Skydivers: © Rick Neves/Moment/Getty

CHAPTER THREE

Innovation Leadership and Professional Governance: Building the Structure for Transformation

Man's mind stretched to a new idea never returns to its original dimensions.
—*Oliver Wendell Holmes*

Chapter Objectives

At the completion of this chapter, the reader will be able to

- Explore professional governance as a vehicle for structural empowerment and innovation.
- Define key concepts and terms associated with innovation.
- Identify the rationale for innovation in healthcare organizations.
- Compare and contrast the work of innovation with the work of routine operations.
- Describe the role of professional governance in advancing the integration of innovation into the work of healthcare organizations.
- Evaluate multiple metrics for the measurement of innovations.

Shared governance models for structural empowerment are transitioning to professional governance models in which the nursing profession continues to increase accountability to the profession, recognize the obligations of professional membership, strengthen partnerships with key stakeholders, and advance evidence-driven decision making (Clavelle, Porter-O'Grady, Weston, & Verran, 2016). These advancements reflect maturation of the not only the shared governance model, but also the engagement and contributions of nurses in broader sense to advance healthcare innovation.

Traditionally, the emphasis of healthcare organizational structures is on stability and goal achievement. Experimentation with patient care processes is discouraged to avoid additional expenses and to ensure that safe and effective patient care occurs. Leaders tend to delay process modifications until there is significant research and evidence for new processes or the current process fails abruptly. Professional governance now requires innovation.

Key Point

Professional governance is the accountability, professional obligation, collateral relationships, and decision making of a professional, foundational to autonomous practice and achievement of exemplary empirical outcomes (Clavelle et al., 2016).

This approach is typical even when current processes are known to be only marginally successful in providing safe and effective patient care. Maintaining the status quo where cost and outcomes are known is preferred to taking risks in which the costs and outcomes are not clearly known. More than 20 years ago, Wheatley challenged leaders to think differently about leadership. She challenged us to search for new ways of understanding leadership, and the integration of innovation more clearly into our leadership paradigm might be finally recognizing Wheatley's challenge (Stuke, 2013; Wheatley, 1992). To be sure, our current approach is understandable but shortsighted. Adopting a leadership mind-set that actively supports both innovation and effective operations is important for organizations to grow, sustain new practices, and excel in the future healthcare marketplace.

In today's healthcare environment, leaders and managers need a wide and varied range of competencies to manage not only the operations of the organization but also the work of continually adapting to new evidence, new technology, and new processes. The work of adapting to new approaches requires knowledge specific to creativity and innovation. This chapter presents the concept of innovation leadership, the rationale for innovation, leadership expectations, organizational structures and strategies to advance and integrate innovation, and metrics to measure innovation. Necessarily, the work of innovation is best served and supported in a professional governance framework. The 21st-century leader must develop these skills to lead in a world in which innovations are the lifeblood of the organization (Kiechel, 2012).

The seemingly contradictory nature of healthcare leadership, which requires both sound business practices to create real value for the organization and a designing eye on the future, is a challenge that has become more intense with the advent of the Internet. Leaders have always been concerned about adopting new work processes, just not with the intensity and frequency they are currently exhibiting. This balancing of initiatives presents the greatest challenge to contemporary leaders: Focusing on the work that is known is much less stressful than working to modify and eliminate the known work in favor of the unknown and untested. The risk-adverse mind-set of traditional organizations too often leads to continually reworking ineffective established processes—much like the metaphorical rearranging of the deck chairs on the *Titanic*!

The believed lower level of risk associated with traditional operations encourages leaders to focus on this work at the expense of designing the future. Innovation leadership makes it possible for the leader to address this challenge and to balance the work of sustaining current operations that result in profitability; simultaneously, the leader can work to re-create the future as new developments emerge in the healthcare world. In fact, innovation leadership allows the leader to develop and present the new processes. Superior innovation, according Davila, Epstein, & Sheltonues, (2006), provides an organization with the opportunities to grow faster, better, and smarter than its competitors—and to ultimately influence the direction of its industry. Coupled with

Key Point

A blockbuster innovation is not a guarantee of success, just an opportunity.

Davila, Epstein, & Shelton, (2006). Making innovation work: How to manage it, measure it, and profit from it, (1st ed.).
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the clarity of the recent study and explication of professional governance, nursing is more than ever well-positioned to contribute substantively to the processes and outcomes of value-based care, documentation of nursing contributions including translation of evidence-based research into practice, team-based care models for population health care in equitable interprofessional relationships and identification of opportunities for innovations in health practices (Clavelle et al. 2016).

Innovation is more than just creating new technology; it is about the continual adaptation to the changing environment and available resources that includes creating new business models and strategies for the organization to survive and thrive into the future. Innovation leadership is about balancing the need for value/profit and the creation of new and improved approaches to health care. Innumerable references and resources are now available on topics of innovation (**Exhibit 3-1**).

Exhibit 3-1 Selected Innovation References for Healthcare Leaders

Burns, L. R. (Ed.). (2005). *The business of healthcare innovation*. Cambridge, MA: Cambridge University Press.

Christensen, C. M., Anthony, S. D., & Roth, E. A. (2004). *Seeing what's next: Using the theories of innovation to predict industry change*. Boston, MA: Harvard Business School Press.

Christensen, C. M., Grossman, J., & Hwang, J. (2009). *The innovator's prescription: A disruptive solution for health care*. New York, NY: McGraw-Hill.

Davidson, S., Weberg, D., Porter-O'Grady, T., & Malloch. K. (2017). *Leadership for evidence-based innovation in nursing and health professions*. Burlington, MA: Jones and Bartlett Learning.

Davila, T., Epstein, M. J., & Shelton, R. (2006). *Making innovation work: How to manage it, measure it and profit from it*. Upper Saddle River, NJ: Wharton School.

Dy Bupin, J. J. (2016). Differences in innovative behavior among hospital-based registered nurses. *Journal of Nursing Administration*, *46*(3), 122–127.

Fagerberg, J., Mowrey, D. C., & Nelson, R. (2005). *The Oxford handbook of innovation*. New York, NY: University Press.

Gottfredson, M., & Aspinall, K. (2005). Innovation vs. complexity: What is too much of a good thing? *Harvard Business Review*, *83*(10), 63–71.

Joseph, M. L. (2015). Organizational culture and climate for promoting innovativeness. *Journal of Nursing Administration*, *45*(3), 172–178.

Kelly, T. (2005). *The ten faces of innovation*. New York, NY: Doubleday.

Ness, R. (2012). *Innovation generation: How to produce creative and useful scientific ideas*. New York, NY: Oxford.

Pauly, M. V. (2005). Competition and new technology. *Health Affairs*, *24*(6), 1523–1535.

Porter-O'Grady, T., & Malloch, K. (2010). *Innovation leadership: Creating the landscape of health care*. Sudbury, MA: Jones and Bartlett.

Rogers, E. M. (1995). *Diffusion of innovations* (5th ed.). New York, NY: The Free Press.

Schumpeter, J. (1943). *Capitalism, socialism, and democracy*. New York, NY: Harper.

VonHippel, E. (2005). *Democratizing innovation*. Cambridge, MA: MIT Press.

White, K. R., Pillay, R., & Huang, X. (2016) Nurse leaders and the innovation competence gap. *Nursing Outlook, 64*, 255–261.

Wisdom, J. P., Chor, K. H. B., Hoagwood, K. E., & Horwitz, S. M. (2014). Innovation adoption: A review of theories and constructs. *Administration Policy and Mental Health*, *41*, 480–502.

It is interesting to note that some researchers are challenging organizations to focus less on the traditional organization chart and more on how decisions are being made. An infrastructure that supports rapid, evidence-driven, and effective outcomes may be more localized in the job descriptions than in the organizational chart (Blenko, Mankins, & Rogers, 2010).

This chapter provides a new perspective and overview of innovation leadership as an essential competency of the quantum leader, the leader who approaches the work of health care from a systems perspective, continually recognizing the importance of sustainability, growth, and renewal for survival. The reader is encouraged to delve further into the rich and extensive writings on innovation.

Rationale for Healthcare Innovation

The rationale for innovation in health care is multifaceted but is primarily driven by the explosion of information on the Internet. Fragmented services, ineffective processes, patient safety concerns, and consumer expectations all have contributed to the need for change in the system. The transformation to a knowledge-based digital world, which includes the Internet, demands that leaders move faster, get optimized, and go global—all sooner rather than later. Contemporary leaders recognize that organizations cannot grow through cost reduction and reengineering alone. Neither can they survive when there is continual chaos and changing processes at the expense of providing value-based service. Organizations of the 21st century must be focused and create flexible structures that meet the new demands of the technology age in a way that supports the introduction, testing, and integration of new ideas. Asking individuals to think outside the box is insufficient for integrated innovation; principles, behaviors, and metrics for success are needed to support innovative thinking. Most important, new leadership mind-sets are needed for leaders to manage these seemingly contradictory expectations of stability and uncertainty.

Group Discussion

Is there any process, product, or technology that should not be changed or viewed as an opportunity for improvement? Is there any truth to the adage, "If it's not broken, don't fix it"? Identify examples of areas that are believed to be immune to change. If appropriate, describe strategies to gain support for evaluating opportunities for new and better approaches.

Healthcare innovation is not limited to creating an electronic medical record. It is about rethinking and re-creating healthcare methods of care delivery that include diagnostic approaches, communication methods with those involved in providing health care, documentation of services, and billing and payment services. Healthcare leaders are called to reinvent a healthcare system that was designed neither with safety in mind or to ensure organized and defined processes that support safety and minimize adverse patient outcomes. Innovations are needed to correct these inefficiencies. Interestingly, as leaders work to integrate the work of innovation into the organization, they are also challenged to identify those processes and treatments that lack evidence for efficacy and to eliminate them.

In the last 30 years, biotechnology has transformed the healthcare industry and has changed the way people are treated for disease. The convergence of biotechnology, information technology, and nanotechnology has transformed the way in which health care is provided. More than 300 biologics—drugs that target specific diseases—are now available (Kimley, 2006). It is now possible to improve treatment because biologics target specific diseases, turning many fatal diseases into chronic conditions. These innovations, although unequivocally beneficial for health, are not always welcomed and easily integrated into the existing healthcare system, which was designed for different products, services, and roles. Other areas that are also changing include patient care delivery processes, technology for diagnostics, patient record keeping, information integration, and the overall business model for health care.

Healthcare consumers are demanding care that does not require complex invasive processes and long recovery times. Providers of health care expect computerization, Internet access, and increasingly interconnected applications that integrate best practices and alerts to identify patient risk situations. Healthcare leaders and policymakers continue to expect more streamlined processes and expeditious communication of costs and transactions within the system.

Herzlinger (2006) identified three general categories that need improvement: methods of patient care delivery to consumers, selection and integration of technology, and the business models that support the entire healthcare system. **Exhibit 3-2** lists examples of areas for healthcare improvement within these three categories. Nearly, 10 years later these three areas of need remain.

Group Discussion

Often, innovation is confused with creativity or performance improvement. In a small group, compare and contrast the definitions and expectations of each of these three concepts. Consider also the advantages and disadvantages of each. Is there a difference in sustainability for each concept? How is each of these supported and funded in your organization? Based on your discussion, what recommendations would you make to advance innovation in your organization?

Exhibit 3-2 Healthcare Challenges

Patient Care Delivery
- Less invasive
- Less painful
- More convenient
- Less costly
- Increased consumer control

Technology
- Pharmaceuticals
- Diagnostic methods
- Patient record keeping
- Interconnected/integrated information

Business Models
- Less fragmentation of processes, providers, payers, settings, vendors, suppliers
- Increased vertical and horizontal integration

Definitions and Concepts Update

Innovation is not a magical, fog-laden concept. Because the concept of innovation is used and defined in many ways that can be confusing or misleading, clarification can assist leaders. Getting to common ground on what innovation is and what it is not serves to minimize confusion and chaos. It is also important to identify the key themes in each of these definitions and descriptions such as the time parameters, levels of change, driver of change, and agency (individual, team, or population). Attention to these components is helpful when an organization is adopting an innovation definition or creating one of their own.

Definitions and descriptions of innovation are as follows:

- Innovation is a historic and irreversible change in the way of doing things—creative destruction (Schumpeter, 1943).
- Innovation can be understood as a process of learning and knowledge creation through which new problems are defined and new knowledge is developed to solve them (Fagerberg, Mowrey, & Nelson, 2005).
- The power to redefine the industry; the effort to create purposeful focused change in an enterprise's economic or social potential (Drucker, 1985).
- Anything that creates new resources, processes, or values or improves a company's existing resources, processes, or values (Christensen, Roth, & Anthony, 2004, p. 293).
- The first, practical, concrete implementation of an idea done in a way that brings broad-based extrinsic recognition to an individual or organization (Plsek, 1997).
- The implementation of new or altered products, services, processes, systems, organizational structures, or business models as a means of improving one or more domains of healthcare quality (AHRQ Innovation Exchange, n.d.).
- Something new or different (*Webster's New Collegiate Dictionary*, 2001).
- The conversion of knowledge and ideas into a benefit, which may be for commercial use or for the public good; the benefit may be new or improved products, processes, or services (Erlendsson, 2005).

Related concepts are as follows:

- *Brainstorming:* A group technique of solving problems, generating ideas, and stimulating creative thinking by unrestrained, spontaneous participation in discussion (*Webster's New Collegiate Dictionary*, 2001).
- *Change:* To make different in form; to transform or modify (*Webster's New Collegiate Dictionary*, 2001).
- *Creative:* Having the quality or power to cause something new to come into being; imaginative (*Webster's New Collegiate Dictionary*, 2001).
- *Creative idea:* An original, novel thought.
- *Creative thinking:* Thinking in a new direction, away from or beyond current mental patterns toward some new pattern (Plsek, 1997).
- *Directed creativity:* Creativity on demand. Directed creativity involves using specific techniques that allow individuals to perceive things freshly, break free of the current mental models, make novel associations among concepts stored in memory, and use judgment to develop rather than reject new ideas. It is the purposeful production of creative ideas in a topic area, followed up by deliberate effort to implement some of those ideas (Plsek, 1997).

- *Disruptive innovation:* An innovation that cannot be used by customers in mainstream markets. It defines a new performance trajectory by introducing new dimensions of performance compared to existing innovations. Disruptive innovations either create new markets by bringing new features to nonconsumers or offer more convenience or lower prices to customers at the low end of an existing market (Christensen et al., 2004, p. 293).
- *Entrepreneur:* A person who organizes and manages an enterprise, especially a business with considerable initiative and risk (*Webster's New Collegiate Dictionary*, 2001).
- *Intrapreneur:* An employee of an organization allowed to exercise some independent entrepreneurial initiative (*Webster's New Collegiate Dictionary*, 2001).
- *Invention:* A new process, machine, improvement that is recognized as the product of some unique intuition or genius (*Webster's New Collegiate Dictionary*, 2001).
- *Process improvement:* The activity of elevating the performance of a series of actions, especially that of a business process with regard to its goal (Lock, 2007).
- *Research:* The investigation or experimentation aimed at discovery and interpretation of facts, revision of accepted theories or laws in light of new facts (*Webster's New Collegiate Dictionary*, 2001).

Innovation and the Quantum Leader

The role of the quantum leader is to create an infrastructure that integrates innovation into the overall work of the organization. Innovation leadership is about creating conditions, securing resources, and providing rewards for innovative work (Malloch, 2010). The desired culture supportive of innovation is one in which employees are encouraged and valued for both challenging existing work processes and providing services that ensure organizational viability. It is important to note that advancing one's culture to embrace innovation can be paradoxical—it takes time to shift a culture to support innovation with changing values, norms, and assumptions *and* the marketplace is demanding speedy changes (Miller & Wedell-Wedellsborg, 2013). Innovation leadership requires continually transforming and remaking structures and processes of the current system to integrate new processes and technology so that systems do indeed perform more effectively (Weberg, 2012).

The system complexity that accompanies healthcare innovation is a source of the accelerated uncertain expectations. Of significant concern for the contemporary leader is how to determine and manage the uncertain expectations associated with innovation, the speed at which change occurs, and the anticipated outcomes of new knowledge, technology, and process interactions with as little negative impact on the organization as possible.

By its very nature, there is no evidence for innovations in the making, only expectations. This reality does not deter most leaders from continuing to expect assurances and metrics for success. Risk taking is not viewed as a classic leadership behavior, and it is not traditionally welcomed and encouraged. Instead, risk taking is viewed negatively. It increases the organization's exposure to unforeseen hazards and to the loss of net income. Playing it safe and being a hardworking employee leads the organization nowhere because the intent is to sustain the past, to continue the practices that have been deemed to work yesterday.

Taking the initiative to advance innovation rather than clinging to the same old routine is now the work of the contemporary leader. This requires that leaders expose themselves to failure, avoid mediocrity, and embrace opportunities rather than retreat from them. The role of the leader is to inspire creativity and hard work and to challenge the past as the means to a

better future. The work of inspiration requires not just inspirational phrases but inspirational behavior. Risk-disposed leaders motivate others by showing what can be done, not merely by sermonizing about opportunities. They also exhibit candor and vulnerability, identify value in marginally successful efforts, and allow others to take risks and experience success and failure.

Innovation Leadership Is Not . . .

Innovation leadership is about integrating innovative ideas into the operation of an organization. Often, when an individual assumes the responsibility to manage the implementation of a technology product, the perception is that this work is innovation leadership. Innovation leadership is not project management. Innovation leadership is about who the leader is and how the world of work is approached. Project management is about the dissemination of processes using a top-down approach. Traditionally, the work of project management is done by a manager who is following and guiding the implementation of a clearly defined plan. However, as the healthcare industry works to better integrate innovation and operations, an innovation leader can also be a project manager for selected projects. This approach increases cross-fertilization of innovation and operations, and at the same time, it provides real-time opportunities for the innovation leader to correct course or modify the project plan to ensure optimal results.

Strategies to Integrate and Advance Innovation

The following considerations are suggested for leaders interested in advancing the work of innovation in the culture of the organization:

- Integrating mission, vision, and values within an innovation paradigm
- Assessing community and team needs
- Evaluating organizational structure
- Supporting organizational processes
- Measuring results

Integrating Mission, Vision, Values, and Innovation

The first consideration, to advance innovation, is a clear statement within the mission, vision, and values. It is important to formally define the organization's commitment to innovation as an integral part of the work of the organization. Using the previous list of definitions and descriptions of innovation, leaders can adopt, modify, or create their own definition to reflect the mission, vision, and values of the organization. The mission incorporates the desire to provide a service or product that is continually viable and able to meet defined goals. The vision statement continues the expression of the desired service and the level of achievement necessary to achieve the mission. The values selected are those that support behaviors necessary to achieve the mission of value and innovation. **Exhibit 3-3** is an example of innovation-based mission, vision, and values statements.

Exhibit 3-3 Innovation-Based Mission, Vision, and Values

Mission: To provide excellent patient care that provides value and makes a difference in people's lives.

Vision: To be the market leader of quality, service, and cost-effectiveness in health care.

Values: Participation, multiple intelligences, creativity, risk taking, respect for chaos, vulnerability leadership, evidence-based processes, and measurement.

Assessing Community Innovation

The second consideration is the identification of the needs of the community for innovation within the confines of the mission, vision, and values. Each organization is challenged to identify the unmet needs of the organization and its customers, the obstacles to excellent patient care, and the bottlenecks for efficient throughput as considerations when integrating the work of innovation with operations. Each of these three areas, according to Anthony, Eyring, and Gibson (2006), can assist the organization in creating a focus for innovation and avoiding the temptation to work on a great idea that is not consistent with the community or organization's needs.

Assessing Team Innovation Skills

In addition to knowing community and organizational innovation needs, it is also important to know the innovation skills of team members in the organization. Knowledge of comfort levels with different innovation skills can assist leaders in the reinforcement of existing skills and the development of new skills. The essence of innovation should be integrated throughout educational offerings. The opportunities to explore mental models associated with skill updates can be especially helpful.

Evaluating Organizational Structure

As previously stated, it is not enough to hold a one-day retreat and ask others to think outside the box. Structure and support are needed to fully embrace and realize the work of innovation. Interestingly, some believe that structure and process are the natural foes of creativity. Leaders often treat innovation as if it were magical, not subject to guidance or nurturing, much less planning. According to Samuel Palmisano, former president and CEO of IBM, that is not true. Rather, there are times, places, and conditions under which innovation does indeed flourish. Innovation and creativity require some restraint. Creativity with a vision, rules about how to get there, and deadlines support rather than hinder new ideas.

Valuing Natural Tensions

As one considers innovation structure, it is important to recognize the natural tensions and competing priorities that exist in a complex organization. There is a natural tension between being creative and delivering value from being creative. Leaders are very experienced in exploiting existing and known processes and less experienced in exploiting new opportunities for growth. Both the lack of time and the intense pressures within the existing work contribute to the limited attention and effort given

Key Point

Certain types of individuals, physical facilities, authority designations, decision-making expectations, and systems to document and measure results are essential elements of an organizational infrastructure. An organization's infrastructure is a reflection of the mission, vision, and values. Innovation leadership is about embedding support for innovative thinking in the mission, vision, and values and from there throughout teams in the organization. Organizational structures are continually evaluated and reshaped to better match the work to be done. Roles are added, modified, or eliminated to improve performance and outcomes. More recently, the advancement in professional governance provides new expectations for optimizing the organizations infrastructure. Each change is accompanied by anticipated but unknown outcomes.

to innovation. O'Reilly and Tushman (2016) challenge organizations to become ambidextrous organizations, or those that emphasize balance between creativity and value capture so that the company generates successful new ideas and gets the maximum return on investment. Balancing these two seemingly disparate processes requires leaders to think differently and to continually develop the skills of middle managers to balance these same processes.

Group Discussion

To increase comfort with innovation thinking, begin small. One example is relooking at the impact and value of continuing education programs. Consider two approaches to creating a continuing education program. In scenario A, the designer will use an established continuing education set of rules or guidelines. In scenario B, the designer will use principles; the expectation that knowledge will be integrated into practice and change behaviors. Compare and contrast the advantages and disadvantages of each approach.

The tension between stability and innovation is especially notable in the area of patient safety. Serious efforts are in place to support high-reliability processes in which there is consistency and redundancy to ensure safe outcomes. Standardization is the goal. What is also known is that despite standardization many patient care processes do not result in safe outcomes. Patients are injured from falls, medication errors, wrong-site surgical procedures, and malfunctioning equipment. Processes to test, innovate, validate, and ensure safety can be achieved through the lens of innovation leadership, organizational resources, and a strong commitment to excellence and continual course correction.

There are two basic models for organizational structuring to support innovation. The first approach is to develop leaders and managers who have the ability both to be rigorously dedicated to value and to support the work of innovation. With this option, the balancing of goals and priorities is much more complex than the balancing required for two distinct groups.

The second approach is to develop two distinct but collaborative groups in the organizational structure: one group focusing on current business value and the other group focusing on potential business. This approach deliberately secludes new ideas and intellectual property until the organization determines they are appropriate to release. With the two distinct groups, role confusion is also minimized. Interestingly, whereas this model is effective in the short term, separate innovation efforts and structures are at risk in times of economic stress.

Regardless of the approach taken by an organization, the leadership team must support operations that are multifocal in nature. The difference between the two options is in the amount of emphasis on each and the time required to support each approach. The skill to operate multifocally is necessary to effectively sustain business while exploring the future and minimizing organizational chaos. Choosing an approach is directly related to the levels of innovation anticipated by the organization and the available skill sets of employees. The integrated approach requires higher levels of leadership skills to plan, collaborate, negotiate, and synthesize when compared with distinct structures for current business and potential business. Seldom does an organization choose an all-or-nothing model. Rather, a combination of focused and integrated approaches is selected.

The anticipated expectations for innovations in the future should be considered in creating the structure. Levels of innovation range from minimal innovations to entire system innovations. Lower levels of innovations are described as incremental or partial and do not completely disrupt the work of an organization. Incremental innovations are introduced using project management methods and change management principles into existing systems to achieve diffusion of the innovation into the core of the organization.

Disruptive innovation, a concept identified by Christensen and colleagues (2004), is a unique approach to introducing innovation. The innovation focuses on disruption to the competitive landscape rather than incremental, semiradical, and very radical innovations that affect both technology and the business model. A healthcare example of disruptive innovation occurs when a large system builds a new healthcare facility that is designed to transform the healthcare experience. New technology, state-of-the-art technology, computerized patient records, and evidence-based architecture meld to create the backdrop for a culture revolution. Every work process and worker role is examined and remodeled to fit with the innovative healthcare facility. Not surprisingly, the work of design and construction is only the beginning. Identifying, role modeling, and sustaining new practices are the work of change management, negotiation, and teamwork.

Innovation Label versus Innovation Role

Another consideration is the use of the innovation label. The label *innovation* can have both positive and negative effects on the intended goals of the organization. Some believe that using the innovation title should be avoided because it further separates the work of innovation from the traditional work of creating value and profit for the organization. Labeling a new team, department, or individual with the innovation label separates business from design. The designers or innovators are frequently perceived as better or different from those in routine operations. In contrast, when senior leaders are able to value and function in both the business and the design worlds, the innovation label recognizes that innovation work is different, is funded differently, and is an important segment of the organization in addition to operations. The goal is to select a title that is consistent with the mission, vision, and values; does not induce hostility or divisiveness among coworkers; and invites as many as possible into the processes of innovation (**Exhibit 3-4**).

Exhibit 3-4 Innovative Leader Titles

- Chief Marketing Officer
- Director of Design and Brand Experience
- Chief Innovation Officer
- Champion of Innovation
- Chief of Design
- Director of Global Innovation
- Director of Strategic Marketing
- Innovation Champion
- Vice President, Enthusiast Services
- Vice President, Strategic Leadership and Competency Creation
- Chief Technology Officer

Supporting Innovation Processes

Walking the talk of the innovation mission, vision, and values requires specific behaviors that reflect the value of innovation for the organization. There are several considerations to support innovation. It is clear that although the traditional culture is one that supports stability and safety, this rationale cannot be used to avoid innovations. Leaders need to be aware of the culture but not blame the culture for failure to advance. These processes can assist leaders in transforming the current healthcare culture from a risk-averse model to one that balances both value creation for net income in the present and designing for the future. Support, measurement, and continual modifications are necessary to ensure the ultimate integration and value production. If this does not occur, the innovation dies a slow, sometimes painful, and sad death.

Interestingly, some organizations find that coming up with a great idea is the easy part; the more difficult work is selecting the right ideas and implementing them. There is no template or road map for innovation sustainability. What are available to leaders are the guiding principles of change management and conflict utilization, along with previous experiences in the integration of new processes and technology. Process activities that continually link innovation to the organizational mission through appropriate metrics and rewards reaffirm the commitment of leaders. Given the complex and multifaceted nature of innovation, no two innovation integration situations are identical.

Integrating innovation behaviors into the organization does not require a revolution inside of an organization. According to Davila and colleagues (2006), what innovation does require is thoughtful construction of solid management processes and an organization that can get things done. Employees want to be involved, valued, and know their work is meaningful (Goffee & Jones, 2013). Innovation should be routine rather than random, central rather than marginal, and exciting rather scary. Similar efforts to integrate quality assurance and performance improvement into the basic structure of the organization have occurred in health care and can be examined to assist in the integration of innovation work. Innovation leadership is about integrating two seemingly disparate worlds of business and design, and about integrating the need for safety and stability with the need to test innovations designed to improve safety, quality, and value.

Democratizing Innovation

Another consideration of integrating innovation is to democratize innovation in the work of the organization. Hippel (2005) proposed this concept in an effort to demystify innovation and to develop the skills of all individuals to respect and value innovation as a core value and process of the organization. Democratizing innovation is considered a 21st-century strategy for success. It is not unlike the efforts of national quality or patient safety initiatives; the work is no longer isolated to a specific department but rather is a core competency for all employees. The diffusion of innovations process described by Rogers (1995) relies on the accountability of leaders to internally and personally adopt innovations before the critical mass diffusion processes across the organization can occur. Leaders are encouraged to identify those individuals who are innovators and early adopters (Rogers, 1995) of change and to support the development of new expectations and metrics for changing work. Greater numbers of colleagues dedicated to innovation create a critical mass of energy and effort dedicated to thriving in uncertainty—uncertainty that is channeled into the productive work of confronting, monitoring, and modeling innovative behaviors whenever possible.

Expect Evidence-Based Processes

Another consideration is work based on evidence. Evidence-based practice and innovation may seem contradictory on the surface. Practice based on evidence seeks consistency and standardization, whereas innovation is about creating new and different processes and products. There is an inherent relationship between evidence and innovation, one that is both dynamic and, at the same time, rigorous and structured. Indeed, both innovation and evidence are essential to each other because innovation frees evidence to alter the trajectory of our practice and evidence disciplines innovation to affirm the veracity of practice (Malloch & Porter-O'Grady, 2013). **Figure 3-1**, the cybernetic interface of evidence and innovation (Malloch & Porter-O'Grady, 2013), is a diagram reflecting the dynamic nature of innovation and evidence. Information is always in process, either as evidence at some level or as an innovation needed to close identified gaps in research, outdated information, expertise, and/or clinical values.

Significant work has occurred in developing a commitment to providing patient care services based on evidence from research, the clinician's expertise and patient's values, and other recognized sources of knowledge (e.g., ethical knowing, sociopolitical knowing, and aesthetic ways of

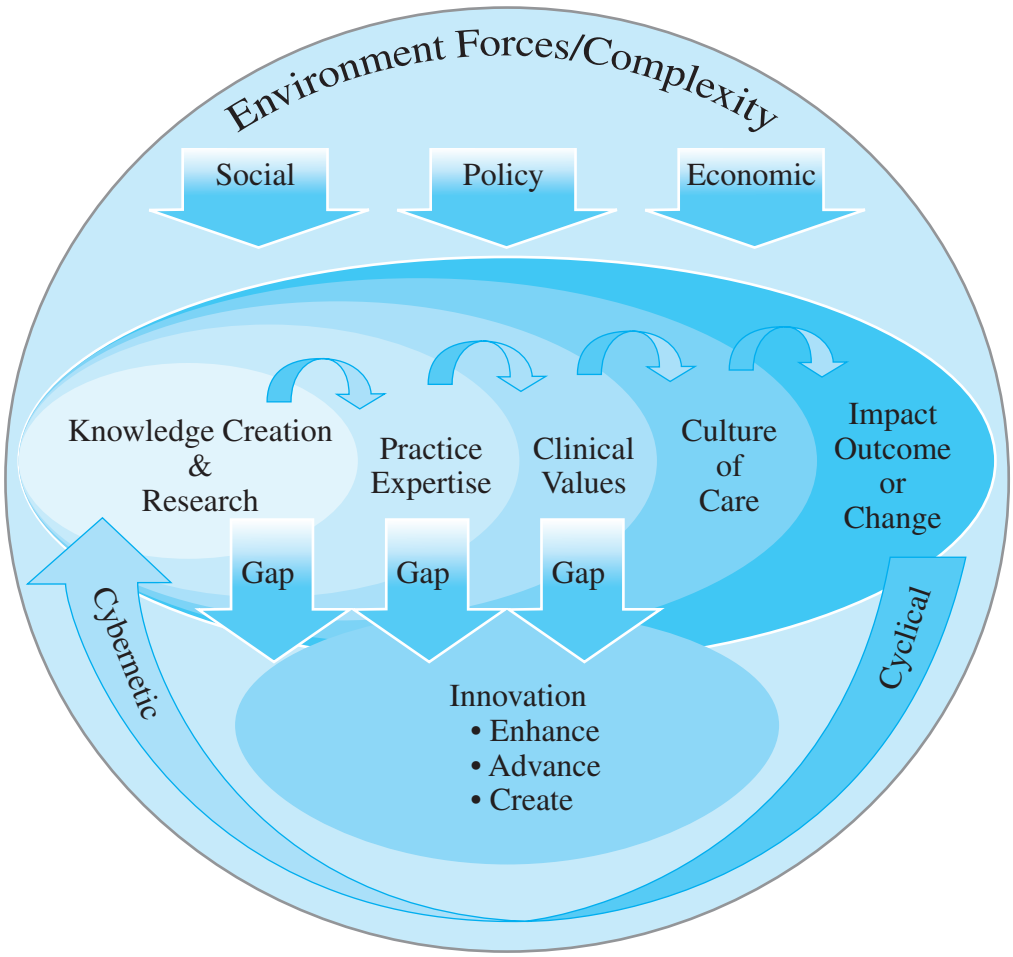

Figure 3-1 The Cybernetic Interface of Evidence and Innovation.

knowing) (Sanares & Hilliker, 2009). The relationship between evidence-based practice and innovation is apparent when there is a gap between research evidence and patient values. The recommendations from valid randomized clinical trials are seldom appropriate for every patient; rather, these recommendations are generalizable to patient clinical conditions. Implanted defibrillators, insulin pumps, and transdermal medications are specific to patient clinical conditions that must be examined for appropriateness prior to application. When a patient has difficulty functioning effectively with these recommended treatments, there is a need for exploration of other ideas and issues to discover innovative solutions that are more likely to achieve the desired outcome.

Valuing Multiple Intelligences

Successful innovations result from a unique combination of ideas, perceptions, beliefs, and skills. The innovation leader creates conditions for the expression and valuing of many intelligences and wide diversity as sources of new ideas. In addition to the traditional valuing of linguistic and mathematical intelligence, additional intelligences are supported and encouraged.

Intelligence theorist Gardner (1993) posited that most theories of intelligence, singular and multiple, assume that intelligence is simply a biological entity or potential and exists in the brain distinct from context. Gardner's theory of multiple intelligences is helpful for innovation leaders. The seven intelligences identified by Gardner recognize other spheres of knowledge and intelligence that could be supportive of creative thinking and the work of innovation (**Exhibit 3-5**). These intelligences each describe ways of knowing the world and how different individuals perceive the world. Each individual's perspective is rich with perceptions, ideas, and potential ideas to transform current realities. Additional intelligences from other authors contribute further to recognizing the wide and varied perceptions from individuals that leaders can access.

Provide Time for Reflection and Idea Generation

The work of the leader is to continually challenge the status quo to encourage new ideas and better ways to provide health care. Most work processes have limited effectiveness times; new technology quickly renders them ineffective and costly. The challenge is to determine which processes are the most obsolete and in need of replacement or elimination. Idea generation requires time and an open mind. Brainstorming, mind mapping, identifying what-ifs, model building, and future state mapping are strategies to support idea generation. Plsek (1997) described directed creativity as one of the essential strategies to assist individuals in bringing forth their creative skills and knowledge. Innovation laboratories also serve to intensely focus efforts on product idea generation from concept to reality. Leadership innovation laboratories

Exhibit 3-5 Seven Intelligences

1. *Linguistic:* The capacity to use language to express ideas and understand others
2. *Logical*/mathematical*:* The capacity to analyze problems logically
3. *Spatial:* The capacity to recognize and use patterns of pictures and spaces in one's mind
4. *Musical:* The capacity to think in music, to hear and recognize patterns
5. *Bodily*/kinesthetic*:* The capacity to use all or parts of one's body to solve a problem
6. *Intrapersonal:* Having an understanding of oneself and one's limitations
7. *Interpersonal:* The capacity to understand other people

Gardner, H. (1983). From frames of mind: The theory of multiple intelligences. Reprinted by permission of Basic Books, a member of The Perseus Books Group.

are less obvious and are traditionally integrated into executive leadership programs in which leaders are continually asked to integrate new knowledge, challenge assumptions, and redesign leadership processes. Leadership of the 21st century now demands new processes and outcomes. The 21st-century leader works to find the appropriate amount of time and frequency in which idea generation can occur.

Group Discussion

Using the seven intelligences, examine the innovation of the 3D printer and identify how each is realized in this innovation. Are some intelligences more prominent than others? Less prominent?

Resource: https://en.wikipedia.org/wiki/3D_printing

Recognize the Value of the Anomaly

Key Point

Be cautious that creative zeal does not crowd out the reality of organizational effectiveness and survival.

Not everyone is ready and willing to explore and consider new ideas. Resistors to innovation or process modification can be hostile and totally unwilling unless there is an overwhelmingly compelling reason to change. The greatest obstacle to innovation is people and their comfort with existing and known processes. Although is it unrealistic to expect all individuals to embrace innovation at the moment of introduction, the opportunity to recognize and value the anomaly is present. Innovation leaders necessarily work to neutralize the organizational resistance that kills off good ideas because they are different from the norm and work to transform the resistance into a meaningful phase of the innovation process. New ideas are anomalous to the norm and require individuals to behave differently. The anomaly, a deviation from the common order, can be considered a potential vehicle to a better future or an aberrant event that will be ignored and soon become extinct (Kuhn, 1970). Anomalies present both challenges that are inherent in the nature of the change process and opportunities to design and mold future systems. Innovations, in the purest form, represent anomalies to the individuals presented with the new idea or process. Some will embrace the novelty, whereas most will respond along the innovation adoption continuum described by Rogers (1995). When faced with an innovation, five characteristic behaviors are present in individuals: innovator, early adopter, early majority, late majority, and laggards. Rogers (1995) described the innovators as venturesome, educated, needing multiple sources of information, and having greater comfort with risk taking. The early adopters are social leaders, popular, and well educated. The early majority are more contemplative and have many social contacts. The late majority are typically skeptical, more traditional, and in lower socioeconomic groups. The laggards get information about innovations from friends and neighbors and worry about costs.

Providing information about the innovation is a crucial first strategy to persuading others of its value, to supporting a decision to put the innovation to use, and finally to accepting it. Resistance to anomalies is not uncommon. The digital world could be considered an anomaly as the move from paper to electronic documentation emerged. Virtual healthcare services, in which there is no physical contact between the patient and the provider, are another. Once the anomaly gains acceptance and is believed to be the preferred way to do work, the leader begins

the adoption process, using sound change management strategies to integrate the anomaly into the emerging paradigm.

Develop Capacity for Rational Risk Taking

Another consideration is proactive support for risk taking. Decision-making styles of leaders vary widely from very decisive to more contemplative. The risk of failure is ever present for all leaders and manifests in a variety of ways. Regardless, the risk of failure must not be paralyzing and counterproductive to organizational success. Rational risk taking is a skill to be learned and practiced within existing organizational structures.

Shifting the notion of risk taking as negative and costly to one of essential work in a complex and rapidly changing organization requires major organizational change in mission, role expectations, rewards and recognition, and measurement of outcomes. Traditional organizations view errors and negative outcomes as costly to the organization from both a quality and a financial perspective. Innovation leaders integrate the work of unsuccessful occurrences into the design work of the organization. These occurrences are viewed as opportunities for discussion and evaluation of the existing system structure and processes.

Rational risk taking is designed to enhance the organization, to support innovative processes, and to avoid obvious negative outcomes. Examples include advancing the organization and skill development. Adding new programs, expanding services, selecting equipment and technology, and selecting priorities are rational and minimize risk when choices are made on the basis of core values, respect for others, the safety of individuals, strategic goals of the organization, and available resources. Another example is developing the skills of employees. Gaining new knowledge and skills is considered a rational risk when those skills are needed to improve job performance or to develop abilities for anticipated opportunities. Examples include developing computer application, public speaking, sports, creative arts, and personal protection skills.

Risk taking is considered irrational in several situations. The first situation is when there is a history of failure and oppression. If the last attempt did not work and there is little interest, the risk should be questioned. It is important to recognize that something might not have been successful previously and could be successful in the future under the right conditions. Continuing to push an idea or product with new energy, new rationale, and new value is irrational. The second situation is poor judgment. Walking in traffic is an example where the risk of injury to oneself and to others is present and probable. This action is irrational and similar to the leader who continues to hire employees in the midst of a financial crisis. The organization incurs additional financial obligations and the positions of new employees will most likely be eliminated. The third irrational risk is in situations where there are unrealistic expectations or very little potential for success. Attempting to implement one more program when the staff is already overwhelmed and frustrated is not rational.

Group Discussion

The iPhone and GPS have contributed to the revolution of communication across the globe. As these tools gain increasing acceptance, their utility seems obvious and irrefutable. Reflect on these innovations and identify at least five obstacles that were offered to resist them. Consider the resistance from funders, policymakers, competitors, potential users, family members, and retailers.

Form Uncommon Partnerships

Another consideration to advance innovation is the creation of partnerships that include individuals from diverse backgrounds and disciplines. Innovation requires teamwork and strategic partnerships that are in-person, verbal, and virtual online relationships. Networks of stakeholders are the building blocks for innovation. Strategic partnerships serve to allow organizations to create value that no single individual or organization could create alone. According to Adner (2006), innovation ecosystems bring both new opportunities and new risks. These new partnerships include risks specific to creating an initiative, ongoing coordination of activities, and adoption strategies to ensure the initiative is fully integrated into the system.

Multiple levels of collaboration and teamwork are needed to support innovation. Internal stakeholders, those who touch the innovation in any way, and others external to the process should be considered for brainstorming and idea generation. Often, those external to the process who could provide new insights are not easily identified. Many successful innovation leaders deliberately invite colleagues with differing viewpoints and points of reference to form a more complete approach. Examples of colleagues external to the process include stakeholders responsible for the location of services, payments, ownership and oversight of the processes, profit status, patient advocacy, technology development, legal accountability, policymaking, and quality measurement.

Measuring the Results: Innovation Metrics and Evaluation Strategies

New metrics are needed when innovations are introduced. In most cases, multiple interrelated metrics are required to adequately reflect the value of the innovation. Measurement of an innovation, both qualitative and quantitative, is essential and fundamental to the work of the organization. What is different about measuring innovations is that initially only historical and anticipated metrics can be selected to examine. The innovation leader selects a group of metrics knowing that they must be routinely evaluated for comprehensiveness and sensitivity and updated as needed as new and unexpected changes occur with an innovation (**Exhibit 3-6**).

Numerous organizational metrics specific to broad operations, human resources, supplies, technology, and patient outcomes are available. Often, single metrics are selected to evaluate effectiveness to simplify the measurement process. The disadvantage to single-metric

Exhibit 3-6 Guidelines for Selection of Innovation Metrics

1. Select metrics to assess innovation progress and costs in advance. Incremental benchmarks are especially important to track and trend progress. Different sets of funding, testing, and performance criteria for incremental, experimental, and potentially disruptive innovations are needed.
2. Aim to identify early successes. Major initiatives often require significant time to realize the full benefits. Interim achievements are necessary to demonstrate progress and the likelihood of achieving the full potential of the innovation.
3. Get data to back up your gut. Successful innovators begin with the "gut feeling" and must move quickly to develop the quantifiable supporting data.

Group Discussion

Innovations in Communication: Blogs, Social Networking, and Podcasting
Blogs, social networking, and podcasting are recent modes of electronic communication. The organization is looking for ideas on how to improve patient throughput in the emergency department. How could each of these modes of communication, or a combination of the modes, be used to obtain ideas and provide new strategies to improve throughput? Consider who should be involved and create a problem statement and measures for success.

Blog: A weblog, usually shortened to blog, is an online publication with regular posts.

Social networking: Internet-based programs used to make connections with others.

Podcasting: A method of distributing multimedia files across the Internet. A podcaster creates content for an audience that wants to listen when they want, where they want, and how they want.

evaluation is the loss of information specific to interim achievements that may ultimately affect the selected single metric. For example, selecting hours per patient day as the single metric to evaluate an innovative model for patient assessment would not consider the quality and completeness of the assessment data. Incomplete data could result in an extended length of stay and patient complications.

When different metrics or different groups of metrics are selected for analysis, additional uncertainty is introduced and the number of potential conclusions increases. The work of the leader is to identify the metrics that reflect the true value of the work.

The greatest difficulty is to identify and measure what really matters—which metrics are the critical variables that indicate value, service, and cost outcomes accurately and comprehensively. Multiple related metrics are required to explain the causality of relationships; seldom does one variable explain one outcome. By its very essence, the complex and dynamic nature of health care renders it resistant to simple linear cause-and-effect metrics. For example, no one intervention is accountable for the resolution of a patient's pneumonia; diet, fluids, medications, and activity all contribute to the resolution of the chest congestion. Similarly, the hours per patient day metric cannot be simply linked and traced to the activities of a single unit leader; the competence of staff, level of illness of patients, number of interventions required, and availability of equipment and supplies all affect the level of hours per patient day used. With each modification of work, the outcome expectations change. New mind-sets, new approaches, and new resources also evolve as expectations change. Consider the evolution of two processes: creating and managing one's personal calendar and the documenting process. It is important to note that as the innovation evolves and becomes more defined, expectations evolve reflecting the intent of the innovation. This evolution of expectations is an integral part of the process of adopting innovations (**Exhibit 3-7**).

Key Point

Innovation never occurs in isolation or by a single individual—it requires a team of dedicated individuals passionately committed to making a difference.

Exhibit 3-7 Personal Calendar: Evolving Expectations and Metrics

Innovation	Expectation (Intent)	Metric
Handwritten calendar	Summary of information	Appropriate space allocation for entries
Computerized calendar	Automated, editable, accessible by multiple individuals, able to archive and retrieve information	Real-time availability, accessible to selected individuals to facilitate scheduling; decreased time in calendar management
Interconnected Internet-accessed calendar	Wireless, Internet access	Accessibility from multiple devices and multiple locations

Not all innovations require new metrics. Some changes in healthcare work result in new expectations for greater involvement of individuals or higher performance targets while the specific metric remains the same. For example, changing from nurse-administered pain medication to patient-controlled analgesia pumps does not change the expectation for pain control; rather, the intent of the change is to improve the level of achievement or performance of the specific metric. Patient satisfaction with pain control and comfort should be better with the patient-controlled analgesia than with nurse-administered pain interventions (**Exhibit 3-8**). Discussed elsewhere in this text are the challenges and nature of innovation valuing.

Course Corrections

Expectations for success are not realized for a variety of reasons (Key Point). The wise leader works to minimize the time spent ruminating about the unsuccessful events and focuses on developing new solutions and course corrections to achieve the desired outcomes. Change often fails if the culture is not supportive or if leaders are not qualified to lead innovation. The lack of urgency, poor communication, or lack of teamwork are common obstacles (Ponti, 2011). According to Rogers (1995), rejection of an innovation may occur any time along the adoption process, which includes awareness of the innovation, interest, evaluation, trial, and then adoption.

Key Point

Getting great ideas into practice is often a challenge and requires several course corrections to achieve the desired result.

Common causes of failure

1. Inadequate preparation
2. Lack of pretesting
3. Lack of engagement of key stakeholders
4. Lack of support for the new idea
5. Poor timing
6. Rigid implementation rules
7. Idea fragmentation: New idea not integrated into the system of care

Strategies to increase success and avoid failures

1. Prepare with those involved in the implementation and longtime use
2. Pretest or pilot the idea
3. Engage and communicate the value to users
4. Support the implementation and follow-up
5. Practice good timing
6. Be open to flexibility in implementation
7. Integrate accountability into the system

Exhibit 3-8 Barriers to Effective Innovation Measurement

1. The business model is flawed, resulting in selection of the wrong levers of value creation.
2. Subjective measures of effectiveness are excluded.
3. Available information technology for data mining and analysis are not used.
4. Information technology replaces analysis and judgment.
5. The right question is not asked about what is being measured.

Davila, T., Epstein, M. J., & Shelton, R. (2006). Making innovation work: How to manage it, measure it, and profit from it (1st ed.). Adapted by permission of Pearson Education, Inc., Upper Saddle River, NJ.

Discontinuance is a rejection that occurs after adoption of the innovation. Further, there are two types of discontinuance:

1. Disenchantment discontinuance, which is a decision to reject an idea as a result of dissatisfaction with its performance
2. Replacement discontinuance, which is a decision to reject an idea to adopt a better idea

Given the inevitability of rejection or discontinuance of a new work process, the emphasis, first, needs to be on making course corrections with evidence and rationales and, second, on realizing the information and lessons that can be learned from the experience. Before implementing course corrections or new strategies, the team must once again be sure that the values of the work continue to be congruent with the organization, and then the team can challenge the assumptions of the work processes that went awry and clarify expectations that new processes have a high degree of potential for success.

Conclusion

For innovation leadership, processes that require and improve performance on the basis of defined innovation as the way of doing business are essential. An assessment of current ways of doing business, identifying the unwritten rules about how work is accomplished and how these processes enable or inhibit innovation, begins the transformation to a balanced value-innovation culture.

Chapter Takeaways

1. Innovation is an essential component of healthcare organizations.
2. Professional governance advances the clarity and quality of nursing's collaborative work in health care.
3. The leadership of innovation includes the following competencies: engaging others, thinking differently, and creating the business case for innovation.
4. Course corrections to new ideas are an essential part of the innovation process.
5. Rational risk taking should be encouraged to continue the growth of the organization.

Case Study 3-1

Innovative Strategies to Prevent Hospital Readmissions

Mission Medical Center is a 700-bed hospital in an urban city in the Southwest. Mission is part of a vertically integrated healthcare system with a number of physician medical groups, ambulatory care settings and surgical centers, a psychiatric hospital, and orthopedic specialty hospital, and a children's specialty hospital. All of the hospitals are within a 50-mile radius of one another. At Mission Medical Center, the nursing division is organized under a chief nursing officer (CNO) who is also the designated chief operating officer (COO) for the medical center.

John has 25 years of experience in nursing leadership, and for the past 10 years, he has been the CNO for Mission Medical Center. Six nursing directors report to John and provide supervision and direction to Medical-Surgical Services, Surgical Services, Maternal-Newborn Services, Rehabilitation Services, Intensive and Emergency Services, and Professional Support Services. John meets with the directors once a week for a Nursing Operations Council that focuses on the operational aspects of providing and coordinating patient care with other professional disciplines. Once a month, John meets with the directors and the clinical nurse specialists (CNSs) for Nursing Executive Council. The purpose of the Nursing Executive Council is to promote the professionalism of nursing, advance strategies and initiatives to improve patient care outcomes, promote research and evidence-based practice, and ensure a healthy work environment that attracts and retains nurses. Mission Medical has been designated as a Magnet organization and is currently working toward redesignation, which is scheduled in approximately 2 years.

As an organization, Mission Medical is very forward thinking and is considered to be one of the top hospitals in the state. One of the reasons that Mission has earned its reputation is because of its recruitment of top medical specialists, attractive new patient bed tower, the latest of capital equipment for patient care and surgical services, and a strong financial foundation. Whereas Mission Medical has strategically sought to advance its market penetration into competitor territory, it has also been thoughtfully conservative not to overbuild beyond its financial capacity. The strategy to emphasize excellence in patient care services, excellence in the work environment, and excellence in medical staff has attracted a constantly growing market share of insurers wishing to contract with Mission Medical and individuals in the community who have elected to purchase medical care through the Mission Medical Plan.

At one of the Nursing Executive Council meetings, a discussion ensues about changes that may need to occur as a result of the new Affordable Care Act. John and the directors realize that reimbursement will be strongly tied to patient outcomes, readmissions to the hospital within 30 days, and other operational metrics. Although the nursing-sensitive indicators, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores, and satisfaction levels of patients, physicians, and nurses are extremely high, the directors realize that they must somehow motivate nurses to identify new ways of providing patient care that will minimize redundancies and maximize workflow. They also realize that they must ensure that every patient is ready to be discharged and able to care for him- or herself at home to prevent readmissions within 30 days of discharge. The directors and clinical nurse specialists discuss a number of ideas. John encourages the open discussion and listens to each of the ideas with interest. While he quietly listens to the input from the nursing leaders, he considers the

various organizational structures and processes that might need to change to support some of the ideas. He realizes that he must also encourage the nurse leaders to consider how they will measure the effect of the changes that they would like to implement, but he does not want to discourage the open dialogue and freethinking during the initial stages of the discussion.

One of the major points of discussion is about the prevention of readmissions within 30 days of discharge. Because of the major financial impact that this issue has on the hospital's bottom line, John and the nurse leaders are keenly interested in any innovative thinking as to how to prevent these occurrences. After several hours of open dialogue, John asks the CNSs and the nursing directors to divide into three teams and challenges them to work together in their teams to identify strategy around preventing readmissions. To incentivize the groups, John states that the team with the best idea will be rewarded with a prize for their respective areas. He also tells them that their ideas must include not only the intervention but also methods of measuring the effect of the intervention on reducing readmission rates. He suggests that the directors work with the chief financial officer (CFO) to develop a return on investment (ROI) on their respective ideas. The group agrees that they will reconvene in 1 month for each group to present their ideas.

Three groups return a month later with posters to illustrate their respective plans, formal PowerPoint presentations, and supporting evidence to substantiate their innovative thinking. Group 1 recommends developing a role in each unit for a discharge resource nurse, who would not be counted in the daily staffing, but who would be responsible for reviewing each patient's status for discharge. The discharge resource nurse would coordinate patients' needs with social services, the discharge planner, the physician, and the patients' family to ensure that all of the resources that the patient needs after discharge would be readily available upon arrival home. In addition the discharge resource nurse would assess patients' understanding of their illness each day and their knowledge of their medications, required therapies, and appointments with their primary providers. A significant part of the discharge resource nurse's role would include patient and family education and assessment of the patient's readiness for discharge. Group 1 suggests that they would measure success by reducing the number of readmissions per quarter from the existing baseline. They estimate that the cost savings from potential losses in reimbursement without the intervention would more than pay for the expense of the new discharge resource nurse position.

Group 2 proposes a very similar intervention; however, they based their proposal on evidence that demonstrated the effectiveness of a patient-centered approach to care in improving patients' knowledge and ability to care for themselves prior to and after discharge. Group 2 proposes defining "patient-centered care" to be patient empowerment, engagement, and activation in their care. The new definition of patient-centered care would reflect nursing's involvement in educating the patient and empowering patients with knowledge to be completely engaged in decisions related to their care, and thereby activating patients' own resources to care for themselves at home. Group 2 presents the notion that every nurse believes that he or she provides patient-centered care without fully understanding the concept or realizing the nurse's role and responsibility in ensuring patients' involvement in their own care. The CNSs in Group 2 propose an educational platform for nurses to promote the new definition of patient-centered care and provide standardized educational plans for high-risk conditions that have been correlated with readmissions in the past. The CNSs propose that they would measure the effectiveness of their plan by having patients and/or their families complete a Readiness for Discharge Assessment tool that they had reviewed in the literature

and to measure the patients' knowledge and abilities to follow up with their proposed treatment plan during hospitalization and after discharge.

Group 3 recommends a collaborative, interprofessional approach using team rounding with the patient each morning to ensure that the patient and family are knowledgeable about the plan of care. In addition to the team rounding, Group 3 suggests changing the unit structure to include a clinical nurse leader (CNL) who would be assigned to approximately 12 patients with a team of primary care nurses. The CNL would coordinate all of the patients' care among the various disciplines and ensure that patients were being instructed and engaged in their care. In addition the CNL would coordinate with the discharge planner, social services, and other specific disciplines to meet with the patient each day of his or her hospitalization in preparation for discharge. Group 3 also proposes adding a responsibility to the primary nurse's role to call each of the discharge patients 1 week after discharge to ensure that they are adequately cared for and following up with medications, therapies, and provider appointments. Group 3's proposal includes the addition of several new positions. They present several studies where the role of the CNL saved money in other organizations and improved patient satisfaction, physician satisfaction, and nurse satisfaction rates and patient outcomes.

John invites the CFO, the CEO, and a guest consultant to hear each of the proposals and to provide feedback to each of the teams. It is a time of great excitement because of the competitive nature of the presentations, but also friendly engagement in discussions about the merits of each of the proposals. It is suggested that the best intervention would be a combination of all three proposals with the development of the CNL who would act as a patient care coordinator and a resource nurse to support the direct care providers. In addition it is suggested that the discharge nurse coordinators assume a greater role in assessing the patients' readiness for discharge and that the CNS group and nurse educators assume a greater role in assessing the patients' level of knowledge and ability to care for themselves and to follow up with the proposed treatment plan while in the hospital or after discharge. It is decided that a previously published instrument, Readiness for Discharge Assessment Tool, would be used with all patients to assess their level of empowerment through education, engagement in decision making and planning, and activation of their own skills for self-care. It is also decided that the Readiness for Discharge Assessment Tool would be used again in a follow-up phone call by a discharge liaison nurse (new role) who would contact each of the discharged patients for the unit on day 2, day 5, and then weekly for a month after discharge. In addition the group decides to develop a "Call a Nurse" hotline to facilitate decision making among discharged patients relative to their questions about their health status, follow-up instructions, or care questions.

The CFO offers to work with the directors to estimate the expense of the new positions and the return on the investment for minimizing the number of readmissions each quarter. All of the participants realize the risks involved in adding new full-time equivalents (FTEs), but also realize the potential loss of revenue that would result from readmissions within 30 days of discharge. The CEO and CFO are particularly impressed with the evidence shared from other hospitals that had implemented the CNL role and subsequently reported positive outcomes from having nurses with master's degrees coordinating the care, discharge, and after-hospitalization experience of a small group of assigned patients. This idea coupled with the other support roles seems to be the best innovation to address the problem of loss of revenue related to readmissions within 30 days of discharge.

Questions

1. What are your thoughts about John's approach to using friendly competition among the three groups to motivate them to think creatively about solving the problem?
2. Of the three possible proposals, which proposal do you think has the greatest merit in reducing readmissions?
3. Because the three groups were charged with designing an innovative solution to the problem, how do you think that the morphing of their proposals into a fourth solution affected the nurse leaders' motivation to think creatively in the future?
4. What would you add to the final solution to ensure its success in decreasing the readmission rate for Mission?
5. What barriers, if any, do you think that the nursing leaders will encounter when implementing the final proposal to reduce readmission rates?
6. What stakeholders do you think should be involved in developing implementation and measurement strategies in the adoption of this new innovation?

Case Study 3-2

Using Innovative Strategies to Correct Unit Problems

There seems to be a serious problem among the nursing staff on the acute care unit at West Memorial Hospital. The unit manager has just received the employee opinion survey results for the past year and is shocked to find that the questions related to "respect among employees" and "open communication among employees" were scored in the 25th percentile. The nursing satisfaction scores on the NDNQI survey are also extremely low in comparison to other nursing units at West Memorial Hospital. The unit manager realizes that something needs to be done to improve the scores, but most important to improve the morale of the nursing staff and their satisfaction with the work environment. The unit manager shares the results with the clinical nurse specialist (CNS) and enlists his help in determining the root of the problem. The two decide to talk with some of the informal leaders among the nursing staff to ask their perceptions of why nurses would rate their satisfaction level and their respect and communication among their colleagues so low on the two surveys.

While talking with several other nurses, it becomes readily apparent that they are not willing to talk or share their feelings with the unit manager or the CNS, and in fact it seems as if some of the nurses are actually fearful of talking at all about the situation. One or two of the more courageous nurses who are interviewed share that they are fearful of reprisal from some of their colleagues. They share that several of the nursing colleagues on both the day and night shifts would refuse to talk with them or help them when they tried to approach them about improving communication among the nurses. The unit manager and the CNS are quite concerned about the situation but are uncertain how to approach correcting the problem.

Not long after the survey results are available, there are two reportable patient falls. When the nurses who were involved in the care of the patients are interviewed, they indicate that in one case the nurse did not ask for assistance from any of the other nurses to get the patient out of bed for the first time because there had been recent occasions when some nurses were openly hostile when asked to assist in patient care. In the second patient fall, the nurse involved indicates that she had asked for assistance from her colleagues, but they had openly refused to help her. Therefore, she tried to ambulate the patient on her own and was unable to

prevent the patient from falling. These two incidents confirm in the minds of the unit manager and the CNS that something needs to be done quickly to correct the attitudes and behaviors of the nursing staff on the unit. Patient safety was at risk, and nursing morale was at the lowest it had ever been.

Although the unit manager tries to discuss the situation in staff meetings and asks the staff to be more collegial with one another, it seems that this message falls on deaf ears. It is quite obvious that the nursing staff are unwilling or fearful to speak to anyone about the specifics of the situation. It is also obvious that there were informal leaders among the nursing staff who may have instigated the bullying behavior toward some of the less experienced and younger nurses.
The unit manager invites a human resources representative, a counselor from the employee assistance program, the CNS, and a member of the Lean/Six Sigma team to a meeting to discuss the situation and to identify possible interventions to address the problem. The group decides to call themselves the "Innovation Team" and decides to use an innovative approach to solving the problem because the traditional method for a quick resolution had failed. After discussion among the Innovation Team, it is decided that a more detailed assessment needs to be done to determine the actual issues among the staff. Because talking with the nursing staff was not effective because of the fear factor, the employee assistance program counselor suggests having a series of education and discussion sessions regarding the importance of a healthy work environment, collegiality, and open communication among the nursing staff for their own well-being and for patient safety. She volunteers to develop a content outline that could be presented to the group at their next meeting. She also offers to have more time available for individual counseling should any of the nurses elect to participate. The CNS offers to do a literature search to find a survey or instrument that could measure nursing attitudes more specifically so that a definitive action might be taken. The Six Sigma representative reviews the problem using an A3 diagram to mind map all possible scenarios that could be causing the problem and also a fishbone diagram identifying the desired outcome and all of the potential barriers that were preventing the desired outcome in the current situation. The group realizes the severity of the problem and the potential for other patient issues; therefore, they place the actions in the high-priority category for implementation.

The CNS discovers several survey tools to measure collegiality, communication, trust, and respect among nurses and prepares a formal institutional review board (IRB) proposal to measure these attitudes and behaviors before and after the educational series. The series would be presented by the employee assistance program (EAP) counselor to raise the staff awareness and knowledge about the benefits of a healthy work environment and the risks of a negative, hostile, and uncooperative work environment to their own health and to the safety of their patients. It is decided that after a few of the educational sessions, the Six Sigma representative would engage the staff in conversations using the mind-mapping technique and fishbone diagrams to openly discuss some of the issues that the staff were obviously feeling. It is felt that this step cannot be taken until more trust is developed among the staff, which is expected after the educational series is presented.

After IRB approval of the proposal, the CNS posts flyers on the unit and announces in the staff meetings that a survey would be available for the staff related to developing a healthy work environment. He also announces that a series of educational classes would be presented by the EAP counselor on developing a healthy work environment and that he hopes that as many staff as possible would participate by completing the survey and attending the classes.

It seems that the nursing staff feels safe in recording their perceptions of the communication, respect, and cooperation on the survey instruments when they were not at all expressive of their feelings in individual meetings or group settings. After the presurvey is completed, the CNS tabulates the results and shares the findings with the nursing staff in the staff meetings. It seems as if the staff are shocked at the level of discontent that is revealed in the survey results. Perhaps these findings motivate the staff to attend the educational sessions offered by the EAP counselor, which focus on crucial conversations, crucial confrontations, collaboration, respect in the workplace, and attributes of a healthy work environment. It is stated in the classes that every employee has a right to feel safe in the work environment; supported by their unit manager and colleagues; respected for their individuality, knowledge, and skills; and accepted as a valued team member. Each class also includes time for discussion; however, in the initial classes most of the participants are absolutely silent. As they receive more content, many of the staff begin to participate by sharing their personal feelings and hopes that a healthy work environment could be achieved. By the end of the educational sessions, it is apparent that the staff are engaged not only in the class content but also in a newly found commitment to improve the unit culture. Informal leaders with negative attitudes suddenly lose their power base and followers as many of the staff begin to demonstrate behaviors that they are more willing to place their affiliation with the group who wants to make a more positive work environment.

After the classes end, the EPA counselor keeps her promise and offers 1 hour of individual counseling to any employee who wishes to meet with her. Many of the staff accept that offer and meet with the counselor. The Six Sigma representative also meets with some of the more positive staff members, and they begin to identify specific causes of some of the issues and identify possible behavioral changes that could create positive changes.

Several months later the CNS readministers the postsurvey, and the findings reveal significant improvement in the staff's perception of open communication, respect among coworkers, nurse satisfaction, and perceptions of cooperation in patient care. Needless to say, the Innovation Team is excited about the findings and develops a strategy for sharing these findings with the staff. Tables and graphs of the improvements are prepared, and the findings are shared in a special staff meeting on both day and night shifts. The EAP counselor is on hand to facilitate discussion among the staff who also seem excited about the results. Many of the staff comment that the changes on the unit are palpable and that coming to work is a much more pleasant experience. It seems that the staff are engaged in resolving the issues and committed to making the work environment more pleasant.

The unit manager and the CNS are excited about the positive changes that they could see on the unit for themselves and that are reported to them by individual nurses who comment on how appreciative they are that steps were taken to change the work environment. The unit manager and the CNS decide to write an article about how their unit's culture changed once the staff realized how the problem was affecting them personally as well as negatively affecting their patients. Increasing the staff's awareness about the potential for a healthy work environment and the behaviors that would be required of them to create such an environment made a significant difference in their overall perceptions of the relationships with their colleagues. The Innovation Team also prepares an abstract for presentation at a national nursing conference on Innovations in Nursing Practice and is selected to share their process of problem identification, problem solutions, and measuring the outcomes of the innovative interventions.

Questions

1. What are your perceptions of the methods used by the unit manager and the CNS to resolve the unhealthy work environment on the unit?
2. What might have been some of the barriers that could have been anticipated by the Innovation Team in resolving the negative work environment?
3. What are the factors that might affect the adoption or rejection of the innovation that was used to improve the work environment?
4. How did the Innovation Team engage the staff in resolution of the poor unit morale?
5. What might you do as an innovation leader to ensure that this change was sustained over time?

References

Adner, R. (2006). Match your innovation strategy to your innovation ecosystem. *Harvard Business Review*, *83*(4), 98–116.

AHRQ Innovation Exchange. (n.d.). Home page. Retrieved from http://www.innovations.ahrq.gov/

Anthony, S. D., Eyring, M., & Gibson, L. (2006). Mapping your innovation strategy. *Harvard Business Review*, *83*(5), 104–113.

Blenko, M. W., Mankins, M. C., & Rogers, P. (2010). The decision-driven organization. *Harvard Business Review*, *87*(6), 54–61.

Christensen, C. M., Roth, E. A., & Anthony, S. D. (2004). *Seeing what's next: Using theories of innovation to predict industry change.* Boston, MA: Harvard Business School.

Clavelle, J. T., O'Grady, T. P., Weston, M. J., Verran, J. V. (2016). Evolution of structural empowerment: Moving from shared to professional governance. *Journal of Nursing Administration, 46*(6): 308–12

Davila, T., Epstein, M. J., & Shelton, R. (2006). *Making innovation work: How to manage it, measure it, and profit from it*. Upper Saddle River, NJ: Wharton School.

Drucker, P. F. (1985). *Innovation and entrepreneurship*. New York, NY: Harper & Row.

Erlendsson, J. (2005). Innovation. Retrieved from http://www.hi.is/~joner/eaps/innodd.htm

Fagerberg, J., Mowrey, D. C., & Nelson, R. (2005). *The Oxford handbook of innovation*. New York, NY: Oxford University Press.

Gardner, H. (1993). *Frames of mind: The theory of multiple intelligences*. New York, NY: Basic Books.

Goffee, R., & Jones, G. (2013). Creating the best workplace on earth. *Harvard Business Review*, *90*(5), 99–106.

Herzlinger, R. E. (2006). Why innovation in health care is so hard. *Harvard Business Review*, *83*(5), 58–66.

Hippel, E. V. (2005). *Democratizing innovation*. Cambridge, MA: MIT.

Kiechel, W. (2012). The management century. *Harvard Business Review*, *89*(11), 63–75.

Kimley, A. W. (2006). Biotechnology leads the way. *Harvard Business Review*, *83*(5), 51–54.

Lock, D. (2007). *Project management* (9th ed.). London, England: Gower Publishing, Ltd.

Kuhn, T. (1970). *The structure of scientific revolutions* (2nd ed.). Chicago, IL: University of Chicago.

Malloch, K. (2010). Innovation leadership: New perspectives for new work. *Nursing Clinics of North America*, *45*(1), 1–9.

Malloch, K., & Porter-O'Grady, T. (2013). Innovation and evidence: A partnership in advancing practice and care. In B. M. Melnyk & E. Fineout-Overholt (Eds.), *Evidence based practice in nursing and healthcare: A guide to best practice*. Philadelphia, PA: Lippincott Williams & Wilkins.

Miller, P., & Wedell-Wedellsborg, T. (2013). The case for stealth innovation. *Harvard Business Review*, *91*(3), 91–97.

O'Reilly, C. & Tushman, M. L. (2016). *Lead and disrupt: How to solve the innovator's dilemma*. Stanford, CA: Stanford Press.

Plsek, P. (1997). *Creativity, innovation, and quality*. Roswell, GA: Quality Press.

Ponti, M. D. (2011). Why change fails. *Nurse Leader*, *9*(4), 41–43.

Rogers, E. M. (1995). *Diffusion of innovations* (4th ed.). New York, NY: The Free Press.

Sanares, D., & Hilliker, D. (2009). A framework for nursing clinical inquiry: Pathway toward evidence-based nursing practice. In K. Malloch & T. Porter-O'Grady (Eds.), *Introduction to evidence-based practice in nursing and health care*. Sudbury, MA: Jones and Bartlett.

Schumpeter, J. (1943). *Capitalism, socialism, and democracy*. New York, NY: Harper.

Stuke, K. B. (2013). Understanding leadership through leadership understandings. *Journal of Leadership Studies*, *7*(2), 55–61.

Weberg, D. (2012). Complexity leadership: A healthcare imperative. *Nursing Forum*, *47*(4), 268–277.

Webster's New Collegiate Dictionary. (2001). New York, NY: Random House.

Wheatley, M. J. S. (1992). *Leadership and the new science: Learning about organization from an orderly universe*. San Francisco, CA: Berrett-Koehler.

Suggested Readings

Kellerman, B. (2006). When should a leader apologize and when not? *Harvard Business Review*, *83*(4), 73–81.

Lindegaard, S. (2013). Innovation culture: The big elephant in the room. Retrieved from http://www.innocentive.com/innovation-culture-big-elephant-room

Middlebrooks, T. (2013). Introduction: New perspectives of leadership. *Journal of Leadership Studies*, *7*(2), 32–34.

Mockler, R., & Dologite, D. (2006, May). Creating the digital hospital. *Healthcare Informatics*, *47*, 50.

Rayport, J. F., & Jaworski, B. J. (2004). Best face forward. *Harvard Business Review*, *82*(11), 47–58.

Schoemaker, P. J. H., & Gunther, R. E. (2006). The wisdom of deliberate mistakes. *Harvard Business Review*, *83*(6), 109–115.

Quiz Questions

Select the best answer for each of the following questions.

1. Which of the following best describes innovation?
   a. Out-of-the-box thinking
   b. Something new or different
   c. A process that requires a laboratory for brainstorming, modeling, and testing
   d. A new product that is successful in the first month of introduction to the marketplace

2. Which of the following characteristics demonstrates the optimal organizational structure for innovation?
   a. It includes the traditional work of operations.
   b. It includes both departments of innovation and operational departments.
   c. It is complex and often confusing.
   d. It considers the innovation work to be done and the available skills of leaders.

3. What is the primary purpose of a department of innovation?

a. To support creativity as an integral part of the organization's mission
b. To isolate creative scientists and leaders dedicated to innovation
c. To create an entity that is easier to develop a budget and goals specific to innovation
d. All of the above

4. How can disruptive innovation be described?

a. Work that does not support required healthcare services
b. Work that requires new thinking by all customers
c. An innovation that cannot be used by customers in mainstream markets
d. Work that has been terminated because of poor outcomes

5. When is rational risk taking appropriate?

a. New skills are being developed.
b. There is adequate insurance coverage.
c. No obvious changes are anticipated.
d. Team members support the risk.

6. Which of the following best describes opportunities for innovation?

a. They are limited to organizations focused on technology.
b. They can be found in all walks of life.
c. They are present in healthcare delivery systems, technology, and business models.
d. They are difficult to identify and integrate in healthcare systems.

7. Which of the following best describes intrepreneurship?

a. Creation of a personal business using company funds
b. The organization and management of an enterprise or business with considerable initiative and risk
c. An innovation laboratory
d. When an employee of an organization is allowed to exercise some independent entrepreneurial initiative

8. Metrics for measuring innovation should include which of the following?

a. Cost of technology and personnel
b. One metric at a time to determine specific impact on the organization
c. Goals that can be identified once the innovation is in place and functioning adequately
d. Multiple variables that are believed to reflect the intended goals of the innovation

9. Which of the following describes course correction for organizations committed to integrated innovation?

a. It is an effective strategy to support risk taking and open discussion of the realities of innovations.
b. It reflects poor planning.
c. It is a strategy to cover up negative outcomes.
d. It is common for all innovations.

10. Resistance to innovation is a result of which of the following?
   a. Personal discomfort and lack of experience with new ideas
   b. Lack of understanding of the goals of the innovation
   c. Excellent performance in one's current role
   d. All of the above

11. Professional governance
   a. is built on shared governance.
   b. has the potential to advance the quality and prestige of nursing.
   c. emphasizes accountability to the profession of nursing, equitable partnerships, and evidence-driven decision making.
   d. replaces shared governance.

12. Creating a unique definition of innovation for your organization can result in:
   a. Greater engagement and understanding of innovation by organizational members.
   b. Distortion of the published definitions of innovation.
   c. Increased collaboration among employees.
   d. Wasting time in light of the available definitions.

13. The impact of minimizing change and innovation in an organization can result in:
   a. Increased stability and safer patient care.
   b. More cost-effective patient care.
   c. Increased employee satisfaction as changes in routines are minimal.
   d. Stagnation and missed opportunities to improve care.

14. System complexity that accompanies innovation in health care can include the following:
   a. High levels of turnover in support staff
   b. Multiple new technology products
   c. The uncertainty of healthcare funding
   d. Innumerable interactions between employers, patients, and the environment

15. Most organizations experience multiple ongoing tensions. These tension between stability and innovation:
   a. Should be minimized as quickly as possible to achieve organizational stability.
   b. Should be valued as necessary for creativity and growth.
   c. Should be valued to learn more about employee interests.
   d. Should be expected in complex organizations.

16. The Cybernetic Interface of Evidence and Innovation model:
   a. Minimizes the role of evidence-based practice.
   b. Recognizes the importance of the gap-analysis process.
   c. Provides a comprehensive view of evidence and innovation development in a complex environment.
   d. Provides a comprehensive view of knowledge development.

17. An anomaly in a healthcare organization is often considered:

a. An opportunity to consider a new way of doing things.
b. An abnormality that needs to be corrected or eliminated.
c. An error in employee performance.
d. An opportunity for innovation.

18. Risk taking in healthcare organizations is looked at in different ways. All but one of these is accurate:

a. Risk taking is commonplace and is seen as a workaround.
b. Risk taking is usually avoided due to believed risks to patient safety.
c. Risk taking is avoided to focus on operations and organizational stability.
d. Risk taking is considered appropriate when risks advance skill development.

19. Selecting metrics for an innovation in staff scheduling would ideally include:

a. Cost of the system and staff satisfaction.
b. Qualitative and quantitative measures to reflect differences between the current and new systems.
c. Level of wireless access and ability to accommodate staff requests.
d. The unique characteristics of the new system.

20. Clinicians in the organization believe the admission process is adequate and not open to innovations. Which criteria or evidence could you present to engage clinicians to consider an innovative virtual model?

a. All clinical processes can be improved upon.
b. Data from the current system is not integrated into a unified document.
c. Resistance to changing individualized forms can be overcome with incentives.
d. Inconsistencies among disciplines in their documentation have rendered the data unreliable.

21. Sources for innovation are everywhere. Select the best source of innovation in health care.

a. Persistent problems or errors that negatively impact care quality
b. Employee performance review recommendations for improvement
c. Recommendations from healthcare technology experts
d. Patient satisfaction ratings below the desired target

22. A community organization has requested your healthcare organization to participate in an innovative approach to cardiac care. Which of the following is the most appropriate response?

a. It is not within our mission provide cardiac care services.
b. A partnership should be explored given the community has identified this need.
c. Invite community representatives to join the organizations innovation team.
d. Take no action.

23. An organization can be considered ambidextrous if/when:

a. Competing priorities are identified and addressed separately.
b. Innovation is recognized as important to the organization and located in a special department.
c. The priority of operations and patient safety are at the top of the priority list.
d. The natural tensions between operations and innovation are optimized to create value and support creativity.

24. Knowledge creation and research in an organization are:

a. Foundational to the cybernetic interface of the evidence and innovation dynamic.
b. Distinct from innovation gaps specific to clinical values.
c. Strongly influenced by economic factors that impact policy.
d. Primarily concerned with evidence-based practices.

25. Support for innovation in healthcare organizations requires all but one of the following:

a. Individuals from diverse backgrounds
b. Internal and external stakeholders to do the work of innovation
c. Experts in the creation of innovative products
d. Effective teamwork competencies