle managers gains importance. Planning with human resources and funding adequate staffing including replacements increased middle managers’ involvement. Protect their time for the many culture and professional development responsibilities. Managers face huge burdens for regulation compliance and ongoing operational management. Enabling them to make time and promoting a learning environment were associated with managers truly valued and took the time to learn new capacities and performed better than those without this support [11, 27, 37].
- Connected health technologies break down the functional, disciplinary and service silos that fragment patient care and organizations. Organizations need to create many mechanisms that bring together the varying perspectives and knowledge from physicians, nurses, administrators and other care professionals. Structures can provide opportunities for each discipline to learn about the others’ strengths and increase their readiness to work across boundaries to change systems [32, 34].
- Because these capacities represent such a huge leap from the ways that clinical managers’ jobs have historically been perceived, coaching proves crucial and is valued. For physicians and nurses, shedding the expert authority and feeling safe to explore possibilities, in fact to become comfortable with not knowing are both important and a radical departure from the training to diagnose and solve problems quickly [14, 32, 41]. Role changes and expansions exacerbate the uncertainty and sense of loss of authority.
Coaching enabled managers to identify their individual blockages and create a path for performance improvement safely and confidentially [41].

Research to identify the most important capabilities for middle managers remains necessary. Innovation planning that recognizes middle managers’ roles in success is urgent. Gaining the energy and commitment of middle managers and equipping them to perform well in the new as-yet uncertain world of care delivery can improve the chances that innovations work well and truly improve patient care and organizational performance.

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Conflicts of interest
None declared.

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