Uncovering the role of middle managers in the implementation of innovations in cancer care

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Learning objectives

1. Understand the substantive role middle managers play in implementation processes
2. Identify factors influencing their commitment to innovation implementation
3. Consider potential strategies to optimize their role in innovation implementation
Today

- Definitions
- Emerging literature
- Recent study
- Wrap up & questions
Definitions

Middle managers: employees who are supervised by an organization’s top managers and who supervise frontline employees\(^1\)

Innovation: an idea, technology, or practice that an organization is using for the first time\(^2\)

Implementation: the transition period that follows the decision to adopt “during which targeted organizational members ideally become increasingly skilled, consistent, and committed in their use of an innovation”\(^2\)
Why middle managers?

Multi-level factors influence the implementation and use of complex innovations in cancer care: a multiple case study of synoptic reporting

Robin Urquhart1,2,3,4*, Geoffrey A Porter1,2,3, Joan Sargeant4,5, Lois Jackson6,7 and Eva Grunfeld8,9

Abstract

**Background:** The implementation of innovations (i.e., new tools and practices) in healthcare organizations remains a significant challenge. The objective of this study was to examine the key interpersonal, organizational, and system level factors that influenced the implementation and use of synoptic reporting tools in three specific areas of cancer care.

**Methods:** Using case study methodology, we studied three cases in Nova Scotia, Canada, wherein synoptic reporting tools were implemented within clinical departments/programs. Synoptic reporting tools capture and present information about a medical or surgical procedure in a structured, checklist-like format and typically report only items critical for understanding the disease and subsequent impacts on patient care. Data were collected through semi-structured interviews with key informants, document analysis, nonparticipant observation, and tool use/examination. Analysis involved production of case histories, in-depth analysis of each case, and a cross-case analysis. Numerous techniques were used during the research design, data collection, and data analysis stages to increase the rigour of this study.
<table>
<thead>
<tr>
<th>Factor</th>
<th>Case A: Mammography case</th>
<th>Case B: Endoscopy case</th>
<th>Case C: Cancer surgery case</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stakeholder involvement</strong></td>
<td>+/- Initial implementation and use were facilitated by stakeholder involvement; subsequent expansion was impeded by low stakeholder (i.e., radiologist) involvement</td>
<td>- Implementation was impeded by limited stakeholder involvement</td>
<td>+ Implementation was facilitated by early, ongoing, and collaborative stakeholder involvement</td>
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<tr>
<td><strong>Managing the change process</strong></td>
<td>- Implementation and use were impeded by sub-optimal change management practices</td>
<td>- Implementation and use were impeded by sub-optimal change management practices, though user training was well conducted</td>
<td>+ Implementation and use were facilitated by high-quality change management practices</td>
</tr>
<tr>
<td><strong>Administrative and managerial support</strong></td>
<td>+/- Implementation was facilitated by high administrative support and high managerial support in some hospitals; implementation was impeded by low managerial support in other hospitals</td>
<td>+/- Implementation was facilitated by high administrative support; implementation was impeded by low managerial support in many hospitals</td>
<td>+ Implementation was facilitated by high administrative and managerial support</td>
</tr>
<tr>
<td><strong>Champions and respected colleagues</strong></td>
<td>+/- Implementation and use were facilitated by clinical and administrative champions; lack of clinical champions in some districts impeded use</td>
<td>+ Implementation and use were facilitated by clinical champions and respected clinical colleagues</td>
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<td><strong>Innovation attributes</strong></td>
<td>+/- Implementation and use were facilitated by alignment with individuals’ and organizations’ values, interests, and needs; use was impeded by perceived tool (and final report) deficiencies and its relative (dis) advantage in practice</td>
<td>+/- Use was facilitated by the tool’s perceived ease of use, but impeded by IT and other technical issues; implementation and use were facilitated by alignment with individuals’ and organizations’ values, priorities, and interests</td>
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Facilitating influence

- Explicitly demonstrating moral support for implementation
- Exerting authority over existing departmental policies, priorities, & resources
- Influencing development of new policy related to the innovation

Impeding or undermining influence

- Choose other priorities, limit resources
- Ensure that implementation was something carried out ‘off the side of one’s desk’

**Table 6 Common and distinct factors influencing synoptic reporting tool (SRT) implementation and use across cases**

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State of knowledge

- Middle managers’ role has received scarce attention
  - Focus on senior (executive) leadership and frontline clinicians

- +++ evidence in non-health sectors of influence on implementation & organizational performance\(^3\text{-}^6\)
  - Commitment to implementation linked to implementation speed, strategy realization, productivity, enhanced competitiveness
  - Positive or negative\(^4\)
State of knowledge *cont’d*

Floyd & Wooldridge\(^{4,5,7,8}\)

- Consider *implementation role* of middle managers as most important

- Implementation not solely carrying out top management intentions, but an adjustment of org priorities & directions to emergent issues
State of knowledge *cont’d*

- Evidence from health care\(^8.9\) that performance is related to what happens at *mid level* of organization
- Several studies exploring middle managers’ support for innovation implementation in health care
Implementing complex innovations: Factors influencing middle manager support

Emmeline Chuang
Kendra Jason
Jennifer Craft Morgan

**Background:** Middle manager resistance is often described as a major challenge for upper-level administrators seeking to implement complex innovations such as evidence-based protocols or new skills training. However, factors influencing middle manager support for innovation implementation are currently understudied in the U.S. health care literature.

**Purpose:** This article examined the factors that influence middle managers' support for and participation in the implementation of work-based learning, a complex innovation adopted by health care organizations to improve the jobs, educational pathways, skills, and/or credentials of their frontline workers.

**Methods:** We conducted semistructured interviews and focus groups with 92 middle managers in 17 health care organizations. Questions focused on understanding middle managers’ support for work-based learning as a complex innovation, facilitators and barriers to the implementation process, and the systems changes needed to support the implementation of this innovation.

**Findings:** Factors that emerged as influential to middle manager support were similar to those found in broader models of innovation implementation within the health care literature. However, our findings extend previous research by developing an understanding about how middle managers perceived these constructs and by identifying specific strategies for how to influence middle manager support for the innovation implementation process. These findings were generally consistent across different types of health care organizations.

**Practice Implications:** Study findings suggest that middle manager support was highest when managers felt the innovation fit their workplace needs and priorities and when they had more discretion and control over how it was implemented. Leaders seeking to implement innovations should consider the interplay between middle managers’ control and discretion, their narrow focus on the performance of their own departments or units, and the dedication of staff and other resources for empowering their managers to implement these complex innovations.
Fading vision: knowledge translation in the implementation of a public health policy intervention

Laura Tomm-Bonde¹, Rita S Schreiber¹, Diane E Allan¹*, Marjorie MacDonald¹, Bernie Pauly¹, Trevor Hancock², on behalf of the RePHS Research Team

Reasons for non-support:
• Inadequate understanding of the vision or intent of framework
• Limited involvement in framework development process
• Expected to implement framework with few, if any, additional resources
Birken et al.¹

Expressions of middle managers’ commitment*

- Implementation policies and practices
- Information diffusion
- Information synthesis
- Strategy / day-to-day activity mediation
- Selling innovation implementation

Implementation climate

Implementation effectiveness

*Middle managers’ influence on healthcare innovation implementation may be positive or negative. Figure 1 Middle managers’ role in healthcare innovation implementation.
Led to study to further examine the (poorly understood) role of middle managers in innovation implementation in health care

Funded by CIHR OOGP (MOP# 133398)
Study aims

1. Explore the role of middle managers in innovation adoption and implementation in cancer care

2. Identify factors that influence middle managers’ support of innovation implementation
Study design & methods

**Design:** Qualitative study using grounded theory

**Setting:** Nova Scotia (NS) and New Brunswick (NB)

**Methods:** Semi-structured interviews

**Participants:** Middle managers in the cancer system (clinical care and/or provincial cancer programs)
- Purposive sampling (maximal variation): training, location
- Theoretical sampling
- Data collection cont’d until data saturation reached
Study findings: participants

17 participants

- 7 NS, 10 NB
- 14 with clinical background, 3 non-clinical background
- Range of depts/programs
Study findings: role

- Translate goals into action
- Recognize they are part of a team

Many roles

Limited DM power

Making it happen
Facilitator, organizer, planner, motivator, evaluator
Study findings: role cont’d

• Clinical & managerial duties, “spread too thin”
• Implementation requires additional work & learning

Many roles

Making it happen
Facilitator, organizer, planner, motivator, evaluator

Limited DM power
Study findings: role cont’d

Many roles

Making it happen
Facilitator, organizer, planner, motivator, evaluator

Limited DM power

• Top management makes the “big decisions” & sets parameters
• Have to work within these parameters
Study findings: support

How easy will this be?

What benefit will it have for patients?
Study findings: support cont’d

How easy will this be?

What benefit will it have for patients?

Resources
- ⬇ demands not met by ⬆ resources
- Competing interests & priorities
- Resources for staff-related costs
  - Ex: staff training
Study findings: support *cont’d*

**How easy will this be?**

**Fit**
- Alignment with organizational goals
- Alignment with current clinical practice
- Staff already possess required knowledge & skills
- Compatible with existing IT infrastructure

**What benefit will it have for patients?**
Study findings: support cont’d

How easy will this be?

What benefit will it have for patients?

Buy-in
• Buy-in from frontline staff integral
  How easy/hard will this be?
• Clinician-driven innovations more likely to \( \uparrow \) staff buy-in
• Top managers buy-in needed for resources & sign-off
How easy will this be?

What benefit will it have for patients?

- **Responsibility** to ensure patients receive best possible care
- **Evidence** for benefit?
- Does solution address a **local gap**?
  - Ex: patient satisfaction
- Clinician-driven more likely to benefit patients
- High benefit to patients \( \approx \) high commitment

Study findings: support *cont’d*
Implications

- Limited involvement in adoption decisions
- Feel they lack skills/training
- Facilitate/organize/plan/motivate/evaluate to make it happen (and in general view it positively)
  - Potentially important and strategic role that goes beyond mitigating informational gaps
  - May be key link between adoption and implementation

*Middle managers’ influence on healthcare innovation implementation may be positive or negative.

Figure 1: Middle managers’ role in healthcare innovation implementation
When organizations adopt innovations, they do so with high expectations, anticipating improvements in organization productivity and performance. However, the adoption of an innovation does not ensure its implementation; adopted policies may never be put into action, and adopted technologies may sit in unopened crates on the factory floor (p. 1077). ²
Implications *cont’d*

What are some *risks* of low middle manager support?

- ‘Drag their feet’
- Undermining credibility of implementation
- Not achieving effective implementation
  - Consistent, committed, skilled use
- Endangering scale-up and sustainability
- Endangering implementation of future innovations
Implications *cont’d*

What might be done to support their role?

- **Individual level**
  - Involve early on so they understand need for innovation
  - Provide (easy) access to external evidence
  - Mentoring / coaching / skills development

- **Organizational level**
  - ‘Networks’ of middle managers (e.g., community of practice)
The role of hospital managers in quality and patient safety: a systematic review

Anam Parand,¹ Sue Dopson,² Anna Renz,¹ Charles Vincent³

ABSTRACT

Objectives: To review the empirical literature to identify the activities, time spent and engagement of hospital managers in quality of care.

Design: A systematic review of the literature.

Methods: A search was carried out on the databases MEDLINE, PSYCHINFO, EMBASE, HMIC. The search strategy covered three facets: management, quality of care and the hospital setting comprising medical subject headings and key terms. Reviewers screened 15 447 titles/abstracts and 423 full texts were checked against inclusion criteria. Data extraction and quality assessment were performed on 19 included articles.

Results: The majority of studies were set in the USA and investigated Board/senior level management. The most common research designs were interviews and surveys on the perceptions of managerial quality and safety practices. Managerial activities comprised strategy, culture and data-centred activities, such as driving improvement culture and promotion of quality, strategy/goal setting and providing feedback. Significant positive associations with quality included compensation attached to quality, using quality improvement measures and having a Board quality committee. However, there is an inconsistency and inadequate employment of these conditions and actions across the sample hospitals.

Strengths and limitations of this study

- This is the first systematic review of the literature that has considered the evidence on Boards’ and managers’ time spent, engagement and work within the context of quality and safety. This review adds to the widely anecdotal and commentary pieces that speculate on what managers should be doing by presenting what they are actually doing.

- The review reveals conditions and actions conducive to good quality management and offers a model to transparently present these to managers considering their own part in quality and safety.

- The search for this review has screened a vast amount of the literature (over 15 000 articles) across a number of databases.

- The small number of included studies and their varied study aims, design and population samples make generalisations difficult. With more literature on this topic, distinctions could be made between job positions.

- The quality assessment scores are subjective and may not take into consideration factors beyond the quality assessment scale used.
Questions?

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Reference list