AMIA
INFORMATICS PROFESSIONALS. LEADING THE WAY.

5B: Leadership Models, Processes and Practices

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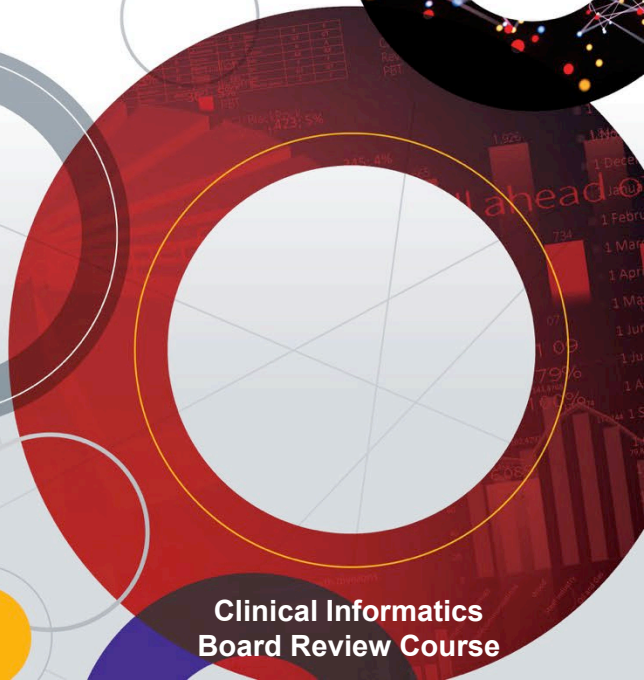


Clinical Informatics
Board Review Course

Clinical Informatics Subspecialty Delineation of Practice (CIS DoP)

Domain 1: Fundamental Knowledge and Skills (no Tasks are associated with this Domain which is focused on fundamental knowledge and skills)

Clinical Informatics

K001. The discipline of informatics (e.g., definitions, history, careers, professional organizations)
K002. Fundamental informatics concepts, models, and theories
K003. Core clinical informatics literature (e.g., foundational literature, principle journals, critical analysis of literature, use of evidence to inform practice)
K004. Descriptive and inferential statistics
K005. Health Information Technology (HIT) principles and science
K006. Computer programming fundamentals and computational thinking
K007. Basic systems and network architectures
K008. Basic database structure, data retrieval and analytics techniques and tools
K009. Development and use of interoperability/exchange standards (e.g., Fast Health Interoperability Resources [FHIR], Digital Imaging and Communications in Medicine [DICOM])
K010. Development and use of transaction standards (e.g., American National Standards Institute X12)
K011. Development and use of messaging standards (e.g., Health Level Seven [HL7] v2)
K012. Development and use of ancillary data standards (e.g., imaging and Laboratory Information System[LIS])
K013. Development and use of data model standards
K014. Vocabularies, terminologies, and nomenclatures (e.g., Logical Observation Identifiers Names and Codes [LOINC], Systematized Nomenclature of Medicine --Clinical Terms [SNOMED-CT], RxNorm, International Classification Of Diseases[ICD], Current Procedural Terminology [CPT])
K015. Data taxonomies and ontologies
K016. Security, privacy, and confidentiality requirements and practices
K017. Legal and regulatory issues related to clinical data and information sharing
K018. Technical and non-technical approaches and barriers to interoperability
K019. Ethics and professionalism

The Health System

K020. Primary domains of health, organizational structures, cultures, and processes (e.g., health care delivery, public health, personal health, population health, education of health professionals, clinical research)
K021. Determinants of individual and population health
K022. Forces shaping health care delivery and considerations regarding health care access
K023. Health economics and financing
K024. Policy and regulatory frameworks related to the healthcare system
K025. The flow of data, information, and knowledge within the health system

Domain 2: Improving Care Delivery and Outcomes

K026. Decision science (e.g., Bayes theorem, decision analysis, probability theory, utility and preference assessment, test characteristics)
K027. Clinical decision support standards and processes for development, implementation, evaluation, and maintenance
K028. Five Rights of clinical decision support (i.e., information, person, intervention formats, channel, and point/time in workflow)
K029. Legal, regulatory, and ethical issues regarding clinical decision support
K030. Methods of workflow analysis
K031. Principles of workflow re-engineering
K032. Quality improvement principles and practices (e.g., Six Sigma, Lean, Plan-Do-Study-Act [PDSA] cycle, root cause analysis)
K033. User-centered design principles (e.g., iterative design process)
K034. Usability testing
K035. Definitions of measures (e.g., quality performance, regulatory, pay for performance, public health surveillance)
K036. Measure development and evaluation processes and criteria
K037. Key performance indicators (KPIs)
K038. Claims analytics and benchmarks
K039. Predictive analytic techniques, indications, and limitations
K040. Clinical and financial benchmarking sources (e.g., Gartner, Healthcare Information and Management Systems Society [HIMSS] Analytics, Centers for Medicare and Medicaid Services [CMS], Leapfrog)
K041. Quality standards and measures promulgated by quality organizations (e.g., National Quality Forum [NQF], Centers for Medicare and Medicaid Services [CMS], National Committee for Quality Assurance [NCQA])
K042. Facility accreditation quality and safety standards (e.g., The Joint Commission, Clinical Laboratory Improvement Amendments [CLIA])
K043. Clinical quality standards (e.g., Physician Quality Reporting System [PQRS], Agency for Healthcare Research and Quality [AHRQ], National Surgical Quality Improvement Program [NSQIP], Quality Reporting Document Architecture [QRDA], Health Quality Measure Format [HQMF], Council on Quality and Leadership [CQL], Fast Health Interoperability Resources [FHIR] Clinical Reasoning)
K044. Reporting requirements
K045. Methods to measure and report organizational performance
K046. Adoption metrics (e.g., Electronic Medical Records Adoption Model [EMRAM], Adoption Model for Analytics Maturity [AMAM])
K047. Social determinants of health
K048. Use of patient-generated data
K049. Prediction models
K050. Risk stratification and adjustment
K051. Concepts and tools for care coordination
K052. Care delivery and payment models

Domain 3: Enterprise Information Systems

K053. Health information technology landscape (e.g., innovation strategies, emerging technologies)
K054. Institutional governance of clinical information systems
K055. Information system maintenance requirements
K056. Information needs analysis and information system selection
K057. Information system implementation procedures
K058. Information system evaluation techniques and methods
K059. Information system and integration testing techniques and methodologies
K060. Enterprise architecture (databases, storage, application, interface engine)
K061. Methods of communication between various software components
K062. Network communications infrastructure and protocols between information systems (e.g., Transmission Control Protocol/Internet Protocol [TCP/IP], switches, routers)
K063. Types of settings (e.g., labs, ambulatory, radiology, home) where various systems are used
K064. Clinical system functional requirements
K065. Models and theories of human-computer (machine) interaction (HCI)
K066. HCI evaluation, usability engineering and testing, study design and methods
K067. HCI design standards and design principles
K068. Functionalities of clinical information systems (e.g., Electronic Health Records [EHR], Laboratory Information System [LIS], Picture Archiving and Communication System [PACS], Radiology Information System [RIS] vendor-neutral archive, pharmacy, revenue cycle)
K069. Consumer-facing health informatics applications (e.g., patient portals, mobile health apps and devices, disease management, patient education, behavior modification)
K070. User types and roles, institutional policy and access control
K071. Clinical communication channels and best practices for use (e.g., secure messaging, closed loop communication)
K072. Security threat assessment methods and mitigation strategies
K073. Security standards and safeguards
K074. Clinical impact of scheduled and unscheduled system downtimes
K075. Information system failure modes and downtime mitigation strategies (e.g., replicated data centers, log shipping)
K076. Approaches to knowledge repositories and their implementation and maintenance
K077. Data storage options and their implications
K078. Clinical registries
K079. Health information exchanges
K080. Patient matching strategies
K081. Master patient index
K082. Data reconciliation
K083. Regulated medical devices (e.g., pumps, telemetry monitors) that may be integrated into information systems
K084. Non-regulated medical devices (e.g., consumer devices)
K085. Telehealth workflows and resources (e.g., software, hardware, staff)

Domain 4: Data Governance and Data Analytics

K086. Stewardship of data
K087. Regulations, organizations, and best practice related to data access and sharing agreements, data use, privacy, security, and portability
K088. Metadata and data dictionaries
K089. Data life cycle
K090. Transactional and reporting/research databases
K091. Techniques for the storage of disparate data types
K092. Techniques to extract, transform, and load data
K093. Data associated with workflow processes and clinical context
K094. Data management and validation techniques
K095. Standards related to storage and retrieval from specialized and emerging data sources
K096. Types and uses of specialized and emerging data sources (e.g., imaging, bioinformatics, internet of things (IoT), patient-generated, social determinants)
K097. Issues related to integrating emerging data sources into business and clinical decision making
K098. Information architecture
K099. Query tools and techniques
K100. Flat files, relational and non-relational/NoSQL database structures, distributed file systems
K101. Definitions and appropriate use of descriptive, diagnostic, predictive, and prescriptive analytics
K102. Analytic tools and techniques (e.g., Boolean, Bayesian, statistical/mathematical modeling)
K103. Advanced modeling and algorithms
K104. Artificial intelligence
K105. Machine learning (e.g., neural networks, support vector machines, Bayesian network)
K106. Data visualization (e.g., graphical, geospatial, 3D modeling, dashboards, heat maps)
K107. Natural language processing
K108. Precision medicine (customized treatment plans based on patient-specific data)
K109. Knowledge management and archiving science
K110. Methods for knowledge persistence and sharing
K111. Methods and standards for data sharing across systems (e.g., health information exchanges, public health reporting)

Domain 5: Leadership and Professionalism

K112. Environmental scanning and assessment methods and techniques
K113. Consensus building, collaboration, and conflict management
K114. Business plan development for informatics projects and activities (e.g., return on investment, business case analysis, pro forma projections)
K115. Basic revenue cycle
K116. Basic managerial/cost accounting principles and concepts
K117. Capital and operating budgeting
K118. Strategy formulation and evaluation
K119. Approaches to establishing Health Information Technology (HIT) mission and objectives
K120. Communication strategies, including one-on-one, presentation to groups, and asynchronous communication
K121. Effective communication programs to support and sustain systems implementation
K122. Writing effectively for various audiences and goals
K123. Negotiation strategies, methods, and techniques
K124. Conflict management strategies, methods, and techniques
K125. Change management principles, models, and methods
K126. Assessment of organizational culture and behavior change theories
K127. Theory and methods for promoting the adoption and effective use of clinical information systems
K128. Motivational strategies, methods, and techniques
K129. Basic principles and practices of project management
K130. Project management tools and techniques
K131. Leadership principles, models, and methods
K132. Intergenerational communication techniques
K133. Coaching, mentoring, championing and cheerleading methods
K134. Adult learning theories, methods, and techniques
K135. Teaching modalities for individuals and groups
K136. Methods to assess the effectiveness of training and competency development
K137. Principles, models, and methods for building and managing effective interdisciplinary teams
K138. Team productivity and effectiveness (e.g., articulating team goals, defining rules of operation, clarifying individual roles, team management, identifying and addressing challenges)
K139. Group management processes (e.g., nominal group, consensus mapping, Delphi method)

Knowledge Statements from the DoP

K131. Leadership principles, models, and methods

- Includes governance

K123. Negotiation strategies, methods, and techniques

K124. Conflict management

K113. Consensus building, collaboration, and conflict management

K128. Motivational strategies, methods, and techniques

- Includes decision-making

K 131. Leadership principles, models, and methods

Includes governance

Definition of Leadership

- The power or ability to lead other people
- The capacity to lead
- The act or instance of leading

Source: *http://www.merriam-webster.com/dictionary/leadership*

Leadership

Leadership as a *behavior*

- of an **individual** when directing the activities of a **group** towards a **shared goal**

Leadership is a *process*

- Whereby an **individual** influences a **group** of people toward the realization of a **goal**

Lekka 2012

Leadership Theories

Leadership Theories

Theories about what makes great leadership and leaders

New theories emerging all the time

- Too many to count

Most can be classified into 8 major types

- Focus on these for boards

Leadership Theories – Major Types

#	Theory	Origin	Description
1	**Great Man Theories**	1840s	• Leaders are born, not made • pre-destined to lead; “natural-born leader”
2	**Trait Theories**	1930s-1940s	• People are born with leadership qualities that will cause them to naturally excel as leaders
3	**Behavioral Theories**	1940s-1950s	• Anyone with behavioral conditioning can become a leader • Leaders are made, not born (opposite of 1 and 2 above)
4	**Contingency Theories**	1960s	• Leader’s effectiveness contingent on how well leader’s style matches situation • Believes leadership style cannot be changed (big difference from Situational Leadership theories – see next slide) • Success depends upon degree of fit between situation and leader’s style

- Amanchukwu et al 2015, Cherry 2016, Lekka 2012, Piyu 2019
- https://www.leadership-central.com/leadership-theories.html#axzz4mvO2jECn

Leadership Theories – Major Types (cont.)

#	Theory	Origin	Description
5	**Situational Theories**	1960s	• Leaders choose a leadership style based on the situation • No single leadership style is appropriate for all situations • Effective leaders able to quickly change style to match situation
6	**Participative Theories**		• Ideal leadership takes input of others into account; encourages participation and collaboration • Idea that this leads to better decisions and more success
7	**Transactional (Management / Exchange) Theories**	1970s	• Transaction (reward, punishment) made between leader and followers • Focus on leader's role in supervision, organization and group performance
8	**Transformational (Relationship) Theories**	1970s	• Focus on connections between leaders and followers • Leaders transform their followers through inspiration and increasing motivation

- Amanchukwu et al 2015, Cherry 2016, Lekka 2012, Piyu 2019
- https://www.leadership-central.com/leadership-theories.html#axzz4mvO2jECn

Transactional Theory for Healthcare

Functional Results-Oriented Healthcare Leadership Model (FROHLM)

- Leadership model developed for healthcare
- Leaders facilitate effective healthcare provision by meeting needs for
  - Task + Team + Individual ==> Results
- Leaders are responsible for measurable outcomes
- Reinforcement (reward) for outcome goals achieved
- In some cases, punishment for not achieving desired outcome goals

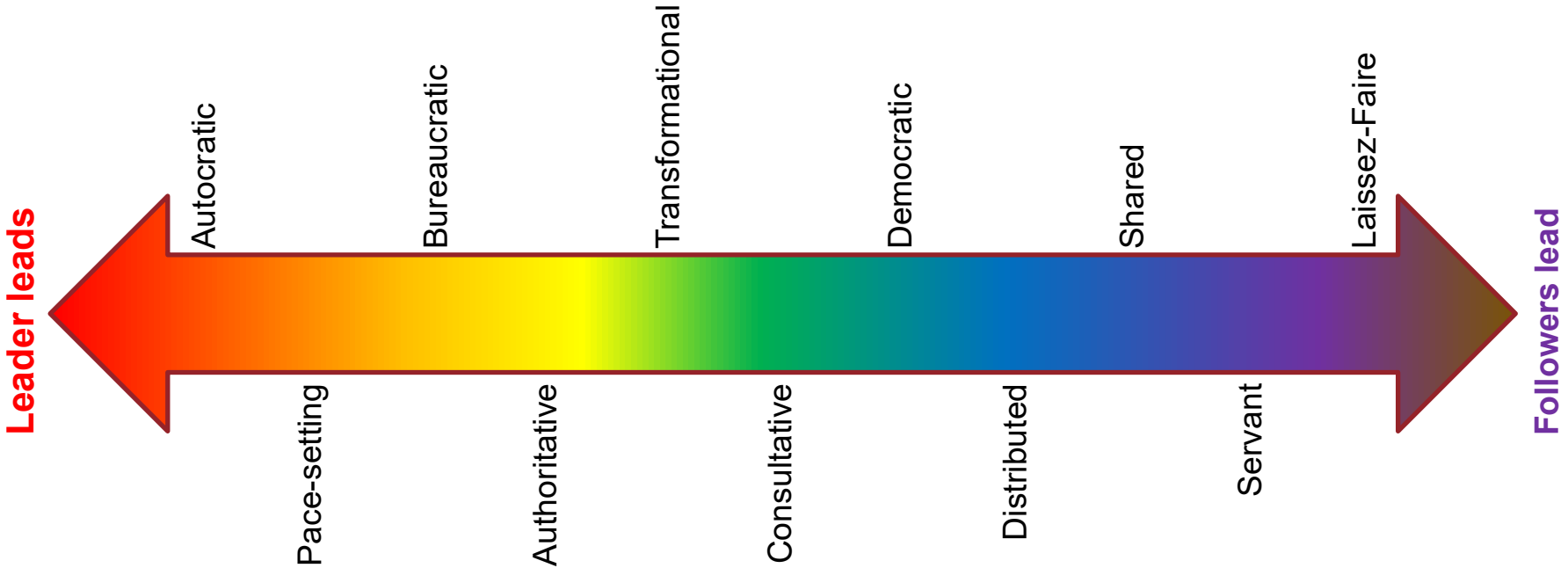
1. Al-Touby SS. Functional Results-Oriented Healthcare Leadership: A Novel Leadership Model. *Oman Med J.* 2012 Mar; 27(2):104-107. Available online Oman Medical Journal-Archive (omjournal.org). Accessed July 20, 2021.
2. Al-Sawai A. Leadership of healthcare professionals. Where do we stand? *Oman Med J.* 2013 Jul;28(4):285-7. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3725246/pdf/OMJ-D-13-00174.pdf Accessed July 20, 2021.

Leadership Styles

Behavioral styles that leaders engage in during leadership activities.

Has overlap with conflict modes (later in lecture).

Leadership Styles



"Research has shown that leaders with the best results do not rely on only one leadership style; they use most of them in a given week."

- Goleman D. Leadership that Gets Results. *Harvard Business Review*. 2000;March-April: 78-91.

Leadership styles (Leader leads)

Leadership Style	Description	Leader Behaviors	Pros	Cons
Autocratic (Coercive) (Authoritarian)	• Leader knows best • Communication flows downwards	• "Do what I say" • Controlling, directive • Makes all decisions • Solves all problems	• Works well in emergencies • Works well in working with problem employees	• In non-emergency situations, inhibits flexibility and dampens employees' motivation • Hostility and rebellion by employees
Pacesetting	• Leader sets the pace and follows it him/herself	• "Do as I do, now" • Conscientious, drive to achieve, initiative	• Useful when need to get quick results from a highly-motivated team • Positive impact on self-motivated employees	• Other employees feel overwhelmed by leader's demands for excellence • Overall negative impact on staff
Bureaucratic	• Leader insists that everything is done according to policy and procedure	• "We are doing this by the book" • Police officer more than a leader	• Useful for tasks performed over and over • Also useful when tasks are dangerous and require precision and exact adherence to processes to stay safe	• Employees may lose interest in job (no creative thought) • Employees do what is required and no more • Habitual adherence to policies and procedures may be hard to break

Leadership Styles (Middle Ground)

Leadership Style	Description	Leader Behaviors	Pros	Cons
Authoritative	• Leader states the goal but allows people freedom to choose means of achievement	• "Come with me" • Self-confidence, empathy, change-catalyst	• Overall one of the most strongly positive styles • Works well when business is adrift, when new vision or clear direction needed • Works well when leader is the expert	• Less effective when leader working with a team of people who are more expert than the leader is
Transformational	• Leader focuses on inspiration and increasing motivation	• "Let's do this" • Effectively communicate vision • Positively influence attitudes toward mission • Brings group to shared sense of mission • Addresses and considers each follower's concerns or doubts	• Overall one of the most strongly positive styles • Works well when business is adrift, when new vision or clear direction needed	
Consultative (Coaching)	• Leader informs members of best concepts • Develop people for the future	• "Try this" • Directive • Teacher of information • Empathy • Self-awareness	• Works well when employees already aware of weaknesses and want to improve • Increases knowledge of employees long-term	• Does not work well when employees are resistant to changing

Leadership Styles (Group leads)

Leadership Style	Description	Leader Behaviors	Pros	Cons
Democratic (Participative) (Collaborative)	• Every member should have input • Communication is open and mutual	• "What do you think?" • Facilitator • Serves as resource • Encourages members' active participation • Share knowledge • Reduce complexity	• Builds organizational flexibility • Builds informed consensus-based decisions • Facilitates interdependency among stakeholders • Most useful for low-key clinical settings, research and healthcare policy settings	• Employees can feel leaderless • May not result in solutions • Process can result in too many meetings
Distributed	• Leader and followers complement each other's strengths and weaknesses	• Sense-making • Relating • Visioning • Inventing	• Works well when members of the group may be more expert than the leader	• Employees may feel leaderless • Teams without complementarity may not function well
Shared	• Empowers followers with decision-making • e.g., LEAN methodology		• Many healthcare workers are very autonomous and like making decisions • Works best for small, rapid process improvement projects (reduces impact of poorly made decisions) • Employees demonstrate leadership behavior, greater autonomy and improved outcomes	• Decisions may be wrong or in conflict with the group's goal(s) • Does not work well when major decisions are needed in times of crisis

Leadership Styles (Followers Lead)

Leadership Style	Description	Leader Behaviors	Pros	Cons
Servant (Affiliative)	• Creates harmony and builds emotional bonds • Leaders develop moral core to serve others, especially the underprivileged	• "People come first" • Focuses on leader's development through self-awareness and self-knowledge	• Builds team harmony • Increases morale • Heals rifts in team • Motivates people during times of stress	• Can allow poor performance to go uncorrected or conflicts to be unresolved • Lack of advice to followers can cause followers to feel like they lack clarity • May lack speed
Laissez-Faire	• Leadership responsibilities assumed by group • Any behavior by group is acceptable because leader does not set limits or expectations	• Passive, non-directive • Provides little to no support or guidance • Sets no limits		• Employees have unmet tasks • Relationship needs of group ignored • Apathy

Collaborative Leadership Style

Collaborative Healthcare Leadership

- Center for Creative Leadership (https://www.ccl.org/)
- Six-part model [Browning et al 2016]
  - Collaborative patient care teams
  - Resource stewardship
  - Talent transformation
  - Boundary spanning
  - Capacity for complexity, innovation and change
  - Engagement and well-being

Leadership Development

Leadership Development

Models describe stages of a person as they progress toward leadership

- There are many but none specific to physicians or healthcare

Case for leadership development in physicians [AHA 2014]

Physician Leadership Development Programs [NCHL 2014] → Theoretical rewards…

Larger talent pool for future leaders	Better physician relations
Better recruitment	Increased engagement and retention
Increased productivity	Better coordinated care
Increased organizational agility and growth	Stronger connections between current and future leaders

Leadership Development

Review of physician leadership development programs by Frich et al 2014

- Gaps
  - Poor study designs
  - Not enough interactive learning
    - Mostly lecture-based
  - Need to measure effect on system outcomes
    - Most studies looked at self-assessments of participants (bias)

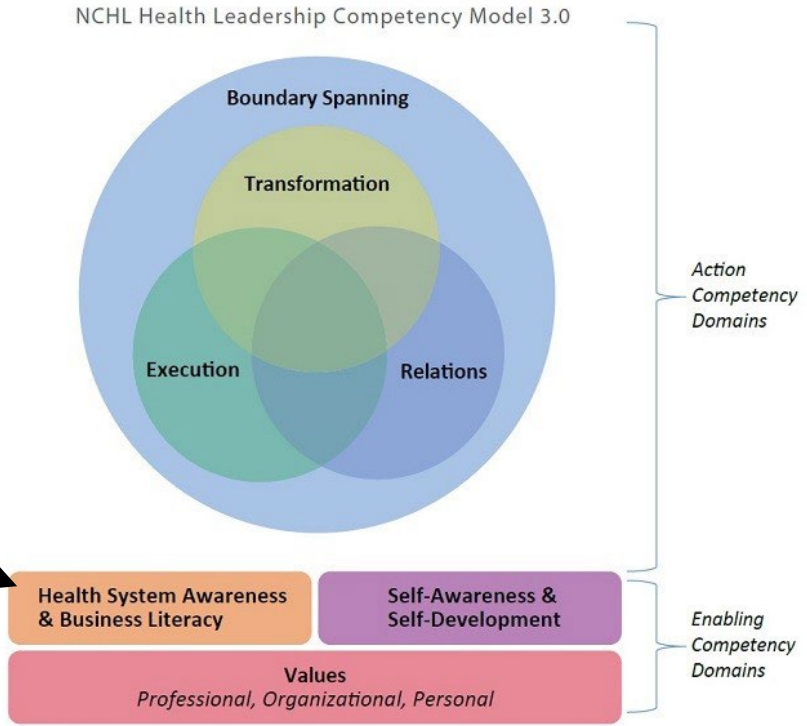
Assessing Leadership Competency

Tools to assess competency of a leader in various leadership areas.

NCHL Competency Model

National Center for Healthcare Leadership (NCHL) [Competency Model 3.0](#) (2018)

- Defines competencies required for outstanding healthcare leadership
- Competencies for information system management
  - Recognizing potential
  - Championing implementation
  - Pursuing leading edge technology



ACHE Competencies

American College of Healthcare Executives (ACHE)

- Leadership Competencies 2015
- Competencies Assessment Tool 2020

Five domains

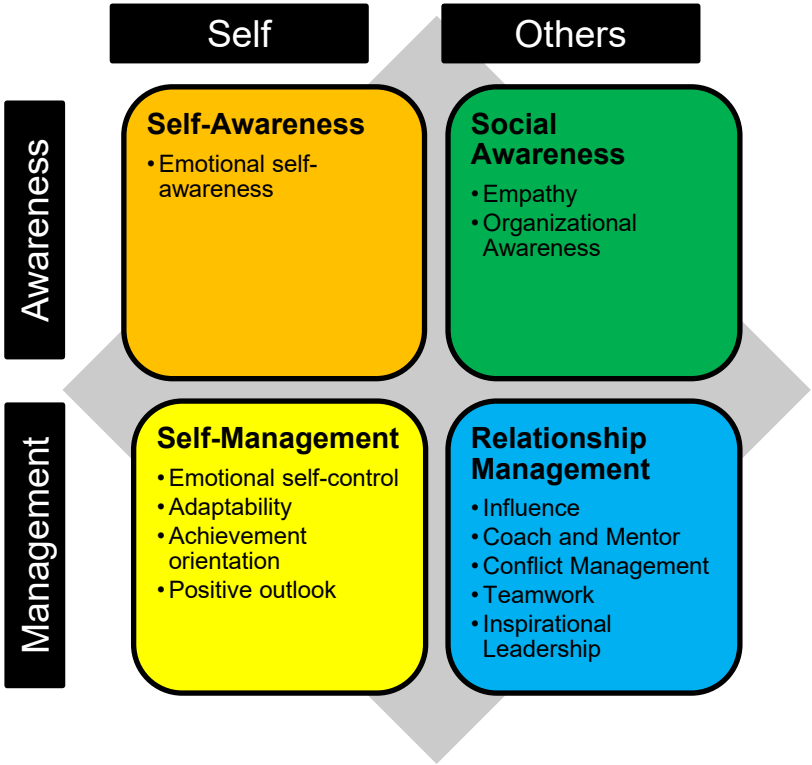
Information management competencies

Emotional Intelligence (EQ)

- Awareness of emotions in yourself and others AND…
- Ability to use this awareness to manage behavior and relationships
- EQ: Emotional Quotient
  - Strong association between high performers and high EQ
  - High EQ can add $1300 to annual salary
  - **EQ can increase with practice**, whereas IQ remains fixed

[Goleman et al 2017]

Bradberry T, Greaves J. Emotional Intelligence 2.0. San Diego, TalentSmart: 2009. ISBN 978-0-9743206-2-5.



Governance

Definitions

- **Leadership** = a **person** leading a group
- **Governance** = a **group** leading a group(s)

Governance in Health IT Projects

Definition

- infrastructure, strategies and approaches to support physicians [clinicians] in the definition of clinical content, refinement of the care processes and the adoption of new technologies before, during and after implementation

Fickenscher K, Bakerman M. Leadership and governance for IT projects. *Physician Exec*. 2011 Jan-Feb;37(1):74. https://pubmed.ncbi.nlm.nih.gov/21302752/

Governance

Responsibilities

- Tasks and functions that the governance structure are required to complete

Authority

- Individual board members do **not** have authority to perform functions
- Only the governing body has authority to carry out its responsibilities
  - Governance bodies may require a **quorum** of voting members for this

K123. Negotiation strategies, methods, and techniques

Negotiation

Definition

- Process by which **two or more parties**
  with **different interests** or perspectives
  attempt to **reach agreement**

Negotiation styles and strategies are similar to those used for conflict management

- Healthy debate (good) → **Negotiation**
- Conflict (bad) → **Conflict Management**

Negotiation

Many styles which can be leveraged according to the situation

- Fisher R, Ury W. *Getting to Yes*. 1991.

Fail to prepare = prepare to fail

Negotiation Process

Focus on interests, not positions

- **Positions** = What people want
- **Interests** = Why people want it

Example:
Blood bank requests a server immediately to manage their quality control so that they don't miss doing additional workups on abnormal blood type findings

- How will a server help?
  - Because the new middleware software will alert them when there is an abnormal blood type pattern.
- Why isn't blood bank being alerted now?
  - Because there are automatic QC flags placed on certain abnormal patterns that we see a lot, and that QC is placed automatically with no alert.
- What would happen if you took off the automatic QC flag?
  - Well, if there was no automatic QC flag attached to the abnormal type, then it would flash an alert in front of us.
- Would having the alert at that point satisfy your needs without causing additional problems?
  - Yes!

Negotiation Process

Frame the discussion

- how you say it is **just as important** as what you say

Negotiation space

- Keep an eye on all parties, not just ones at table

https://hbr.org/2013/10/negotiation-strategies-for-doctors-and-hospitals#. Accessed July 20, 2021.

Negotiation vs. Conflict Management

Healthy Debate (needs Negotiation)	Conflict (needs Conflict Management)
Open to hearing others' ideas	People assume they're right
Listen and respond to ideas (even if they don't agree with them)	People state their ideas without responding to others' ideas
Try to understand the views of others	No interest in other points of view
Stay objective Focus on the facts	Personal attacks Blaming
Systematic approach to situation and solutions	Hot topics get thrashed out in an **unstructured** way

Bens I. Chapter 7: Facilitating Conflict. In: Bens I. *Facilitation at a Glance.* Salem, NH: GOAL/QPC; 2012.

K124. Conflict management

Conflict Management

Common sources of conflict

- Individualistic behavior within organization
- Poor communication
- Organizational structures
- Inter-individual conflicts
- Inter-group conflicts

Conflict Management

Conflict-Handling Modes

- **Thomas-Kilmann Conflict Mode Instrument**
- People use one of 5 modes when engaged in conflict
- Natural conflict mode can be flexed to another mode depending on the situation

Competing (Forcing)	Individual pursues own concerns at the expense of others
Collaborating (Problem-Solving)	Individual attempts to get "win-win"
Compromising	Individual looks for compromises where both parties partially get what they want, typically in order to achieve resolution to conflict quickly
Avoiding (Withdrawing)	Individual does not address the conflict.
Accommodating	Individual neglects own concerns to satisfy the concerns of another person. Element of self-sacrifice.

- Thomas KW, Kilmann RH. Thomas-Kilmann Conflict Mode Instrument. Mountain View, CA: CPP; 2007.
- https://www.aamc.org/download/185102/data/conflict_management_negotiation_styles.pdf. Accessed July 20, 2021.

Conflict Management

Facilitative Conflict Management Process

1. **Clarify** the issue
2. Have **rules** for appropriate norms in place (e.g., good behavior)
3. Set **time frame** for the discussion
4. Explain the **process** to be used
5. Analyze the **facts** of the situation
6. Generate a **range of possible solutions**
7. **Evaluate** the solutions
8. Plan to **implement** the highest-ranked solution

https://www.aamc.org/media/21621/download. Accessed July 20, 2021.

K113. Consensus building, collaboration, and conflict management

Collaboration

- Collaboration as a leadership tool considers and attempts to meet the needs of all parties involved in a process
- Based on a premise of cooperation to achieve effective outcome
- Particularly helpful when
  - You need to consider a variety of viewpoints for effective solution
  - There have been previous conflicts in a group or organization
  - Multiple stakeholders must meet the needs of their own sub-groups

Leadership in Collaboration

Collaborative leaders

- Lead the process, not the people
- Focus the discussion rather than making the decision

Collaboration **advantages**

- Buy-in, trust, elimination of turf issues
- Access to more and better ideas
- Fertile ground for new leaders to grow

Collaboration **disadvantages**

- Time-consuming and need for conflict management
- May need to overcome resistance to collaboration
- Group may go a different way than leader likes
- Leaders must let go of their egos

[University of Kansas Community Tool Box]

K128. Motivational strategies, methods, and techniques

Includes decision making

Motivation

Definition

- The desire of an **individual** to behave in certain ways

  OR

- for **organizations**, a behavioral, affective and cognitive process that influences the willingness of workers to perform their duties in order to achieve personal and organizational goals, influencing the extent and level of their effectiveness at work

[Okello 2015]

Motivation

Extrinsic motivation

- Generated when an action or task is performed to receive external rewards or outcomes
  - e.g., monetary rewards, incentives, promotion

Intrinsic motivation

- Generated when actions or tasks are performed for internal fulfilment or enjoyment of the activity itself
  - e.g., self-esteem and a feeling of belonging

Motivation

Cannot only focus interventions on extrinsic motivation

- Leads to low trust
- Undermines intrinsic motivation

Intrinsic motivation is linked to…

- positive health worker behaviors
- enjoyment of the work
- quality of work performed
- retention of health workers in current jobs

Motivation Theories

Humanistic theories	• Self-determination theory • Herzberg's theory • Maslow's theory
Socio-cognitive theories	• Social Cognitive theory • Self-efficacy theory • Goal theory
Cognitive theories	• Attribution theory • Expectancy Value theory

Humanistic Theories of Motivation

Self-determination theory

- Self-determination achieved by intrinsic motivation
- Intrinsic motivation achieved through autonomy, competence and relatedness
- Example: Getting patients to change their behavior

Autonomy	Level of intrinsic motivation for change
Competence	Patient's confidence and ability to change
Relatedness	Patient's perception of being respected, understood, cared for

Humanistic Theories of Motivation

Herzberg's theory

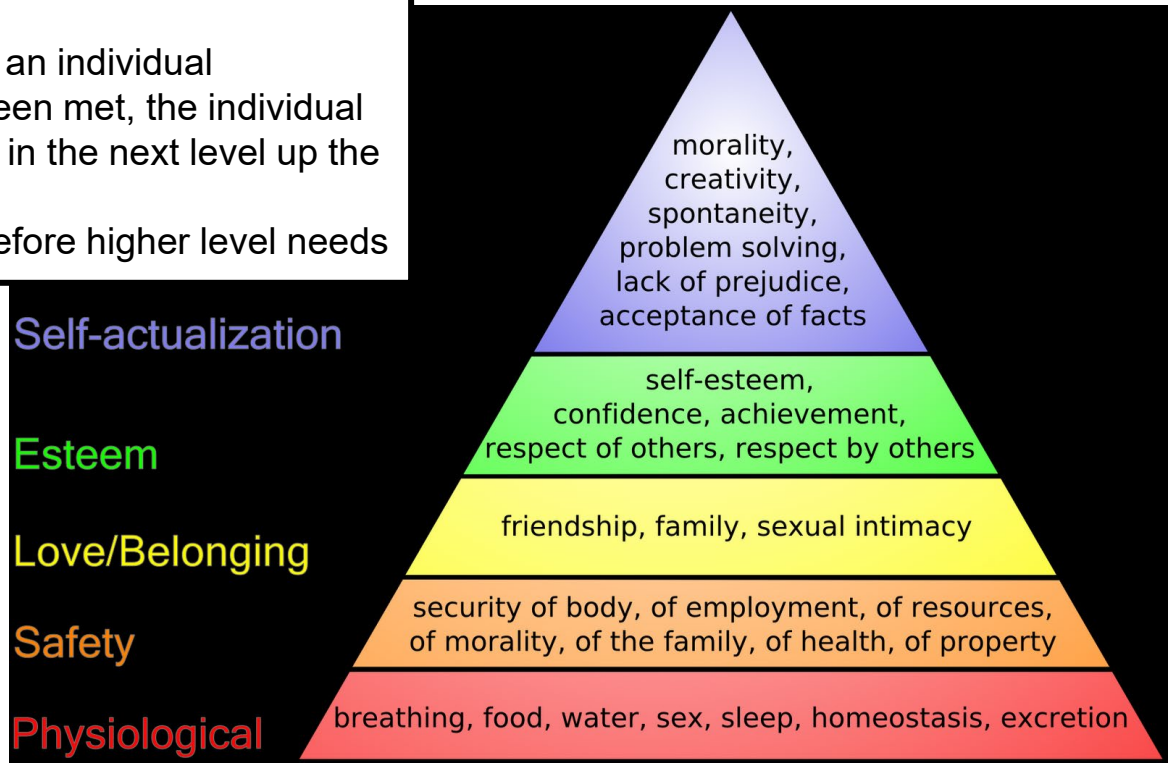
- Focus on motivating employees
- **Motivator-hygiene theory** (a.k.a. two-factor theory)
  - Motivator factors: Duties or position itself → increased satisfaction
  - Hygiene factors: corporate aspects → decreased satisfaction

Motivator factors	Hygiene factors
Achievement Recognition Work itself Responsibility Promotion Growth	Pay and Benefits Company policy and administration Relationships with co-workers Supervision Status Job security Working conditions Personal life

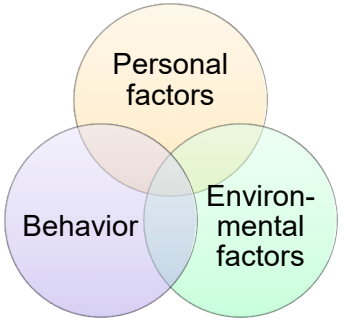
Humanistic Theories of Motivation

Maslow's theory

- Only unsatisfied needs motivate an individual
- Once needs at one level have been met, the individual is motivated to satisfy the needs in the next level up the pyramid
- Basic needs must be satisfied before higher level needs

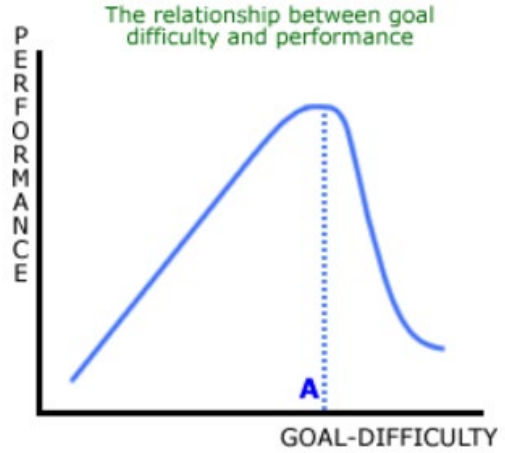


Socio-cognitive Theories of Motivation

Theory	Description	Image
Social Cognitive	Individual's learning directly related to: • Individual observation • Learning through imitation • Influences of own thoughts • Influences of learning environment	
Self-Efficacy	Person's perception of their ability to perform appropriately or reach a goal • Cycles can be positive or negative • Success drives positive cycle (more confidence, more motivation, etc.) • Lack of success drives negative cycle (lower confidence, lower motivation, etc.)	

Socio-cognitive Theories of Motivation

Theory	Description	Image

Goal Theory	• Edwin Locke
	• To motivate, goals must have:
	  • Clarity
	  • Challenge
	  • Commitment
	  • Feedback
	  • Task complexity
	• **SMART goals** – Specific, Measurable, Attainable, Relevant, Time-Bound
	• Generally accepted as most valid in organizational psychology
		
		• https://wikispaces.psu.edu/display/PSYCH484/6.+Goal+Setting+Theory

Cognitive Theories of Motivation

Attribution Theory

- Theory of why we *attribute* outcome X to causal factor Y, often automatically

Factors that influence attribution	**Stable Factors** (unlikely to change soon)	**Unstable Factors** (likely to change soon)
Dispositional Factors (internal to person; his/her disposition or MOTIVATION)	A person's intelligence, personality, judgement, or willpower	A person's moods, exertion of effort, momentary whims
Situational Factors (external to person; the situation)	Institutional factors, economics, social structures	Coincidence, weather, good luck, bad luck

https://www.psychologynoteshq.com/attributiontheory/; Accessed September 3, 2020

Cognitive Theories of Motivation

Attribution Theory

- **Controllability**:
  - our perception of how well we can control a situation
  - influences our attitudes toward the situation
- **Fundamental Attribution Error**:
  - When we **succeed**, we attribute our success to **dispositional** factors.
  - When we **fail**, we attribute failure to **situational** factors.

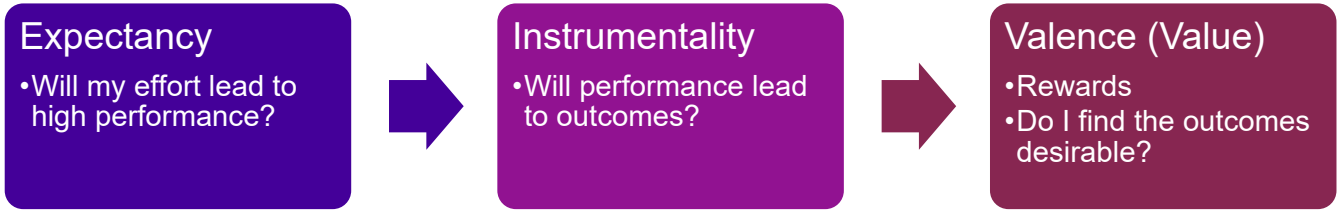
- https://www.psychologynoteshq.com/attributiontheory/. Accessed July 20, 2021
- https://www.britannica.com/topic/motivation/Observational-learning. Accessed July 20, 2021

Cognitive Theories of Motivation

- **Expectancy-Value Theory**
  - Behavior is a function of Expectancy and Value

$$\boldsymbol{B = f(E \times V)}$$

  - Behavior more likely if likelihood of meeting expectation is high and the return has high value



  - must occur in sequence for motivation to occur

https://www.britannica.com/topic/motivation/Observational-learning. Accessed July 20, 2021.
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Question

When considering how best to increase the motivation of an employee to engage in changing to a new EHR using Herzberg's theory of motivation, which of the following factors would be MOST important to include:

A. Increase the employee's pay and benefits
B. Give the employee increased responsibility for the conversion
C. Ensure that the employee's work is covered by company policy
D. Reassure the employee that his/her job is secure

Answer

When considering how best to increase the motivation of an employee to engage in changing to a new EHR using Herzberg's theory of motivation, which of the following factors would be MOST important to include:

A. Increase the employee's pay and benefits

B. Give the employee increased responsibility for the conversion

C. Ensure that the employee's work is covered by company policy

D. Reassure the employee that his/her job is secure

Herzberg's theory focuses on motivating employees through motivator factors which include achievement, recognition, the work itself, responsibility, promotion and growth. Hygiene factors result in decreased satisfaction and include Pay and Benefits, Company policy and administration, Relationships with co-workers, Supervision, Status, Job security, Working conditions and Personal life.

Decision Making

Decision-Making

Traits of effective decision-making

- Everyone has clarity of the purpose of decision-making
- People with power to make decision are present
- People understand and follow decision-making approach
- All ideas viewed as equally important
- No domination by a single party
- Deadlocks are examined and resolved
- Discussion ends with clear action plan

Bens I. Chapter 6: Effective Decision-Making. In: Bens I. *Facilitation at a Glance.* Salem, NH: GOAL/QPC; 2012.

Decision-Making

Levels of empowerment

I. Management decides then informs staff
II. Management gets staff input before deciding
III. Employees decide and recommend
IV. Employees decide and act

Decision-Making

	Pros	Cons	Uses
One person decides (unilateral decision)	Fast Clear accountability	Lack of input, buy-in No synergy	One person is expert and accountable
Majority voting	Fast May have dialogue Clear outcome	Too fast? Winners / losers No dialogue	Trivial matters Clear options
Compromise	Discussion	Win-lose Adversarial Divides group	When positions polarized; consensus improbable
Multi-voting (rank ordering options based on a set of criteria)	Systematic Objective Participative Feels like a win	Limits dialogue Real priorities may not surface	When there are many solutions to choose from
Consensus Building	Collaborative Systematic Encourages commitment	Slow Requires data Requires skills	Important issues When total buy-in needed for success

Decision-Making Theories

http://changingminds.org/explanations/theories/a_decision.htm

Decision analysis and influence diagrams

- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4818954/
- Covered elsewhere in this course

Additional Suggested Readings

Organizations

- American College of Physician Leadership (https://www.physicianleaders.org/)
  - Formerly American College of Physician Executives (ACPE)
- American College of Healthcare Executives (https://www.ache.org/)
- National Center for Healthcare Leadership (https://www.nchl.org/)
- Center for Creative Leadership (https://www.ccl.org/)

Supplemental Material

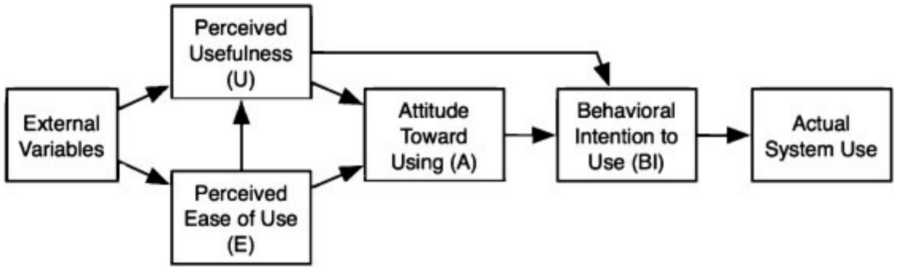
Corporate Governance Theories

Shareholder Theory	• Board operates to please the shareholders • Focus is on profits and $$$ only [Corplaw 2013]

Principal-Agent Theory (Agency Theory)	• Focuses on relationship between two actors: Principal and Agent
	  • **Principal** engages the **Agent** to perform a task
	• Example: Principals = board of governors; Agents = employees
	• Assumes that goals of principals and agents are different
	  • Agent may be hard to control or will shirk duties
	• Emphasizes monitoring with incentives or sanctions as needed
	• Diminishes board's role in setting strategy, mission and objectives
	[Kivistö et al 2015, Devos et al 2015, Brinkerhoff et al 2012, Bonazzi et al 2006, Pyone et al 2017]

Stakeholder Theory	• Decision-making occurs after taking all identifiable stakeholders, internal and external, into account • Ensures group representation, balances competing priorities and avoids dominance of one group over another • Can be risk averse, bland and lowest common denominator for decision making [Business Professor 2015]

Corporate Governance Theories

Technology Acceptance Model	• Only governance theory designed specifically for software and technology • Dominant model for user acceptance of new technology  [Rahimi et al 2018]
Stewardship	• Managers and owners share common agenda and work side by side • Board's role is to develop strategy but not to monitor or enforce • Can lead to failure, strategic drift or inertia
Resource Dependency	• Board's role is to minimize uncertainty caused by external factors by creating dependencies on internal resources • Board provides advice, access to information, preferential access to resources and legitimacy • Too overtly focused on external issues

Question

A board of directors sanctions the IT department with reduced paid time off after a monthly audit shows that that several large important projects were delayed. This type of governance best aligns with which governance theory?

A. Shareholder Theory
B. Agency Theory
C. Stakeholder Theory
D. Technology Acceptance Model

Answer

A board of directors sanctions the IT department with reduced paid time off after a monthly audit shows that that several large important projects were delayed. This type of governance best aligns with which governance theory?

A. Shareholder Theory

B. Agency Theory

C. Stakeholder Theory

D. Technology Acceptance Model

Agency theory (also known as Principal-Agent theory) emphasizes distrust between the board and its agents, thus necessitating monitoring (audits) with sanctions as necessary. Incentives are applied to prevent agents (employees) from engaging in activities which are not aligned with the principals' (board's) goals.

Question

The resource dependency governance theory has which of the following disadvantages?

A. Does not focus on vision, mission or strategies
B. Too risk averse to make timely decisions
C. At risk of inertia and strategic drift
D. Too overtly focused on external issues

Answer

The resource dependency governance theory has which of the following disadvantages?

A. Does not focus on vision, mission or strategies
B. Too risk averse to make timely decisions
C. At risk of inertia and strategic drift
D. Too overtly focused on external issues

The resource dependency governance model states that the board's role is to minimize uncertainty cause by external factors through creation of dependencies on internal resources. As a result, this method of governance can be too focused on external issues, and critical internal barriers or obstacles to performance and quality may be missed.

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That’s a wrap!