Chapter 18
Managing from the Middle

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Organizational Structure

Healthcare organizations have evolved significantly since the 1990's to a model which exemplifies larger systems with fewer layers. The norm of this era has been mergers and acquisitions with larger regional healthcare systems replacing smaller individual providers, leading to significant organizational changes within these systems [1]. The emphasis on continuous improvement, quality management, reengineering, elimination of redundancy and standardization of operations is a consequence of healthcare systems having to operate on a more competitive basis [2]. The impact of the organizational restructuring highlights the distinct hierarchy in healthcare organizations. In every organization including hospitals and healthcare systems, there are top influencers, workers, and 'middles' [3].

The Role of Stakeholders and Top Executives

Top executives in a system are responsible for the overall shaping of the system. They create the vision and roadmap to ensure the organization is always poised strategically to be ahead of external market factors [3]. Top managers are often easy to identify in the organization's hierarchical structure. Their status has clear visibility within the hospital/healthcare system. They occupy the top tier of the organization's hierarchy with other senior managers and hospital executives [4]. The emphasis on efficiency and cost effectiveness in the new healthcare corporate

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structure has influenced the shaping of healthcare organizations significantly in recent years [4].

They are the catalyst for strategic change in the organization. In the traditional organizational structure, the flow of information and power goes from senior managers to middle managers to individual employees.

The Role of Workers/Employees as Front-Line Staff

Workers or employees such as salaried physicians, nurses, and technicians are responsible for 'doing the work' or rendering the services for the system [3]. They enhance their systems' bottom line due to their intimate front-line knowledge requirements of the work that needs to be done daily. Unlike times past, in our current healthcare environment, physicians often do not have the final say in organizational decisions. Their main contribution is towards issues involving diagnostic decisions, care and treatment of patients [4]. Managers have become the main decision makers within healthcare organizations and hospital environments.

The Odds/Push and Pull Between Top Managers and Employees

In most organizations, senior leadership, and employees are often in conflict over many fundamental issues [3]. Workers may not share the vision or performance pillars defined by leadership. They may not agree with the allocation of resources across the system and may react negatively to calls for change even when mandated by overarching regulatory bodies such as Joint Commission and the Center of Medicare and Medicaid Services (CMS).

Definition of the Middle Manager

A middle manager is an employee, supervised by top managers and senior executives but directly in charge of frontline employees [5]. These front-line employees could be hospitalists, mid-level providers, house staff and administrative assistants.

The term comes from the fact that they are wedged in the 'middle' of top managers and employees who do the work. In addition to being directly in charge of implementing innovation and change, middle managers are essential for integrating the executive organization leaders and frontline employees and synchronizing various system functions for the two [5].

Role of the Middle Manager

In healthcare organizations, the responsibility of middle managers has grown significantly over the years as the concept of teams has become more common. Clinicians and administrators often have to work together in the hospital setting to effect change [6].

A. *Disseminate information from the top to frontline employees and vice versa*

Middle managers are responsible for disseminating necessary information to the front-line staff that may need an action plan [7]. In large organizations and healthcare systems, communication is typically generated from top leadership as well as from other middle managers. These may be merely informational or may actually impact workflow and the quality/quantity of work for front-line staff. The middle manager is responsible for ensuring that the information relevant to the employees/groups/teams is received.

For any innovation or change to be implemented, the middle manager has to be able to communicate to be able to affect change [8]. The forums to communicate may be varied to include social networks, long-term relationships built from associations with other middle managers and even front-line staff outside of their own direct influence [9]. Likewise the middle manager is also responsible for ensuring that top managers and senior leaders receive necessary information that affects the shaping of the organization. This bi-directional communication often involves direct feedback from the hospitalists to develop realistic performance metrics.

Dr L is a hospitalist director at a community hospital and has been charged with ensuring that all patients on her floor are discharged with a discharge order and completed discharge checklist. Feedback from hospitalists and nurses on her unit, as well as feedback other middle managers, showed that a fix in the Electronic Medical Record is necessary to achieve 100 % compliance set by hospital senior leadership. This feedback has to be communicated to top managers who will be responsible for approving resources to allow IT perform the necessary solution.

B. *Synthesize and integrate information*

Middle managers are responsible for integrating and interpreting facts and packaging information in a relevant fashion for the recipients [7]. They have the arduous task of breaking down the big picture painted by the upper level management and delivering the same message in a clear and concrete version for employees who are on the frontline [10]. A medical director may be responsible for heterogeneous teams, consisting of teaching and nonteaching physicians or they may be in charge of a geographical unit in a hospital made up of physicians, mid-level providers, ancillary staff and front desk staff. Given this potentially mixed group of recipients, the message from the top managers must come in a form that is relevant and easy to understand and this falls to the middle manager [11].

Dr L., who supervises different individuals on a medical floor, will have to communicate differently with every member of the team to implement changes

necessary to reduce Cather Associated Urinary Tract Infections (CA-UTI's) on her floor. The message from the top may have to do with outcome measures and reducing rates of CA-UTI's however Dr M will need to have one type of message for the hospitalists who place orders for Foley catheters and another for the nurses those who place the catheters in patients.

C. *Act as liaisons between strategy and practical activities*

Organizations often fail in their mission to perform at high standards due to the lack of a common culture across their hospital system [12]. Organizations who strategize without factoring the internal culture may not meet their innovation goals because of lack of trust and morale among front-line staff [13].

Middle managers can bridge the gap and be more successful at implementing change because they understand internal culture and they are able to translate the information they receive, into actionable tasks that must be carried out [14].

D. *Encourage and justify changes to employees*

The middle manager has the ability to convey and justify change to their employees because of their familiarity with day-to-day operations, patients and employees. They understand the culture of the organization from both sides and their interaction with front-line staff renders them more approachable. They know the issues and frustrations facing employee performance with regards to change implementation [1].

In recent years, many hospitals have adopted a change/innovation system such as LEAN Methodology or Six Sigma to improve productivity while reducing waste and redundancy. The role of the middle manager in the hospital setting is even more profound in implementing any system focused on changing workflow to boost productivity. The buy-in from the employees doing the work is absolutely essential to creating targets, evaluating process measures and establishing outcome metrics. This is a clear example of the role of the middle managers such as medical directors and nurse managers in 'selling innovation' to the front-line staff to get their support and buy-in.

E. *Integrate front-line staff and direct supervisors across floors, units, and departments*

A role unfamiliar to many middle managers is the one of 'connector and integrator' across their system. In this model, the middle manager integrates with other front-line supervising peers, outside their own organizational ladder structure [3]. In the hospital setting, this may include connecting with nurse managers, division chiefs in other departments and hospitalist directors of other hospitals within the system's regional network. Through such collaboration, frontline employees as well as the organization as a whole, benefits from the combined knowledge and information sharing. Creating these informal and horizontal networks enables middle managers to turn to each other for advice and support. Additionally, these networks

can also help to put the reality litmus test into context before attempting to implement a new change [15].

Dr L has increased her network of middle managers across the hospital. When she has questions or needs feedback on an approach to a hospital innovation, her list of individuals includes the hospitalist director in the VA system of her hospital, the Nurse Manager in-charge of Perioperative testing and a new hospitalist director on the Orthopedics unit.

Challenges Faced by Middle Managers as a Result of Their 'middleness'

Hectic Pace of the Job When Answering to Top and Bottom

The sheer nature of a middle manager's job is prone to a very hectic pace. Representing both upper managers and front-line staff often leads to endless meetings, never completed to-do lists and many errands to run [3]. In addition to being responsible for the day-to-day operations of their units, they are also often called upon by senior leadership to answer questions, give accounts and report of various initiatives while still performing their daily direct work.

A. *Confusing role, having to answer to top and bottom demands*

The balancing act of advocating for both leadership and workers leaves middle management truly in the middle and not necessarily belonging to any particular group for gratitude and support [3]. Middle managers are often required to take different bits of information to find solutions even when they themselves may not be sold on the idea. The confusion is further compounded by behaviors the middle manager has to take on to perform the various roles as 'change leader' versus 'change implementer' [16].

For example: When Dr M tried to get buy-in from her fellow hospitalists for a geographically cohorted unit, she had to focus on the message of convenience and less running around even though the geographical unit had a larger census than her team would have been used to.

B. *Neither a strategic planner nor an implementer*

Middle managers find themselves wedged between operationalizing the vision of those who get credit for shaping the organization, and then creating actionable tasks for those who do the work and are credited for rendering the service to fulfill the vision. This can lead to a feeling of insignificance [3]. Some of the middleness dilemma is perpetuated with senior management expecting middle managers to be act as leaders of change while they are also expected to be the unwavering implementers, which can lead to frustration [17].

C. *Often unable to act independently*

Forced to be in reactive mode constantly, middle managers often work in an environment where they can not initiate a plan or act independently. They are either implementing or getting feedback from workers. For some, this can affect their morale long term. They often find themselves in a situation where they have to take corporate ideas and vision and interpret it in a way that makes sense within the realm they operate. Senior managers are often absent to help middle managers with the role of making sense of larger corporate ideas, leading to frustration and anxiety [15].

D. *Taking failures personally*

Some have added the role of therapists to the role the middle manager plays. Middle managers especially in their role as change implementers leverage their relationships with employees to help them cope with change, similar to the role of a therapist. These relationships allows them understand the needs of the front-liners [8]. However with the amount of effort exerted by middle managers to understand and cater to the emotional needs of employees and even senior managers, middle managers themselves often do not have a specific niche for emotional support, to prevent them from taking their failures personally [3].

During a pilot to change discharge times to earlier in the day, it was suggested that attending physicians on the academic service come in 2 hours earlier than their usual time, to round on patients and identify early discharges before morning teaching didactics. Many of the teaching attendings had chosen the teaching path for stable hours in lieu of a lower salary. Dr M had to explain this to hospital leadership, while trying to find a solution.

Unique Challenges of Hospitalist Middle Managers

A. *Expectations of significant administrative work and clinical duties combined* [16]

Different hospitalist models have varied nonclinical time designated for their hospitalist directors. Therefore hospitalist middle managers may be carrying out their duties as administrative leaders in addition to full clinical duties. Depending on one's schedule, i.e.: day shifts, night shifts; this may prove to be quite frustrating and difficult to sustain long term.

B. *Shifting middle. The issue of multiple stakeholders*

In health care, stakeholders include patients, employers, payers as well as the executive leadership team for providers. As has been described earlier in this chapter, managing from the middle is fraught with dilemmas associated with the very variable nature of the middle manager's job and this is especially true in the healthcare environment [17].

A hospitalist middle manager such as a hospitalist program director may have multiple stakeholders they report to. In the academic setting, the Dean, Residency program directors as well as Departmental heads may be among the individuals a middle manager may have to interface regularly with. In other settings, a hospitalist director may report to third party payer executives, regional hospital system senior leadership as well as their own CMO and CEO's. As the number of stakeholders increase, the demands on the middle manager for meetings, creating reports, translating ideas from leadership to the hospitalists they supervise can be overwhelming and lead to a high burn-out rate, especially if the middle manager has significant clinical requirements.

C. *Difficulty with relevance/significance*

Hospitalist middle managers may have difficulty demonstrating their value as a result of their middleness. When strategic ideas lead to wins downstream, senior leadership and top managers are given credit for their strategic planning. Likewise front-liners are congratulated for their hard work in carrying out any innovation that led to improvement. The hospitalist middle manager who is often the individual responsible for creating the actionable plans may not be celebrated for wins but blamed instead, if there are any problems with implementing change.

D. *Changing regulatory landscape*

The dynamic regulatory climate affects strategic planning and information passed from top managers via Hospitalist middle management. CMS mandates can have both compliance and financial implications for hospitals. Hospitalist middle manager must ensure that front-liners are equipped operationally and emotionally to handle these changes.

In recent years, hospitals nationwide had to invest significant resources to ensure patients were designated as 'observation status' as compared to 'inpatient status'. Hospitalist directors and team leaders played a major role in working with case managers, billing and financial partners to ensure inappropriate patient designations did not lead to CMS audits or denial of payment of services. In the middle of this workflow overhaul came the new CMS Two Midnight rule, which was a modification of criteria for observation or inpatient [18]. Hospitalist team leaders once again had to ensure that the new changes were carried out without instability among front-liners, which can be overwhelming.

E. *The culture difference between clinical practice and financial* drivers

The philosophical difference between standards for 'clinical best practice' versus 'the financial bottom line' may lead to mis-alignment of pillars of success between physicians and hospital leadership. Non-physician executive leaders usually rely on hospitalist middle managers to explain the feasibility of a strategic plan in the clinical setting to them [16]. The financial impact of reducing length of stay while discharging patients earlier in the day may have lead to many corporate innovation ideas. Hospitalist middle managers have had to ensure that the implementation of

these plans did not affect patient safety, and the lack of clinical orientation of some senior hospital executives could have made this an uphill task without them.

F. *Physicians as front-line employees can be difficult to manage*

Physicians are trained to be independent, autonomous thinkers. The physician as a front-line employee can be difficult to manage for various reasons [19].

Direct care providers are almost middle managers in their own right because they often have to interact and supervise house staff, house officers, billing representatives, case managers, ancillary staff and even students, with regards to the care of their patients. This can put the hospitalist team leader's authority on shaky ground. In addition, if the hospitalist director lacks the natural ability to delegate responsibility or confront their physician staff for inappropriate behavior, their role as middle manager will be threatened [22].

G. *Avoiding negative attitude pitfalls among middle managers*

While the role of the middle manager can be frustrating, overwhelming and thankless, it is important to avoid the following:

- Avoid passive-aggressive ways of showing discontent about an innovation to front-liners or top management.
- Speaking negatively about a new process or change to front-line employees.
- Speaking against front-line employees to top managers and vice versa.
- Exerting influence by threatening front-line staff with reporting everything to top managers.
- Resentment of high performing employees being favored by top executives, leading to unprofessionalism.

Invaluable assets middle managers bring to their unique position in your hospital system:

– Bringing the real experience from being a hospitalist to the top managers [23]. Your knowledge of how processes work makes you an asset to your hospital. Top managers are often far removed from the operationalizing of work and they need individuals who can lead with knowledge of the internal culture. Use this as leverage to make decisions, to share your point of view and suggest solutions. Relegate more difficult decisions back to your hospital leadership or the stakeholders in your reporting structure [3].
– Direct knowledge of how to motivate fellow hospitalists. Empower hospitalists to resolve their issues and conflicts on their own in the role of a 'coach' as opposed to a 'fixer' [3]. This has many advantages. It reduces some of the micromanagement of hospitalists which can lead to burn-out but also gives the front-liners necessary basic skills in conflict resolution which will help as more innovation ideas flow downstream from top management.

- You know your fellow hospitalists well enough to get to the truth about anything. Your input as a stabilizer and expert in operations means you must maintain the first hand knowledge of the front-lines. Ensure that you maintain the relationships with all the hospitalists you supervise and that you are comfortable with the basic functioning of any area under your jurisdiction. If you have both teaching and nonteaching hospitalists, daytime, mixed schedule or nocturnist hospitalists, you need to strive to be abreast of all the basic operational functions and workflow of their jobs.
- You know the vendors as well as the competitive landscape for EMR, quality reporting database, skilled nursing facilities or any other vendors whose real performance may elude top executives. Use this as leverage to be seen as an entrepreneur. Use your knowledge from the front-lines to advice senior hospital leadership on projects with significant financial consequences such as revamping the hospital's EMR/IT program.
- You do not have to blindly defend any vision or strategic planning initiative. You can be open and honest [23]. Your clinical know how and first hand knowledge makes you the right individual to speak honestly about the feasibility of projects being strategized by senior hospital leaders. Projects to improve patient safety, quality and financial metrics may have potholes that only a person on the ground can identify. Speaking honestly may reduce the feeling many hospitalist middle managers may share of being a marionette being pulled in many directions by senior leaders without having any input [24].
- You have the skills to bring hospitalists and specialists of diverse backgrounds and multiple system hospitals to work together. In the same vein, cultivate collaborative relationships with other 'middles' within and outside your hospitalist leadership structure. Connect with nursing leaders, hospitalist directors on other teams as well as in other hospitals. This will reduce the feeling of isolation and alienation [3].
- You know the adopters and constipators that will support or sabotage any change initiative. Ensure that you have the right people at the table at all times. Identify those fellow hospitalists on the front-lines whose opinions tend to sway their colleagues in one direction or another and get them on your side. If there are individuals who are habitually negative about any change or innovation, keep them out of the first round of planning. This will reduce some of the frustrating issues that come with getting a project started [19].

H. Keep track of your personal career goals and ensure you have a plan towards that goal. If there are opportunities for personal and career growth, seize them. Avail yourself of leadership academies and conferences to hone in on your leadership skills and to network with other 'middles'. Obtain a terminal degree if that option is available such as an MBA or Masters in Medical Management to name a few to boost your CV and help with career defining [24].

Enhance your leadership skills by mentoring new hospitalists and faculty. In turn, look for individuals within or outside your organizational hierarchy who may serve as mentors [24].

Mentor those below you and seek mentorship above.

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