

THESIS FOR THE DEGREE OF LICENTIATE OF PHILOSOPHY

At the End of the Funnel: Translation of Improvement Approaches in Healthcare

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Gothenburg, Sweden 2018

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Technical report no L2018:97

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Cover illustration:

In developing a local management model for improvements in healthcare, different approaches can serve as building blocks, which can be funneled down into more useful shapes in a translation process.

Printed by Chalmers Reproservice
Gothenburg, Sweden 2018

AT THE END OF THE FUNNEL:
TRANSLATION OF IMPROVEMENT APPROACHES IN HEALTHCARE

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Abstract

Myriad approaches aimed to improve different aspects of healthcare organizations, such as *Lean healthcare* and *patient-centered care*, are presented to managers in pursuit of operational improvements. At the same time, the focus of healthcare improvement is shifting from quality to value, and *value-based healthcare* has become one of the more bespoke contemporary improvement approaches (IA). However, many attempts to implement such IAs have failed. One vital factor for the successful application of IAs is the process of implementation, for which several guiding frameworks have been presented. However, other scholars have challenged the often instrumental view applied in implementation science by proposing that IAs – which are more ambiguous than more technical care interventions – are *translated* into a context, implying a greater acceptance for transformations of the original concepts.

This thesis builds on a participative, longitudinal single-case study of implementation of value-based healthcare to the context of psychiatry, using qualitative methods and elements of action research. Focusing on the aspects of content, context, and process of the implementation, a model is proposed for how IAs can be viewed and handled as moldable concepts that are translated into a context-dependent local management model in the target organization. The thesis suggests that both practitioners and scholars could benefit from actively considering the contexts in which IAs are applied, including preexisting IAs and attitudes among organization members, to better grasp the complexity of healthcare management.

Keywords: *Translation, Implementation, Value-based health care, Ambiguity, Improvement approaches, Health care, Psychiatry, Quality improvement, Healthcare improvement*

List of appended papers

Paper I

The Complexity of Using Value as Driver for Improvement in Psychosis Care
Colldén, C., Gremyr, I., Hellström, A., Lifvergren, S., Sporraeus, D.

Conference paper

The paper was presented orally at the EurOMA Conference in Neuchatel, Switzerland, June 28–July 1, 2015.

Contributions:

Colldén was the lead author, collected parts of the data, and conducted most of the analysis. Gremyr and Hellström contributed equally to the design of the study, analysis of data, and writing up the paper. Lifvergren assisted in parts of the writing. Sporraeus collected parts of the data and assisted in the analysis of data.

Paper II

A Value-Based Taxonomy of Improvement Approaches in Healthcare
Colldén, C., Gremyr, I., Hellström, A., Sporraeus, D.

Accepted for publication

The paper was submitted on August 22, 2016, revised by May 23, 2017, accepted on July 6, 2017 and finally published in *Journal of Health Organization and Management*, Vol. 31 Issue 4, pp. 445–458. DOI: 10.1108/JHOM-08-2016-0162.

Contributions:

The paper was written mainly by Colldén, with support from Gremyr, who also jointly collected and analyzed some interview data. Hellström assisted in designing the theoretical model and in writing the paper. Sporraeus collected parts of the data and assisted in the analysis of some of the data.

Paper III

Value-Based Healthcare Translated: A Complementary View of Implementation

Colldén, C., Hellström, A.

To be submitted

The paper will be submitted to BMC Health Services Research in spring 2018.

Contributions:

Colldén was the lead author of the paper, collected all data, and conducted an initial structuring analysis of data. The analysis was then jointly conducted by Colldén and Hellström. Hellström also assisted in writing the paper.

Acknowledgements

Indeed, I am a lucky man for the opportunity to immerse into a (for me) new field of knowledge and for being able to combine practice and theory. Being a manager and a scholar in parallel is both demanding and rewarding but picturing my work life without academia appears as a frugal existence. There is a number of individuals that I would like to thank for making this possible.

First, I am very grateful to my boss, Pia Rydell, who trust me to control my time freely – to study, write and conduct research as part of my job as manager.

Second, my main supervisor Ida Gremyr deserves a big thank you for her incredible ability to always be there with a smile on her face, perfectly balanced between driving and supporting.

Third, thank you also to my co-supervisor Andreas Hellström for all his good input and interesting discussions, and to Svante Lifvergren for connecting me to Centre for Healthcare Improvement and help initiating my research.

Fourth, I especially thank Andreas Gremyr, who has commendably led the practical project together with me during the course of this research project and provided invaluable insights. Thank you also to Lars Alfredsson, Pia Ram and all other colleagues at the department of psychotic disorders who have patiently agreed to participate in interviews, group reflections, and other activities connected to my research.

Last but not least, a big thank you to Hannah and Ada for your patience, discussions on English expressions and grammar, and accidental extra letters and punctuation marks (you probably know who did what).

Thank you!

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Abbreviations

CFIR	Consolidated framework of implementation research
IA	Improvement approach
MI	Management innovation
MIATT	Model of improvement approaches translation and transformation
PCC	Person-centered care
PROM	Patient-reported outcome measure
RQ	Research question
TQM	Total quality management
VBHC	Value-based health care

*“Please squeeze in, though the gate is strait, ’cause here’s a something happenin’
dam ba dam bam bam bam”*

– Sten-Åke Cederhök. Free translation (of course).

1. Introduction

1.1 Background

Booming medical and technological progress (CBO, 2008; Pammolli et al., 2012), escalating service expectations (Fenton et al., 2012), and ever-aging populations (Breyer et al., 2010) have forced healthcare systems to constantly strive for increased cost-effectiveness. Hence, healthcare improvement is called for (e.g. Davidoff, 2011) and, since the early 21st century, *quality improvement* has been promoted, which Batalden and Davidoff (2007, p. 2) defined as “*the combined and unceasing efforts of everyone—healthcare professionals, patients and their families, researchers, payers, planners and educators—to make the changes that will lead to better patient outcomes (health), better system performance (care) and better professional development (learning).*” Quality improvement, which is sometimes inspired by quality management in other industries, has brought improvements to patient safety, experiences of care, and clinical outcomes (Boaden et al., 2008). However, in recent years, the discourse concerning healthcare improvement in high-income countries is changing paradigm from *quality* to *value* (Gray, 2012).

Within the field of healthcare improvement (either focusing on quality or value), different innovations, concepts, tools, and models have been presented with the aim of improving quality and value outcomes (Boaden et al., 2008; D’Andreamatteo et al., 2015; Kaplan and Porter, 2011). In the present thesis, concepts aimed to improve healthcare are collectively referred to as improvement approaches (IAs), following Boaden’s (2008, p. 46) definition of such approaches as concepts that promote “*a way of working – which may include a variety of different tools, sometimes to be used at specific points along a methodological ‘roadmap’ [and that] may be applied to the organisational system as a whole, and may also be applied to systems spanning organisations.*”

The present thesis is built around a case in which the author is deeply embedded. In the context of a psychiatric department at a large hospital in Sweden, it was recognized that different IAs were recurrently brought in, sometimes voluntarily by strategic decisions in the department and sometimes imposed by external instances. The aim was to change operations to achieve improvements with scarce financial resources. However, the

effects sometimes seemed to be only cosmetic or quickly transient, while on other occasions the IAs seemed to stick and have positive effects over time. In most cases, the IAs' resemblance to the original descriptions were limited. At the onset of the research project of this thesis, Value-Based Healthcare (VBHC) was widely promoted by the hospital's top management and in Swedish press. Hence, the opportunity to study a phenomenon appearing in a local context was one of the starting points for this research project.

VBHC is of the most widely discussed contemporary IAs (Fredriksson et al., 2015; Porter, 2010; Porter and Teisberg, 2006). According to the broader paradigm of value (Gray, 2012), VBHC is centered on the definition of value as outcomes that matter to the patient in relation to the costs of care. The IA also suggests that competition on condition-specific outcome measures, use of supporting IT systems, reorganization of services, and reimbursement by bundled payments will lead to increased value outcomes (Porter and Lee, 2013).

However, value is a multifaceted and complex concept (Babin and James, 2010; Colldén et al., 2015; Fredriksson et al., 2015). It can be both a matter of outcomes and processes (Gummerus, 2013); synonymous with cost-efficiency of healthcare organizations (Gray, 2012; e.g. Kaplan, 2014; Lega et al., 2013), and discussed in terms of being created by organizations, by customers, or as being co-created (Gummerus, 2013; McColl-Kennedy et al., 2012; Vargo and Lusch, 2004, 2008). Hence, *value* can have different connotations in different contexts and even among different individuals within the context, and can therefore have a wide variety of (context-dependent) definitions. One common definition is that value is quality or outcomes in relation to costs (e.g. Gray, 2012; Porter et al., 2016; Tseng and Hicks, 2016). However, both "quality" and "outcomes" are ambiguous terms, as highlighted by, for example, Kollberg et al. (2006, p. 12) who argued that *"there are many different customer groups to health care services [and] depending on the perspective, the definition of value will hence differ."* Consequently, the use of the value concept in IAs brings a certain ambiguity and complexity; therefore, both in research and managerial practice, it is important to identify what is meant in situations where the word "value" is used.

Further, improving value and quality by use of IAs can be somewhat complicated. Many IAs fail to deliver the improvements promised by advocates of the IA (Fältholm and Jansson, 2008; Ham, 2003; Hellman et al., 2015; Plesner et al., 2013; van der Wiele et al., 2006), thereby missing the opportunity to bring about increased quality of care, reduced costs, and improved value outcomes. In the healthcare context, identified reasons for failures include the complexity that characterizes the sector (Mintzberg, 2002), conflicting logics and goals (Hellman et al., 2015), underdeveloped performance measurement systems (Nembhard et al., 2009), and a failure to create commitment among healthcare professionals (Lifvergren and Bergman, 2012). Also, implementation processes that are overly instrumental and time-constrained have been identified as causes of failure (Lifvergren, 2013; Nembhard et al., 2009).

Hence, implementation is crucial for successful application of IAs. In this process, IAs can be seen as a type of innovation (defined by Greenhalgh et al. (2004, p. 582) as “*a novel set of behaviors, routines, and ways of working that are directed at improving health outcomes, administrative efficiency, cost effectiveness, or users’ experience and that are implemented by planned and coordinated actions*”). For innovations, several frameworks have been proposed to guide implementation. Pettigrew (1987) suggested three analytical categories to guide analyses of strategic change: *content*, *process*, and (inner and outer) *context*. These categories can also be recognized in many later implementation frameworks, although they have been extended and further developed (e.g. Damschroder et al., 2009). However, scholars studying the phenomenon of *management fashions* (e.g. Abrahamson, 1996; Benders and van Veen, 2001) have pointed out that innovations such as IAs are inherently fuzzier and more ambiguous (Clark, 2004; Giroux, 2006) than, for example, medical and technical innovations and they have therefore refused the concept of implementation in favor of *translation* (Czarniawska and Sevón, 1996; Røvik, 2011). Translation implies a need for adaptation and interpretation in relation to the context – in contrast to the view that successful adoption equates to the establishment of a local copy of the original concept – and can be defined as “*the process in which ideas and models are adapted to local contexts as they travel across time and space*” (Lamb and Currie, 2012, p. 219). Adopting this view, the inherent ambiguity of IAs can even be seen as an asset, and Giroux (2006, p. 1251) suggested that “*positive value and ambiguity could be related*”. In the present thesis, when referring to the application of an IA to a setting, the term *implementation* is used

when a traditional and instrumental view is adopted, whereas *translation* is used when the transformative quality of the process is emphasized. Moreover, in line with Røvik (2008), the term *contextualization* will be used for a series of repeated translations at different levels in a system; that is, a “*hierarchical chain of translation*” (p. 252).

Moreover, Røvik (2011) emphasized that IAs are not passively spread into organizations; instead, organizations handle IAs actively. Depending on more or less conscious decisions (that is, deliberate choices by members of the organization that affect the translation of the IA), IAs can take different trajectories in an organization after the decision has been made to adopt it (Heusinkveld and Benders, 2012; Madsen, 2015; Røvik, 2008, 2011). Thus, it can be assumed that a managerial awareness of the active handling of an IA during the translation process is beneficial in order to control the trajectory of the IA, and hence actively improve the operational end result.

In sum, there is a recognized phenomenon from practice that many IAs are brought into local healthcare settings to improve operations. Simultaneously, within the field of healthcare improvement, a change in focus from quality to value has been recognized. However, value and quality are ambiguous concepts, as are (inherently) most IAs, which are proposed as means to improve value and quality in healthcare. Also, implementations of IAs are not always successful, so translation may be a more fruitful approach than implementation for IAs. These central points of departure for this thesis are displayed in Figure 1.1.

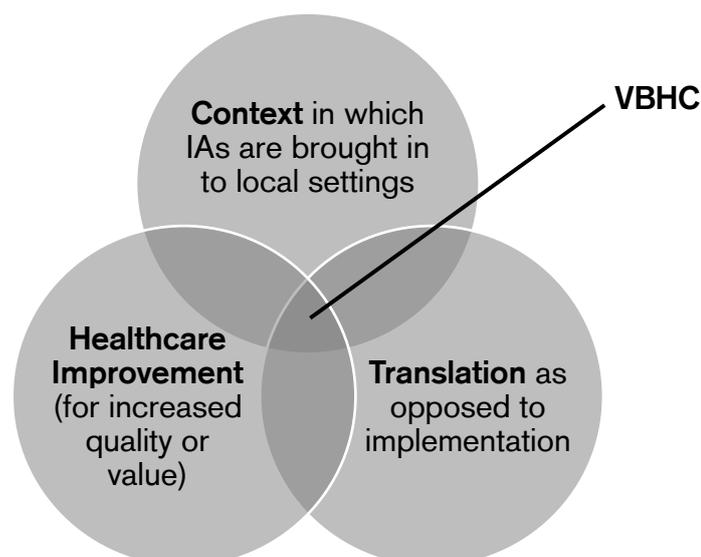


Figure 1.1 – Points of departure for the thesis, with VBHC as the primary study object (as an example of an IA).

1.2 Purpose and research questions

Investigating the phenomenon of IAs being brought in to healthcare settings, the purpose of this thesis is to provide support for an active translation process of improvement approaches to local healthcare settings, with the long-term aim of increasing value outcomes for care organizations. Based on a longitudinal, participatory single-case study of introduction of VBHC, aspects of content, process, and context will be investigated in order to enhance the understanding of translation of IAs to local contexts.

Following the purpose described above, the thesis aims to answer three research questions (RQ). First, as described, IAs can be seen as translated, rather than instrumentally implemented. The active handling of an IA can result in different trajectories and operational end results. Naturally, some end results are more desired than others from a managerial point of view. Hence, the first research question is:

RQ1: How can translation theory provide guidance for use of IAs in local contexts?

As described, there is a trend towards focus on value outcomes (Fredriksson et al., 2015; Gray, 2012; Porter, 2010), but the concept of value is inherently fuzzy and contains a great deal of ambiguity. Consequently, for IAs that focus on value (e.g. VBHC) the value concept adds to the fundamental ambiguity that all IAs hold. However, this ambiguity is a double-edged sword. As Giroux (2006) argued, it admits more than one course of action, which makes IAs easier to adapt to different contexts, but it also increases complexity (Spear, 2005), which is known to hinder implementation (Damschroder et al., 2009). Hence, the second research question is:

RQ2: In what ways can the ambiguity in the value concept hinder or support translation of IAs?

When translating IAs to specific healthcare settings, preunderstanding of the local context, as well as of the IA itself, is important in order to handle ambiguities pragmatically; that is, by strategic choices that increase the chance of achieving the desired organizational or operational end result (Giroux, 2006). Contexts also often include other, preexisting, IAs (e.g., Card, 2017; Røvik, 2008). Hence, it can be assumed

that it is insufficient to look at translation of *one* IA to *one* context, so it is necessary to include a broader perspective:

RQ3: How can coexisting IAs be handled in the translation process?

Thus, in local healthcare settings, managers struggle to improve quality and increase the efficiency of services in order to keep up with ever more demanding preconditions. They are presented with different, often coexisting IAs that are meant to help in this struggle. However, knowing that many introductions of IAs fail, the managers need to carefully choose IAs and use their ambiguities pragmatically to form a fitting *management model*, defined as “*the choices made by a company’s top executives regarding how they define objectives, motivate effort, coordinate activities and allocate resources; in other words, how they define the work of management*” (Birkinshaw and Goddard, 2009, p. 82). The present thesis intends to provide some guidance in the delicate task of how to take in new IAs into the local management model, to improve operations in terms of quality or value outcomes.

1.3 Outline of the thesis

After clarifying some limitations, a theoretical background is presented that comprises an overview of IAs introduced to healthcare, the complexities of the healthcare context, and implementation and translation of IAs.

The following methodology section describes the design and methodological underpinnings of the longitudinal and participatory research project, including the more specific methods used in each sub-study. An extended description of the context of the studies is also provided.

The three appended papers are then summarized and further discussed. A model is proposed for how IAs can be translated to fill niches in an ever-developing management model. The conclusions section summarizes the main points of the thesis, as well as some indications on practical and theoretical contributions, before outlining some potential paths for future research.

1.4 Limitations

The thesis is limited to the processes of translation of IAs within the context of a healthcare organization. Aspects of spread and fashion of IAs *between* organizations or industries are beyond the scope of this study, as are aspects of implementation of technical or medical innovations. Further, the concept of value is used in a large variety of scientific and philosophical contexts. The present thesis does not intend to dig further into meanings of value outside the management area. The empirical material is limited to a single case.

2. Theoretical background

This section outlines the previous research and theories in order to provide a background to the phenomenon of IAs being introduced to healthcare organizations that seek to improve quality and value outcomes and, hence, adopt IAs and fit them into their existing managerial operations.

2.1 Healthcare improvement

The field of healthcare improvement has been largely influenced by quality improvement and quality management (Boaden et al., 2008) and has, in recent years, been proposed as a science of its own (Bergman et al., 2015; Marshall et al., 2013). Many IAs have been proposed in association with the efforts of healthcare improvement (Boaden et al., 2008) and the emerging science of improvement includes components from renowned IAs in other industries, such as TQM and Six Sigma (Bergman et al., 2015). Further, Røvik (2008) proposed the term *multi-standard organizations* to describe the phenomenon that several streams of organizational ideas (like IAs) affect organizations simultaneously. This phenomenon is not new to healthcare, but has grown in the last three decades (Lifvergren, 2013). Some of the more influential IAs in the context of this research project are outlined below.

Starting in the late 1980s, *Total Quality Management* (TQM) became a widespread and cherished IA in healthcare, as it had been somewhat earlier in manufacturing industries (e.g., Short and Rahim, 1995). In the 1990s, some critical voices pointed out the obstacles and limitations of TQM within healthcare and other politically governed organizations (e.g., Sitkin et al., 1994; Zabada et al., 1998). In the late 1990s, the Institute of Medicine held a roundtable on quality (Bergman et al., (2015), which led to the subsequent influential publications entitled *To err is human: Building a safer health system* (Institute of Medicine, 2000) and *Crossing the quality chasm: A new health system for the 21st century* (Institute of Medicine, 2001), which had an impact on healthcare sectors both in the US and internationally. Today, TQM can be recognized in Sweden in concepts like *quality assurance systems* (Socialstyrelsen, 2011), assigned quality developers in many departments, and benchmarking initiatives in the form of quality registers and *open comparisons* (Socialdepartementet, 2014; Socialstyrelsen, 2009).

Lean spread to healthcare during the first decade of the 21st century (see, e.g., Spear, 2005; Young et al., 2004). As in other industries, there was a hope that it could increase productivity and promising results have been described in a growing stream of research (D'Andreamatteo et al., 2015; Mazzocato et al., 2010; De Souza, 2009). As in *Lean* in general, the focus is on streamlining core processes, eliminating waste, and striving for continuous improvements (Aherne, 2007). The concept is sometimes also used to create a learning organization (Ballé and Régnier, 2007). However, more recent research has pointed out several difficulties with its implementation in healthcare, such as the healthcare professionals' unfamiliarity with elements like teamwork (Drotz and Poksinska, 2014) and the issue of sustainability of the initiatives (D'Andreamatteo et al., 2015). Several authors have also emphasized the need for more holistic applications of *Lean* (that is, not just implementing certain components or tools), and studies of such initiatives (D'Andreamatteo et al., 2015; Mazzocato et al., 2010).

Six Sigma was proposed for healthcare in the late 1990s (Chassin, 1998) and further promoted in the following decade in parallel with *Lean Healthcare* (Young et al., 2004). The two IAs have also often been intertwined in practice (Boaden et al., 2008). Several case studies have shown positive results on a number of different aspects, such as patient outcomes, staff satisfaction, cost reductions, etc. (Lifvergren et al., 2010; e.g. Taner et al., 2007), but the concept has not achieved as much attention as *Lean* in relation to healthcare.

Emanating from a different field, but also aiming to improve healthcare, is *patient-centered care* (PCC) (Kitson et al., 2013). Stemming mostly from nursing and medicine, PCC aims to increase patient satisfaction and efficiency of care (for example, in terms of shorter hospitalizations) by improved nurse-patient and doctor-patient relationships, supporting areas such as empowerment and patient satisfaction (Ekman et al., 2011; Rathert et al., 2013). Ekman et al. (2011, p. 249) described PCC as “...*a shift away from a model in which the patient is the passive target of a medical intervention to another model where a more contractual arrangement is made involving the patient as an active part in his or her care and the decision-making process.*” Several authorities have promoted PCC (Socialstyrelsen, 2010; The Health Foundation, 2014), and the IA has also been applied to a number of conditions and medical specialties, such as geriatrics

(Westphal et al., 2015), cardiology (Ekman et al., 2011), and schizophrenia (Ali et al., 2016).

Value-Based Health Care (VBHC) was first suggested by Porter and Teisberg (2006) to address issues of increasing costs and poor – or at least varying – quality. Centered on the definition of value as outcomes that matter to the patient in relation to the costs for providing that care, the IA has then been further described and developed in a number of articles (e.g., Kaplan and Porter, 2011; Porter, 2009, 2010; Porter et al., 2016; Porter and Lee, 2013). In summary, the model makes the following suggestions (Porter and Lee, 2013):

1. *Measure true outcomes* (that is, those that are most important from the perspective of the patient) and associated *costs*, to let providers compete on value outcomes.
2. Organize around medical conditions in *integrated practice units*, instead of in departments based on medical specialty, in order to align better with the patients' needs.
3. Reimbursement by *bundled payments for full care cycles* (from onset to end-stage or yearly for chronic conditions, with adjustment for severity of the condition), instead of cost-driving fee-for-service or care-limiting global capitalization.
4. *Expand the best services geographically* to allow for faster change to services, providing better value outcomes.
5. *Integrate care delivery on system level* (that is, coordinate care processes between facilities and provide care in the most cost-efficient locations).
6. Use integrated, *enabling IT systems* to support all other included suggestions.

Hence, VBHC attempts to address the problem of fragmentation in healthcare systems and to shift the focus from medical specialties and delimited procedures to the comprehensive needs of different patient groups, along with an emphasis on improved measures to evaluate value outcomes (i.e. efficiency).

VBHC has been discussed widely and has had an impact on improvement in healthcare, even though the interpretation of the IA is not consistent (Fredriksson et al., 2015). VBHC also adheres to a broader movement towards a focus on value (Gray, 2012) and promotion of *patient-reported outcome measures* (PROM) as preferred measure for

results of care interventions (Erichsen Andersson et al., 2015; Nordin et al., 2017; Porter et al., 2016). Seen in relation to the simultaneous and widely promoted IA of PCC, the patient perspective in VBHC and PROMs is on group level, while PCC focuses on the individual patient (that is, VBHC adopts a patients' perspective, whereas PCC adopts a patient's perspective) (e.g., Card, 2017; Elf et al., 2017). These different views can be seen as conflicting, but ways to combine these IAs have also been proposed (Tseng and Hicks, 2016).

2.2 Value

As mentioned above, an increased focus on value for patients and other stakeholders can be recognized within the healthcare sector and value is a central concept in the content of for example VBHC. However, value is a multifaceted concept that has several meanings and a close relation to the concept of quality. Donabedian (1966, p. 167) defined quality within the context of healthcare as *“almost anything anyone wishes it to be, although it is, ordinarily, a reflection of values and goals current in the medical care system and in the larger society of which it is a part.”* Donabedian (1997) later divided the notion of healthcare quality into two elements: one technical, equal to effectiveness, and one interpersonal, which concerns social expectations. Similarly, Grönroos (1982, 1990) proposed a two-dimensional view, distinguishing between functional quality (speed and convenience of services) and technical quality (the end result of services). Similar divergent meanings are recognized for the concept of value. Babin and James (2010, p. 471) argued that value *“is seen as a measuring stick assessing the extent to which service has succeeded.”* Hence, quality and value are both concepts that can embrace almost everything that is good for the organization's stakeholders. However, in the contemporary trend towards focus on value rather than quality, value is explicitly seen as taking scarcity of resources into account (Gray, 2012; Porter, 2010). Gray (2012, p. 21) further argued that *“the value of a service is assessed by comparing its outcomes with its costs but money is a much less important measure of the resources used than either carbon or opportunity cost, namely, what else could be done with the money, staff time, facilities and equipment.”* Thus, this view sees value as quality in relation to costs.

Hence, there are different understandings of the value concept. In the field of marketing, where value for customers has long been a phenomenon of interest (Babin and James, 2010), Gummerus (2013) identified two main streams in view on value: *value creation*

For managers in healthcare (as in other industries), achieving high-value outcomes is a central task that is performed through management activities and principles. Birkinshaw and Goddard (2009) suggested the term *management model* for a framework dimensionalizing management (that is, the way of running business in a broad sense) in terms of four principles: (1) how objectives are managed, (2) how individuals are motivated, (3) how activities are coordinated, and (4) how decisions are made. Hence, one important means by which IAs can effectuate improvements is by altering dimensions of the local management model and thus change how managers manage their organizations to enhance value outcomes.

The background on value presented in this sub-section will be used to guide data collection (such as interview guides) and analysis, and informs RQ2, which is concerned with ambiguity of concepts. The notion of management models informs RQ1 and RQ3, as it can be seen as a recipient context for IAs brought into an organization.

2.3 The context of healthcare

However, managing healthcare is considered especially complex, largely depending on the coexistence of different logics (Mintzberg, 2002). Glouberman and Mintzberg (2001) argued that healthcare is comprised of four “worlds” that adhere to different logics: *community* (the perspective of trustees or, in a Swedish context, politicians), *control* (managers within the healthcare system), *care* (nurses and other first line, within-the-system care personnel), and *cure* (doctors); see Figure 2.2. Individuals from different worlds differ in having their focus *in* versus *out* and *up* versus *down* in the system, respectively. Thus, they have perceived the logic of the system differently. Attempts to change the healthcare system often fail because groups or individuals adopting different logics do not understand each other and, hence, improved understanding of other groups perspectives is needed (Mintzberg and Glouberman, 2001). Mintzberg (2002, p. 205) further argued that “*to manage a network effectively is to be everywhere within it. Also, in a sense, it is to be everyone within it.*”

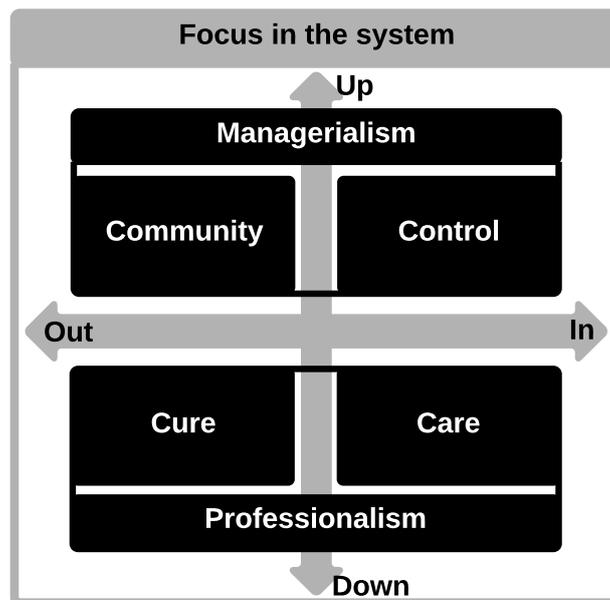


Figure 2.2 – Different, co-existing logics of healthcare creating its complexity (inspired by Glouberman & Mintzberg (2001), Choi (2011) and Öfverström (2008)).

These differences in understanding of the healthcare system between managers and administrators on one hand, and first-line healthcare professionals (both doctors and nurses) on the other, have also been described in a Swedish context; these are sometimes referred to as *managerialism* and *professionalism*, respectively (Choi, 2011; Öfverström, 2008), as illustrated in Figure 2.2. A lack of understanding between the logics can cause cleavages, which may also, for example, result in decisions made at higher levels of the system being ignored at the first line level, where the cure and care logics (that is, professionalism) dominate (Mintzberg, 2002). This *decoupling* of policies adopted by higher management and daily operations has been recognized by several authors (e.g., Boxenbaum and Jonsson, 2008; Meyer and Rowan, 1977; Palmer et al., 1993).

One explanation for failed implementations of IAs is that top-down introductions are often perceived with much skepticism among healthcare professionals (e.g., Ham, 2003; Nembhard 2009). Hence, in professional organizations it is especially important to obtain enthusiasm and support from professionals (Ham, 2003; Kumar, 2013; Mintzberg, 1980); also, changes in organizational culture (which several IAs suggest (Drotz and Poksinska, 2014; McCormack and McCance, 2006)) are similarly or even more difficult to accomplish (Scott et al., 2003).

The notions outlined in this sub-section provide an important background for understanding the context, which is to be changed when an IA is applied. Hence, these notions will inform all my research questions and the action research work described further in Section 3.

2.4 Translation of IAs

As described, myriad different IAs have been introduced to healthcare over the last decades (Hellström et al., 2010; Kaboolian, 2000; Lifvergren et al., 2010; Røvik, 2008), all aiming to improve healthcare in terms of quality and value. However, these IAs have not always delivered the promised effects (e.g., Ham, 2003; Hellström et al., 2010) and attention has turned to the spread and implementation of IAs (Madsen, 2015). Several scholars have described the fashions (e.g. Abrahamson, 1996), diffusion (e.g. Rogers, 1995), adoption (or rejection) (e.g. Madsen, 2015), and subsequent implementation of IAs. Numerous frameworks of implementation have been presented; among them, Damschroder (2009) offered a comprehensive synthesis of such frameworks in a *consolidated framework for implementation research* (CFIR), which has been applied to a broad range of healthcare interventions (Kirk et al., 2015).

However, the term *implementation* can be seen to imply an instrumental application of a concept (such as an IA) to a local setting (e.g., Latour, 1986). In contrast to this view, other scholars have stressed the organizations' active handling and adaptation of IAs in the implementation process and proposed alternative terms like *transposition* (Boxenbaum and Battilana, 2005), *adaptation* (e.g., Ansari et al., 2010), and *translation* (Czarniawska and Sevón, 1996; Latour, 1986; Røvik, 2008). In the present thesis, the term *translation* is used for the application of an IA to a context, in order to emphasize the activeness of the process.

After an organization has made the decision to adopt an IA, a *post-adoption phase* takes place (Madsen, 2015) where the IA can take various trajectories (e.g., Røvik, 2011). In this phase, translation takes place in several steps at different levels in a system or an organization, in a process that can be referred to as *contextualization* (Røvik, 2008). In the contextualization, the IA is handled by the (individuals within the) organization, leading to more or less transformation of the original approach; that is, elements can be added, subtracted, or converted. As illustrated in Figure 2.3, Røvik (2008) further

described three modi operandi for contextualization of ideas: the reproducing, modifying, and radical modi.

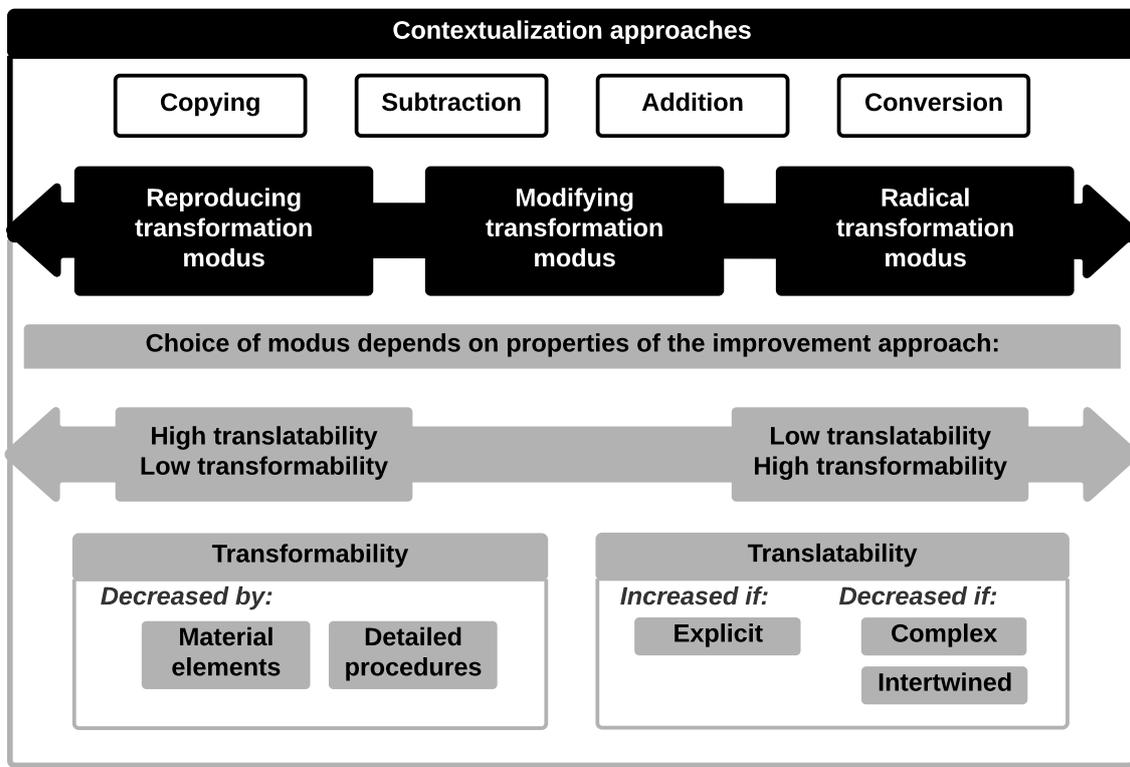


Figure 2.3 – Illustration of Røvik's (2008) framework on the contextualization of IAs in organizations.

Two main properties of the IA determine their fit to the different modi operandi; namely their translatability and their transformability (Røvik, 2008). The translatability depends on the extent to which the model is (1) explicit, (2) complex, and (3) intertwined. The more explicit (that is, codified, linguistic, clear, and communicable), the less complex (that is, technologically simple, involving few stakeholders, and not demanding high competences), and the less intertwined (that is, less anchored or embedded in the organizational context) – the easier the idea is translated into a context without modifications. The transformability is related to the degree of physical-material elements or detailed procedures in the model, where more such components decrease the transformability. Ideas with high translatability and low transformability are the easiest to apply by the reproducing modus (copying the concept), while ideas with the opposite properties (as is often the case with IAs) better fit the radical modus, which includes a more profound reshaping. The modifying modus includes addition and/or subtraction of elements, but is closer to the original idea. This framework informs the

analysis and relates to all RQs, as it elaborates on translation processes in connection to attributes (such as ambiguity and complexity) of IAs.

Thus, in terms of Røvik's (2008) framework, IAs often have low translatability and high transformability, as they are attached to a significant ambiguity (e.g., Örtenblad, 2010). The ambiguity of IAs have been described in terms as *interpretative flexibility* (Benders and van Veen, 2001) and *pragmatic ambiguity* (Giroux, 2006), indicating the advantage of ambiguity for adoption to organizations and subsequent translation. Ansari et al. (2010, p. 83) also argued that an IA has greater interpretive viability if "*it operates at a fairly abstract level, providing greater opportunities for divergent interpretation and sensemaking.*" Further, Rogers (2003) argued that organizational members that have participated in transforming an IA to a greater extent experience ownership over the IA and, therefore, the degree of transformation may correlate positively with sustainability of change.

2.5 Summary

This chapter has briefly outlined the content of a number of approaches to improvements that have influenced healthcare during recent decades. It has also pointed to a contemporary change in focus from quality to value. It then described the contextual properties of healthcare as a background to the complexities that can be encountered in trying to change healthcare organizations by use of IAs. Last, the process of translation of IAs was described with elaboration on ambiguity as a quality of IAs and on the concept of contextualization, implying a chain of consecutive translations resulting in a changed management model at local level.

As described above, Pettigrew (1987, p. 657) proposed three categories for analysis of strategic change: *content* (the formulation of areas of intended change), *context* (the inner and outer social, economic, and political environment), and *process* (the "*actions, reactions and interactions*" leading to the future state). Further, Pettigrew (1992, p. 7) argued that "*A further development of the context, content, and process analysis is to examine how variations in context and process explain different performance outcomes.*" Hence, the analytical framework in this thesis will include *content* (of IAs and of local management models), *process* (of contextualization of IAs), (inner and outer) *context* (of healthcare at large and of specific characteristics of settings in which

IAs are applied), and *outcomes* (in terms of value), as presented in Figure 2.4. The studies included in this thesis focus primarily on the first three components, assuming that they will have an impact on outcomes. However, the present thesis does not include studies aimed to empirically measure outcomes.

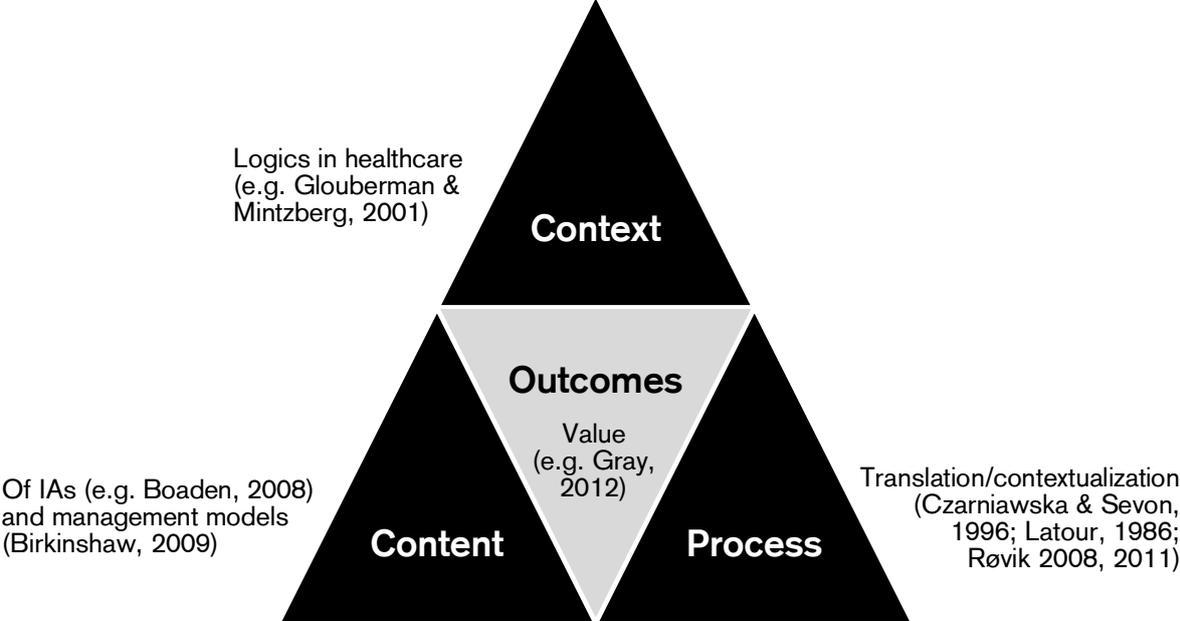


Figure 2.4 – Overarching framework for analysis and discussion, with examples of associated literature. Studies focus on black triangles but are assumed to affect outcomes.

3. Research methodology and design

My research project adheres to a tradition of studying organizational processes from a perspective close to practitioners (as an insider or closely following events and processes) in case studies and by use of complementary qualitative methods and elements of action research (Gadolin, 2017; Gustavsson et al., 2016; Johansson, 2011; Lifvergren et al., 2010; Vuorinen et al., 1998; Woodard and Weller, 2011).

3.1 Overview of the research project

The research was initiated in 2013, when VBHC was introduced to the Sahlgrenska University Hospital as a new main management concept. A few pilot projects of implementation of the concept had been initiated, led by an external consulting firm, which aroused my own interest in VBHC. After stating some preliminary RQs, the research project was planned as shown in Figure 3.1.

In 2013, VBHC was still new to the organization, and no decision had been made as to when the local implementation should start. At this point, the first study was conducted, focusing on the value concept and the preunderstanding of VBHC within the setting. Next, as the larger introduction program for the entire hospital continued, plans were laid out for a longitudinal study of the implementation process in greater detail and the study (which eventually became Study 3 in this thesis) was initiated. At this point, myself and others within the department management team held high hopes for VBHC, so the focus was largely on how to improve quality and outcomes by using the concept. However, as VBHC was introduced to the context and the implementation process proceeded, the attitudes gradually changed and the high hopes were moderated to seeing VBHC as one of several IAs that can be used as a starting point to pursue improvements in quality and efficiency. Also, the issue of how to manage several coexisting IAs within the same organization was actualized and addressed in a second study.

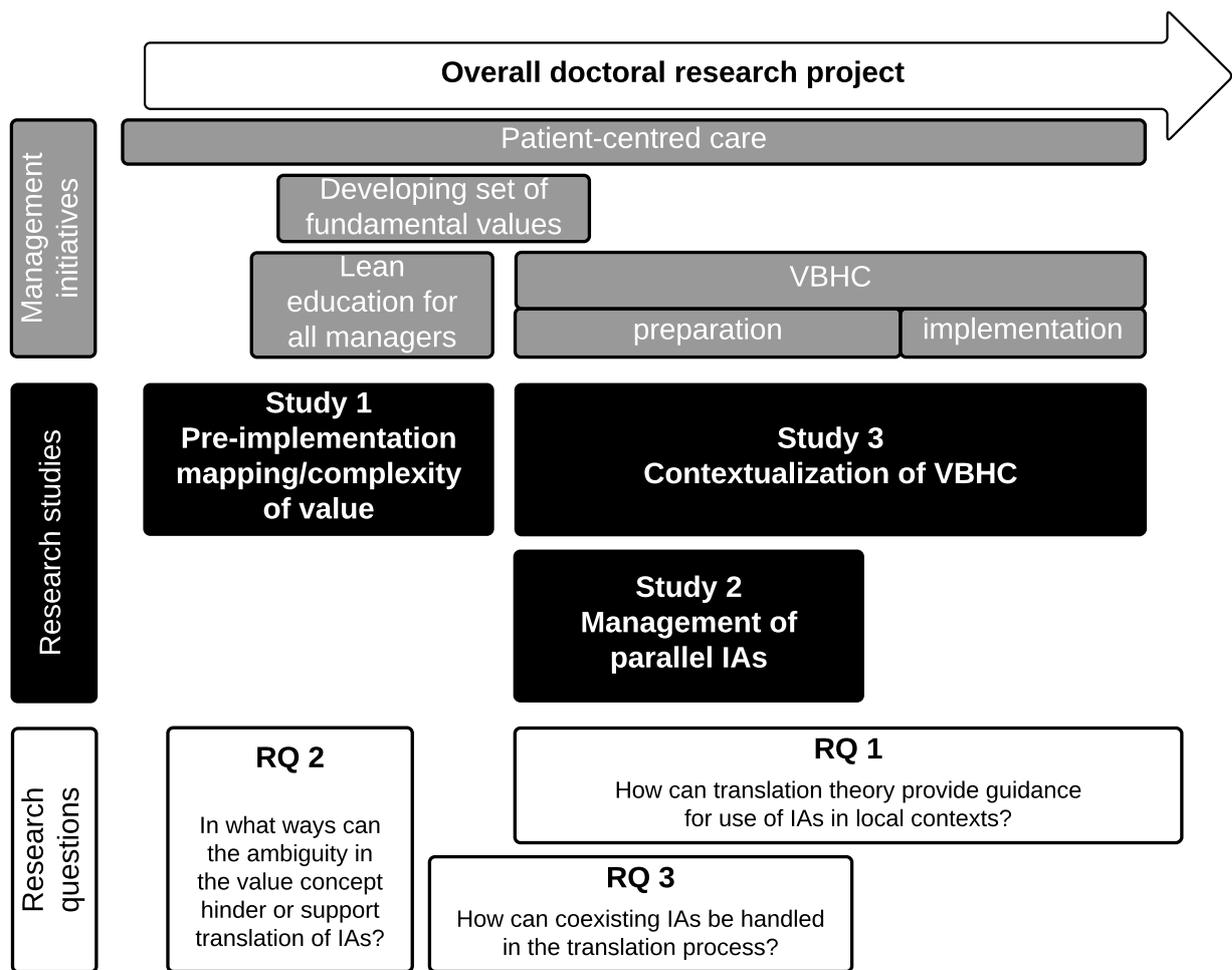


Figure 3.1 – Timeline of included studies and relation to research questions and to management initiatives in the setting of the studies.

As stated, the purpose of this thesis is to provide support for an active translation process of IAs to local healthcare settings, with the long-term aim of increasing value outcomes. Departing from this purpose, three research questions were stated and approached in different steps, as shown in Table 3.1. I used literature that focused on 1) the value concept, 2) improvement approaches, and 3) change efforts in relation to healthcare (inherent complexities and theories describing implementation, or translation, of IAs) as a foundation and qualitative data from interviews and observations forms the empirical base of the studies. For the first studies (concerning RQs 2 and 3), the output is inductive and in the forms of (first) descriptive insights and (next) a proposed taxonomy (framework). For the final, longitudinal, study, the output is deductive, contributing to earlier theories by descriptive insights and propositions (Barratt et al., 2011).

Table 3.1 – Input and output per research question.

RQ	Literature	Output
<i>RQ1 – How can translation theory provide guidance for use of IAs in local contexts?</i>	Literature delineating different perspectives of the value concept, and literature on complexities of the healthcare system, affecting the prerequisites for change efforts	Descriptive insights
<i>RQ2 – In what ways can the ambiguity in the value concept hinder or support translation of IAs?</i>	The consolidated framework of implementation research is combined with theories on the translation of IAs to local contexts and related to original works on VBHC	Descriptive insights and propositions for how to further develop an existing framework
<i>RQ3 – How can coexisting IAs be handled in the translation process?</i>	Literature on the concept of value and complexity of healthcare are used to create a taxonomy. Descriptions and reviews of the IAs Lean, VBHC, and patient-centered care are used to relate the concepts to the taxonomy	Proposed taxonomy (framework)

3.2 Research design and strategy

3.2.1 Reflections on research strategies

The present research project is to be seen as phenomenon-driven (Schwarz and Stensaker, 2014), and the overall approach was inspired by the principles of pragmatic case studies, as described by Fishman (1999). The concept builds on pragmatism and accedes to social constructionism rather than an objectivist ontology. As Fishman argued, *“the pragmatic ‘truth’ of a particular perspective does not lie in its correspondence to ‘objective reality,’ since that reality is continuously in flux. Rather, the pragmatic truth of a particular perspective lies in its usefulness of the perspective in helping us to cope and solve particular problems and achieve particular goals in today’s world”* (ibid. p. 130). Hence, the design and methodology of the studies will concentrate on matters of practical importance and aim to provide guidance to practitioners, as well as to bring about improvements during the course of the research project. That is, even though the choice to apply a certain IA is not always in the hands of the studied organization, the aim is to *make it* useful for operational improvement by collaboration with practitioners in a pragmatic action research approach (Greenwood and Levin, 2007). Also, the research is influenced by the principles of systematic combining (Dubois and Gadde, 2002, 2014), implying an abductive approach (Alvesson and Sköldbberg, 2000) in which the researcher moves from theory to reality, then repeatedly back and forth to understand and explain the on-going and emerging processes.

3.2.2 Research design

Taking its departure from the pragmatic and abductive approach, the overarching research project is designed as a qualitative, longitudinal, participatory single-case study, with notable elements of action research. The rationale of a longitudinal case study is the chance to study change processes in context, including several interconnected levels of analysis.

A qualitative approach is appropriate since the RQs focus on the *how* of organizational processes (Bryman and Bell, 2011; Yin, 2003). Furthermore, the theories that constitute the basis of the research are rather nascent – Edmondson and McManus (2007, p. 1158) defined such a theory as one that “*proposes tentative answers to novel questions of how and why*” – and argued that a qualitative approach is appropriate for such theories (Edmondson and McManus, 2007). Earlier research on the translation of improvement approaches aiming to enhance value outcomes in healthcare has only constructed theories on a general level that cannot be directly applied and tested, and there is a need for a deeper understanding of the concept and its context in order to be able to create more specific theories that can later, potentially, be tested (Suddaby, 2006; Yin, 2003).

A case study allows for investigation in phenomena where “*the boundaries between the phenomenon and context may not be clearly evident*” (Yin, 2003, p. 13) and, as Pettigrew (1990, p. 269) argued, “*explanations of change are bound to be holistic and multifaceted*”. A longitudinal case study also allows for a narrative that can be analyzed as a whole and not only as isolated before and after states. As Van de Ven and Huber (1990, p. 214) argued: “*events represent changes in variables and these changes are the building blocks of process in an input-process-output model. But since our process question is not whether, but how, a change occurred, we first need a story that narrates the sequence of events that unfolded ...*” The choice to conduct a single-case study over a multiple-case study also allows a deeper understanding instead of a more superficial comparison. A multiple-case study is not easily feasible either, as there were not (at the time) many similar organizations available to include. Thus, this setting “*exploits opportunities to explore a significant phenomenon under rare or extreme circumstances*” (Eisenhardt and Graebner, 2007, p. 27).

The choice of a participatory approach, including elements of action research, further improves the possibility of in-depth insights into the *how* of the change process, and allows for operational improvements as an additional goal for the project. As Greenwood and Levin (2007, p. 5) put it, “*Action research refers to the conjunction of three elements: action, research, and participation.*” This view is shared by Coghlan and Brannick (2014, p. 6), who further specified that action research is “*research in action, rather than about action*” and emphasized the collaborative aspect of the approach. The choice of an action research approach over a more traditional qualitative approach allows both an opportunity to improve operations (Lifvergren et al., 2015; Macaulay et al., 1999), and a deeper understanding of the studied phenomena (Bradbury-Huang, 2010), in line with the pragmatic presupposition of the research project.

3.2.3 Study setting

Following the choice of a participatory approach with elements of action research, the study setting needed to allow access to in-depth data on the longitudinal process of translation of an IA to a local context. Also, the secondary goal – to create knowledge together with practitioners and allow for operational improvements – required a setting in which the researcher was allowed close and continuous access and where practitioners were willing to be involved in research activities on top of their organizational activities. Due to these demands, the Department of Psychotic Disorders at the Sahlgrenska University Hospital (from here on “the Department”) was chosen as setting for the research project. In this specific setting, unique access to data and understanding of the inner and outer context is granted, as I occupy a role as manager within the organization. During the course of the research project I held a position as section manager and as such I was the first-line manager of the approximately 15–20 physicians within the in-patient section of the Department. The managerial tasks accounted for half of my working hours and most of the remaining time I worked as a resident physician in training to be a psychiatrist. I had held the position since 2011 and was known to many among the staff of the Department, but had most of my interactions with the physicians. I had also cooperated closely with the top management of the Department, as a part of the management board. In September 2017, after the studies included in this thesis were completed, I moved to a role as deputy head of department, a second-line management position.

The Department was established in 2011, after a reorganization of the psychiatric departments within the hospital, and is responsible for the care of patients with schizophrenia and schizophrenia-like disorders (diagnoses coded as F20-F29 in the ICD-10 classification system of medical conditions (World Health Organization, 2004a) within the Gothenburg area in Sweden. A staff of approximately 400 employees provides both in- and out-patient care for the 2600 patients in eight out-patient units (a few of which also have seven or eight in-patient beds) and four hospital wards with a total of 48 beds.

The main diagnosis group of the Department – schizophrenia and schizophrenia-like disorders – are characterized by symptoms like hallucinations, delusions, and impaired cognitive functions, and treatment usually needs to be maintained life-long, from an onset usually between 20 and 35 years of age (Alda et al., 1996). The conditions are often severe in more active periods, and the World Health Organization has classified active psychosis in the highest disability class, together with, for example, quadriplegia and terminal-stage cancer (World Health Organization, 2004b, p. 33). Outcomes are often measured in terms of remission, which focuses on reduction of symptoms, assessed by medical professionals (Andreasen et al., 2005). However, it has been shown that social functioning may be more important from the perspective of the patients (Bridges et al., 2013) and *recovery* has been proposed as an alternative outcome (Lieberman et al., 2002), but is difficult to measure adequately in practice. Also, the impaired cognitive functions that are often present complicate the use of patient-reported outcome measures and, hence, measurement of value from the perspective of the patient.

The Department applies an out-patient care model named Resource group Assertive Community Treatment (RACT) (Malm et al., 2015; Nordén et al., 2012) and is also implementing person-centered care (PCC) (Ekman et al., 2015; Westphal et al., 2015). In parallel, the hospital has completed a project aimed at developing a set of fundamental values in the organization (that is, improving by altering the company culture) and, in 2013, initiated a program aimed at implementing VBHC for all the larger patient groups. Thus, several approaches for improvement of care operations (and ultimately value outcomes) were present during the course of the research project.

The patient group “schizophrenia and schizophrenia-like disorders” (that is, practically all of the patients of the Department) was enrolled in the VBHC introduction program in August 2015. Detailed guidelines for the local implementation projects had been established by the overarching hospital administration, including three phases, as shown in Figure 3.2: (1) *preparation* (approximately six months recommended), (2) *implementation* (12 structured weeks), and (3) *further development* (which is not part of the project, but stresses continued improvement work).

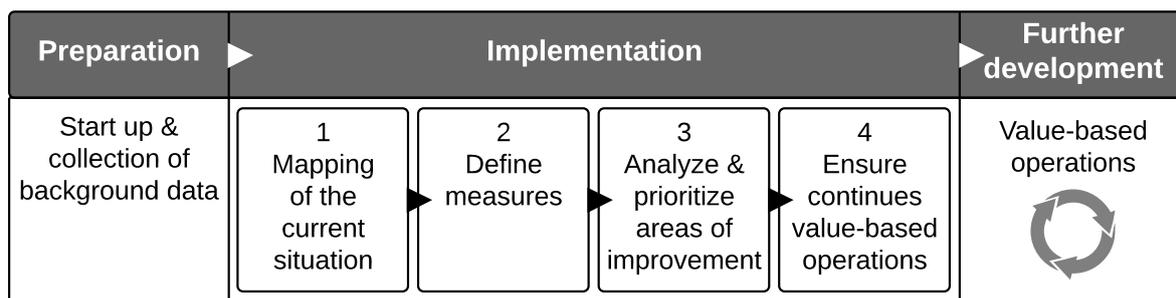


Figure 3.2 – The process of VBHC implementation as outlines in the hospital’s introduction program (originally in Swedish).

Every local implementation project was to be conducted by a *project group* consisting of at least a project leader with medical competence (in the Department planned to be shared between me and a care developer), a controller, a care developer, someone with competence in registries (that is, relevant databases), a “VBHC coordinator” at higher hierarchical level, and an administrative support. A *steering committee* and a *reference group* were also to be established, which should both function as a broader sounding board to the project group, and revise and sanction its work. At the Department, the preparation phase started in August 2015 and members of the project group (n=4), steering committee (n=7), and reference group (n=12) were assigned in June the same year. The implementation phase was first planned for December of 2015, but was postponed and finally initiated in January 2016.

3.3 Research methods

As described, the research project includes three different, but partly overlapping studies. Study 1 was conducted before VBHC was introduced to the Department and concerns perceptions of the value concept and VBHC in the context. Study 2 focused on handling of parallel (that is, coexisting) IAs, and Study 3 was on the process of

implementation, or translation, of VBHC. An overview of the methods used is presented in Table 3.2 and then elaborated for each study in the remainder of the section.

Table 3.2 – Purposes and methods per study.

	Study 1: Pre-implementation mapping	Study 2: Management of parallel IAs	Study 3: Contextualization of VBHC
Purpose	To illuminate the complexity of the value concept as a driver for improvements in care operations.	To construct a taxonomy as support for management of parallel improvement approaches in healthcare.	To understand, in-depth, the translation process of the general IA VBHC to local practice, in order to provide guidance on how to handle general IAs in specific contexts.
Connection to RQ	Base for further investigation into RQ 2	RQ 3	RQ 1, 2, and 3
Data sources	Four expert interviews 36 open-ended patient questionnaires 16 semi-structured interviews	Previous research literature on quality improvement approaches, the value concept, and logics of healthcare 3 key informant interviews	Continuous field notes of observations and reflections Participation in 62 project meetings (six audio-recorded in full) 53 documents 13 audio-recorded group reflections with the project group
Sampling method	Purposive sampling	Theoretical sampling of literature and purposive sampling for interviews	(Holistic approach (MacQuarrie, 2010))
Time of study	March 2014–April 2015	October 2015–April 2016	2015–2016
Used in paper	Paper 1 & 2	Paper 2	Paper 3

3.3.1 Study 1 – Pre-implementation mapping/Complexity of the value concept

The data for the first study was collected by interviews, which is appropriate since the aim is “to understand the meaning of respondents’ experiences and life worlds” (Gubrium and Holstein, 2001, p. 83). Data collection started with four *expert interviews* (Flick, 2009), with the aiming of obtaining an overview of the contemporary discourse and dialogue on value and VBHC in the context of psychiatric care in Sweden. One VBHC consultant, one project leader for the implementation of VBHC at another psychiatric department, one government official with responsibility for psychiatry in Sweden, and one politician focusing on healthcare policy were selected deliberately as interviewees in order to include as many perspectives as possible and individuals with unique insights into the topics of value in relation to healthcare and to VBHC. Examples

of questions included “*What are your experiences of VBHC?*”, “*What is your opinion on how value can be measured?*”, and “*How do you interpret the term value in the context of psychiatric care?*” Supplementary questions differed largely depending on the interviewee’s role and experiences. I conducted all of the interviews in personal meetings at the respondent’s office or by telephone; each interview lasted approximately 30–60 minutes. Next, I listened to the audio-recorded expert interviews and transcribed the relevant parts, which were used as a base for constructing both a semi-structured interview guide and a short, open-ended questionnaire to patients.

Sixteen interviewees were then identified by purposeful sampling (Patton, 2002) to include a wide diversity of perspectives from the setting, taking into account aspects of profession, role (for example, manager, employee, or group leader), amount of experience, and familiarity with different existing IAs (such as RACT and PCC; see Section 3.2.3). A master’s student and myself then conducted semi-structured interviews (Flick, 2009), mostly at the respondents’ workplaces, but some by telephone. The interviews focused on the meaning of “value” in the context of psychosis care, value creation mechanisms in the context, and the VBHC concept. Examples of questions include: “*What does the word value mean to you, when it comes to psychosis care?*”, “*If you were to decide, what measures would you choose to measure the value that psychosis care creates?*”, and “*Can you describe what it [value-based healthcare] means?*” The interviews lasted approximately 15–30 minutes and were audio-recorded and listened to by both interviewers individually, for identification of key responses for each question. Relevant parts of interviews were then transcribed.

Open-ended questionnaires were distributed to 16 patients with psychosis diagnoses who were about to be submitted from hospital after a period of hospitalization. The questionnaires were included in a larger battery of surveys and rating scales as part of another research project (approved by the Regional Ethical Review Board in Gothenburg, application number 773-13) and were presented to patients by external researchers, who sometimes helped the patient understand the question and/or write down the response. Starting from the categories of views on value by Gummerus (2013) (see Section 2.2), the four questions concerned *what the most important improvements for them during the hospitalization stay had been, what they would wish for in the future* (that is, outcomes), and *how the healthcare system could help in that* (that is, processes).

All patients who we considered able to complete the surveys were included (that is, a complete sampling during a delimited period of time). Methodologically, the questionnaires can also be seen as (very short) focused interviews, for which the in-patient stay is the initial stimulus and some pre-defined questions are asked by the interviewer (and written down) (Flick, 2009). This method was used to be able to include patients, even though some suffered from complicating cognitive impairments.

A joint analysis of the data was then conducted together with external investigators (my supervisors) (Breen, 2007; Pugh et al., 2000) to strengthen the validity (Eisenhardt and Graebner, 2007). Common and diverging themes were identified using NVivo. Also, inspired by the principles of pattern matching (Yin, 2003), data was analyzed according to congruence with theoretically developed dimensions of value and value logics.

3.3.2 Study 2 – Management of parallel IAs

For the second study, the data from the expert and semi-structured interviews from study 1 was revisited and analyzed with a theoretical framework that focused more directly on the view on value as processes and/or outcomes. The data was also further analyzed (again, jointly by me and my supervisors) concerning the view on VBHC and other IAs that appeared in the interviews. Also, my main supervisor and I jointly conducted three new semi-structured interviews (Pugh et al., 2000) with key informants, focusing on management of coexisting IAs and presenting a theoretically derived, preliminary taxonomy for validation purposes. The taxonomy was then adjusted somewhat based on the responses. Again, NVivo was used for the analysis, which I conducted with my two supervisors, in order to strengthen the validity of the analysis (Breen, 2007; Eisenhardt and Graebner, 2007).

3.3.3 Study 3 – Contextualization of VBHC

The third study concerns the longitudinal process of implementation of VBHC and comprehends the full, pragmatic (Fishman, 1999) scope of the overarching research project (although with a narrower purpose), and is hence designed as a longitudinal, participatory single-case study with elements of action research conducted by an insider (Coghlan and Brannick, 2014). Data was collected in several forms over a period of almost two years. I was appointed as one of two cooperating project leaders for the local implementation project. Accordingly, I participated in weekly project group meetings

(n=35), as well as larger periodic meetings with the steering committee and the reference group (n=9) and other meetings and events (n=18) related to the project, following the principles of participant observation (Flick, 2009). Field notes were taken continuously (and also in between meetings and events), including personal reflections on the ongoing processes, and documents produced by, or directed towards, the project group were collected (n=53) (e.g., Bryman and Bell, 2011). Some key meetings (n=5, including kick-offs for new phases and closing meeting) were audio-recorded in full and the project group, sometimes together with an internal consultant from the hospital, were regularly invited to jointly reflect on the implementation process immediately after regular meetings (n=13) for 5–15 minutes, which was also audio-recorded.

The collected data was revisited regularly during the process, resulting in shorter memos, which were organized into an event data file (inspired by Maxwell (2005)) with weekly and monthly summaries, structured by *characteristics of the intervention, inner context, outer context, process, and influence of individuals*, inspired by Pettigrew (1987) and Damschroder (2009). An exemplifying excision is provided in Table 3.3. The data (primarily the event data file) was then analyzed individually by myself and my co-supervisor, followed by a joint analysis from insider and outsider perspective (Breen, 2007; Pugh et al., 2000), to find emerging themes, with the theoretic lens of translation theory and CFIR, inspired by the principles of qualitative content analysis (Flick, 2009).

3.4 Research quality

3.4.1 Method limitations

The qualitative, longitudinal, participatory single-case study design inevitably has some limitations. The main problem concerns the generalizability of results. A qualitative approach delimits the possibility to measure the size of effects and to use statistical tools to prove the significance of the findings. Results from this single-case study are heavily dependent on contextual factors and specific characteristics of the setting. Hence, statistical generalizations are not possible. Also, because building theory from qualitative case studies requires multiple cases (Eisenhardt, 1989), the results of this project are only indicative, but they can be transferrable to other contexts (Ritchie and Lewis, 2003) where further case studies can be conducted.

Table 3.3 – short excision of the event data file (originally in Swedish) as example of the structure.

Month	Week	Date	Event	Observations	Reflections (structured by relevant domains)	Data sources
February	6	16-02-12	Workshop on measures	<p>Project group + volunteers from steering and reference groups. Updated the “connection map” and reviewed measures connected to it → preliminary first and future scorecard (strongest focus on the first).</p> <p>Content-wise, many group members lean toward rating scales, but in practice it is often hard to get the staff to perform/register ratings systematically. We had to be realistic and restrict ourselves to what is possible for first scorecard.</p> <p>Stressful to develop a scorecard so fast. Some frustration about not achieving a really good scorecard. The participants did get an improved insight into the complexity.</p> <p>Tried to relate the measures to three aspects: process levels, the connection map, and temporality (measuring frequency and speed in impact of efforts)</p>	<p>Content: Pros and cons with different measures, composition and balancing of scorecard.</p> <p>Process: Engaged persons in the inner context are frustrated that the progress is slow/the ambition level is too low. The project group has to slow down considering the silent majority of the staff, who we think will be hard to get to perform activities such as ratings. Increased insight in the steering and reference groups of the complexity of the task. Channeled partly by use of first and future scorecard.</p> <p>Inner context: See above. Is pushing the process.</p> <p>Outer context: Technical systems are impeding the possibility to use some measures and means of data collection. Unreliability in data due to different systems. The [internal consultants] provide good support – they control through their stipulated process, but not actively in the content of the work.</p>	Field notes and photos (File)
February	Monthly summary			<p>Content: Focus on development of scorecard and achieving the steps in checklists provided by the internal consultants.</p> <p>Process: Frustration over the restart – how important is it to include everyone, introduce new (replaced) group members, etc.? Handling of visionary vs. pragmatic attitudes by first and future scorecard. Similarly: Spread in ‘faithfulness to the concept’ vs. ‘use to accomplish things one already wanted done.’ We choose voluntariness on measures (e.g., by pilot tests) as a pedagogical strategy to make progress.</p> <p>Inner Context: Driving – continued initial enthusiasm but incipient insight on the complexity. However, majority of the department probably still unaware/do not feel that this project affects them in practice.</p> <p>Outer Context: The internal consultants are driving by use of clear milestones that we are obligated to meet and report on throughout the 12-week period.</p>		

3.4.2 Quality criteria

The quality of a qualitative studies can be judged by its *trustworthiness* (Bryman and Bell, 2011). In order to be trustworthy, the research must have *credibility*, *transferability*, *dependability*, and *confirmability* (Shenton, 2004).

Credibility is ensured by the use of established research practice, such as semi-structured interviews (Flick, 2009) (Studies 1 and 2) and rigorous field notes and *peer debriefing* (Guba and Lincoln, 1986) by regular reflections together with outsider researchers (all studies, but most markedly for Studies 2 and 3). Triangulation of methods also increases credibility (Shenton, 2004) and is obtained by use of interviews, field notes from participation in activities, and collection of documents. Also, *iterative questioning*, *frequent debriefing sessions*, and my own *reflective commentary* (Shenton, 2004) were used in Study 3, which further strengthens the credibility.

Transferability of a single-case study, as mentioned above, is dependent on a detailed description of the case and its context (Lincoln and Guba, 1979). Descriptive data on the organization are provided in the papers, along with information about preceding or coexisting concepts and activities. However, restrictions in length of paper have constrained the described richness in detail. This thesis provides a more elaborate description of the context and the phenomena under investigation in order to improve the conditions for comparisons to be made and, thus, increase transferability. However, it is not easy to determine what level of detail is enough (Guba and Lincoln, 1986). Furthermore, a number of concepts related to transferability have been proposed (Gobo, 2008). For example, Yin (2003) suggested the term *analytical generalization*, “*in which a previously developed theory is used as a template with which to compare the empirical results of the case study*” (p. 33). This principle is used in Paper 3 and, to some extent, in Paper 2.

Dependability concerns the replicability of results (Ritchie and Lewis, 2003) and, in qualitative research, is achieved by being clear about which methods were used and why (Shenton, 2004). This is also particularly relevant in action research, for which Bradbury-Huang (2010, p. 101) argued that “*if there is a rule in action research on the creation of quality, it is to be transparent about the choice-points we make and about the limitations that come as a result of these choices.*” Interview methods and sampling approaches are

made clear in the present thesis and in the appended papers. However, it is more challenging to describe all the choices made pragmatically throughout the course of the longitudinal and participatory study. The use of joint reflections with the project group is one example of a methodological choice made to fit into daily activities, to collect data and involve organization members, which I have described in this thesis as an attempt to be clear about methods used, even when strict traditional interview methods were not applicable.

In order for results to be transferrable to other contexts, it is necessary to have sufficiently detailed descriptions of the context so that others can assess the similarity to another context (Shenton, 2004)

Confirmability also concerns openness, not only about the limitations that methodological choices entail, but the biases that the intrusion of a researcher inevitably brings with it (Shenton, 2004). In this thesis, I have devoted a separate section to reflections on action research aspects, and my own role and views on the context and phenomena are elaborated on in the context section.

3.4.3 Reflections on the action research approach

The elements of action research included in the research project involve some issues that need to be considered and mitigated. Coghlan and Brannick (2014) argued that a research project can be described in two dimensions: the degree of intended self-study in the actions of (1) the researcher and (2) the organization. This framework is presented in a model with four archetypes of research located in different quadrants of the chart (Figure 3.3). The aim of my research project was to investigate the organization in action, placing it in the right half of the matrix; further, my intention was not primarily to inquire into myself in action, even if my deep involvement in the core project requires a certain amount of self-reflection. Therefore, this research project fits in the second quadrant, although with significant elements of quadrant 4.

Consequently, the emphasis of the research is mainly on second-person inquiry (that is, collaborative work) but it is also necessary for me to include elements of self-reflection, touching on first-person inquiry (Heron, 1996). Third-person inquiry implies



Figure 3.3 – Framework of study focus by Coghlan and Brannick (2014), including indication of the position of the present research project.

engagement of wider groups of individuals in research and has not been emphasized in my research project this far. Reason and Torbert (2001) argued that all persons (first-, second-, and third-) should be integrated to increase the validity of the produced knowledge and the effectiveness of our actions in practice. Such integration is not explicitly provided in this thesis, but reporting and extrapolating from the concrete (such as findings from the single case presented in this thesis) to the general can actualize third-person inquiry (Coghlan and Brannick, 2014).

First, concerning second-person work, the studied project is a case of *planned change* (Buono and Kerber, 2008), which is characterized by a clear goal but with room for some modifications and a flexible and participative change process, in contrast to a tightly controlled *directed change* on one hand, and an experimental and collaborative *guided change* on the other. In this case, the top management of the hospital prescribed elements of VBHC that should be implemented, but modifications were accepted, and care professionals were to participate in the change process. Coghlan and Brannick (2014, p. 79) argued that “*the planned change approach provides a very useful format for most insider research projects*” and further proposed a four-phase iterative model for the process of planned change in an action research project, based on Beckhard (1997). This model guided the project, as shown in Table 3.4, including activities from different iterations of the model in practice.

Table 3.4 – The four-step model guiding management of a planned change project and connected activities in the project of this thesis.

Phase	Connected activities
1. Determining the need for change	Implementing VBHC was not optional, but in my role as a manager I saw a need for a way to measure performance of the organization (in better ways than rough productivity measures and overall financial deviation). My preunderstanding of the organization was that employees want to do good for their patients, but different approaches were used and no one could tell what worked and what did not.
2. Defining the future state	The project group for VBHC implementation (Study 3) worked hard to involve employees through means such as regular reference group meetings, a workshop, and pilot testing of change ideas. The development of a first and a future scorecard was allowed much time and a lot of effort was put into reaching consensus on vital parts.
3. Assessing the present in terms of the future to determine the work to be done	The first study, which mapped current perceptions of the value concept, was deliberately planned to serve as a base for how to present the VBHC concept to the organization. The identification of many coexisting interpretations of value and VBHC told me (and the project group) that a common definition of value in relation to VBHC needed to be established before operationalization.
4. Managing the transition	Many activities can be included in this fourth phase. For example, the choice to reduce the number of measures in use before introducing new ones, in order not to burden professionals with too many tasks that they perceived outside of their core job, and hence provoke resistance.

Further, in order to conduct second-person inquiry with people that I already knew and to handle (and use) my own preunderstandings of the context, I adopted Coghlan and Brannick’s (2014) suggestion that a researcher should combine advocacy and inquiry in order to avoid diminishing the spirit of inquiry. One example of how this was considered is the repeated joint reflections with the project group. That is, even though observations were made continuously, I focused on advocacy during project group meetings, and inquiry during reflections, not to neglect any part.

Second, touching on first-person issues, Jagosh et al. (2012, p. 335) argued for participative research that *“healthy conflict, resistance, negotiation, and consensus building are integral to establishing trust and rapport among stakeholders”*, but also pointed to the risk of negative results if conflicts are left unresolved. Such conflicts can obviously appear between researchers and practitioners. However, when conducting action research within one’s own organization, conflicts appear within the same person, between the different but parallel roles. This phenomenon is acknowledged as *role duality* (Coghlan and Brannick, 2014), which implies issues related to knowing what role to take on (and what role others attribute to you) in what situation, and *“when you are*

caught between loyalty tugs, behavioral claims and identification dilemmas, you initially align yourself with your organizational role” (p. 140). I believe that this has been true for me, and I think most of the organization’s members have seen me as a manager rather than a researcher, even though they have been aware of my research project. Hence, it has been important to take time for reflection and note-taking after meetings and the joint reflections in the project group were especially valuable as a situation in which I could take on the role of researcher.

Moreover, being an insider researcher implies a risk of two different types of bias. First, my preunderstanding of the organization and involved individuals is not only an asset but will inherently influence the analysis of data (Herr and Anderson, 2005). Second, results and phenomena of special interest to myself, or results that reflect positively on me or my organization, may be stressed at the expense of other crucial findings (Coghlan and Brannick, 2014). Attempts were made to mitigate these risks by joint analysis of data with an outsider researcher (Pugh et al., 2000). However, risks cannot be fully avoided and, ultimately, findings need to be reproduced in other settings and by other methods to be established.

3.4.4 Research ethics

Research involving other people implies certain ethical issues that need to be considered. Herr and Anderson (2005) pointed out three ethical aspects to consider, emanating from the Belmont Report (The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979): *respect for persons*, *beneficence*, and *justice*.

Respect for persons demands that individuals be seen as capable, autonomous, and able to make personal decisions on their participation (Herr and Anderson, 2005). On the other hand, individuals with diminished autonomy, due to factors such as age or mental capability, must be protected based on their vulnerability. In this research project, interviewees were informed about the research project, the voluntary nature of participation, and that anonymous quotes could be used. Interviewees were also given the opportunity to participate without being quoted. Members of the groups involved in the implementation project were informed of these points, in advance by e-mail and orally at the kick-off and again at first meeting with each group. They were given the

possibility to abstain or not be quoted. Audio-recording of meetings and group reflections were announced before the recording was started. Meyer (1993), for example, noted that, despite these precautions, participation in action research is always forced to some degree, while Williamson and Prosser (2002) further argued that informed consent is not irrelevant, but because it is more complicated in cases of action research, other ethical principles must be more strongly emphasized and individuals sometimes need to be more sheltered.

The researchers addressed the respect for patients (who are more vulnerable than organization members) in an adjacent research project, following the approval decision by the Regional Ethical Review Board in Gothenburg (application number 773-13). No other patients were involved in or directly affected by this research project.

Beneficence implies a wish not to do harm, to minimize any possible harm, and to maximize benefits (Herr and Anderson, 2005). This principle is in line with the overall pragmatic approach of the present research project, which has pervaded all studies. In (rare) situations of conflict, what was best for individuals or healthcare operations has had priority over research activities. However, as Morton (1998) identified, there is a dilemma in terms of how much of an organization's time and money an action researcher can spend on theorizing for the benefit of himself or herself, beyond what a pure consultant would spend. As an industrial PhD candidate, my research has been approved to be conducted on paid working hours and even though I believe that my management efforts have improved by the combination with research, the use of scarce resources deserve some attention.

Justice refers to a fair distribution of benefits and inconvenience by the research, including minimizing exploitation of vulnerable groups (Mastroianni and Kahn, 2001). This aspect does not have direct implications for this project. The pragmatic approach ultimately aims to improve care for the entire vulnerable group of individuals suffering from psychotic disorders, even though limited to a specific geographic area. The potential inconveniences (such as taking the time to reflect in group on current processes) are minor and do not affect any vulnerable group.

4. Summary of appended papers

4.1 Paper 1: The Complexity of Using Value as Driver for Improvement in Psychosis Care

Starting from the management idea of *Value-Based Healthcare* (VBHC), which at the time was widely discussed in the context of Swedish healthcare, Paper 1 examines the concept of value (a core content of VBHC) in relation to healthcare operations for patients with psychotic disorders. The purpose is to illuminate the complexity of the value concept as a driver for improvements in care operations. This is done by illustrating diverse interpretations of the concept of “value”. An interview study is presented from a healthcare context in which VBHC has not yet been implemented, focusing primarily on conceptualization of the concept of value and secondarily on VBHC.

The results reveal seven common themes among staff, and seven among patients (which largely conform), regarding what value is in the context of psychosis care. Furthermore, value is perceived both as processes (activities) and outcomes. Thus, there is a decent degree of consensus between patients and professionals, although value as concept is generally fuzzy and contains many dimensions and potential interpretations. For example, many patients and employees consider treating patients with “respect and dignity” to be a value in itself, whereas others interpret value as an increased social functioning and a few others view it as decreased costs of care.

Furthermore, there is a complexity in the fact that medical conditions affecting cognitive capacities and perception of reality, such as psychotic disorders, impair the ability to make reasonable value judgements. Thus, for value to be measured and subsequently used as a driver of improvements, it needs to be viewed in wider perspectives. For example, it is not possible to measure value outcomes for a delimited episode (such as a single hospitalization) and considering the wide variety of perceptions of value, an attempt to quantify value must include several perspectives (including symptoms, social functioning, and burden on relatives).

Paper 1 draws the four following conclusions: 1) value cannot be determined solely from one perspective, 2) the nature of the medical condition of psychosis means that patients themselves are not always capable of presenting value judgements, 3) value needs to be measured in a broader perspective than today's system enables, and 4) the cost side of the value equation need to be recognized more in order to be true to the conceptualization of value as proposed in VBHC.

4.2 Paper 2: A Value-Based Taxonomy of Improvement Approaches in Healthcare

Recognizing the two contemporary phenomena of 1) value as a concept in fashion in healthcare, and 2) multiple IAs often existing simultaneously in healthcare settings, Paper 2 aims to construct a taxonomy supporting the management of parallel IAs in healthcare.

First, three contemporary improvement approaches currently applied in the studied context (VBHC, Lean, and PCC) are analyzed in terms of organizational focus and content. A taxonomy is then presented, combining *view on value*, in terms of a process- or outcomes-view, with *organizational focus*, in terms of what logic is adopted – that of managers or healthcare professionals.

A case study is presented to illustrate the applicability of the taxonomy. Interviews with experts, managers, and healthcare professionals are analyzed in terms of view on value as processes or outcomes, showing that both groups accepted the view on value as outcomes, whereas managers and individuals with developmental tasks additionally tend to embrace a view on value as processes. The dimension of organizational focus (and associated different logics) is also recognized in key informant interviews. Positions of the improvement approaches in the taxonomy can be discussed, but the usefulness of the taxonomy as a framework for constructing a coherent management model (Birkinshaw and Goddard, 2009) is confirmed in the illustrative case. The conceptual contribution of the paper is the delineation of two important dimensions of IAs and the suggestion that use of the taxonomy can further theoretical understanding of IAs in general.

Paper 2 concludes that a taxonomy recognizing different views on value can be valuable for managers, both to provide theoretical understanding of contemporary improvement

approaches and to guide adoption and adaptation of new IAs into a local context. A taxonomy may help facilitating a dialogue with professionals in order to increase motivation for change and ultimately to improve operations.

4.3 Paper 3: Value-Based Healthcare Translated: A Complementary View of Implementation

The third paper appended in this thesis focuses on the process of implementation of management innovations (MI). The decision to focus on MIs rather than IAs was made to better align with frameworks of implementation, which are central to this paper. The MI concept overlaps substantially with IAs, but only includes approaches that aim to change matters of management and organization, which have been identified as especially complicated to implement. On the other hand, unlike IAs, MIs also include innovations aimed at other managerial activities than those seeking to improve value outcomes. The theoretical background is constituted by the *Consolidated Framework of Implementation Research* (CFIR) (Damschroder et al., 2009) on one hand, and a perspective viewing innovations as being *translated* to a context (referred to in Paper 3 as *translation theory*) (Czarniawska and Sevón, 1996; Latour, 1986; Røvik, 2008) on the other hand. The aim of Paper 3 is to investigate how the perspective of translation theory can inform and develop CFIR, with the goal to advance understanding of the processes of putting a management innovation into practice.

To do this, the longitudinal case of this thesis (that is, the implementation of VBHC to the Department of Psychotic Disorders at the Sahlgrenska University Hospital) is used as empirical base. The case is presented with special focus on two themes identified in the analysis, based on the CFIR domains: *Intervention Characteristics* and *Process*. These two themes are then analyzed again, applying the view of translation theory. Next, the differences that emerge when adopting different theoretical lenses are discussed and three ways in which CFIR can be informed and developed by translation theory are presented. First, the logic of implementing a specific MI is not always connected to strength of scientific evidence, but rather arguments relating to common sense and adhering to what is contemporarily discussed in positive terms in business press. Second, the CFIR construct *adaptability* is stressed and elaborated within translation theory under labels like *interpretative flexibility* (Benders and van Veen, 2001) and can be even more emphasized when CFIR is applied to MIs. Third, CFIR adopts a rather

instrumental view of the implementation process, implying advance planning and subsequent execution of implementation activities. For MIs, a more fruitful approach can be to adopt the translation theory view that the innovation is *contextualized* in repeated translations (Røvik, 2008).

Paper 3 concludes that if these suggestions for development of CFIR are considered, better guidance for implementations of MIs is provided. Hence, managers are encouraged to actively translate MIs to fit their organizations, rather than trying to be true to original concepts.

4.4 Summary

Table 4.1 provides a summary of the purposes, empirical foundations, and conclusions drawn in the papers included in this thesis. Section 5 discusses the papers in combination to elaborate on what lessons can be learned when the pieces are put together.

Table 4.1 – Summary of appended papers

Paper	Dataset	Purpose	Conclusions
<i>The complexity of using value as driver for improvement in psychosis care</i>	Expert interviews (4, open-ended) Patient questionnaires (36, open-ended) Semi-structured interviews (16, staff and managers)	“Illuminate the complexity of the value concept in the context of psychosis care; discussing both the potential and the limitations in the use of the concept as a driver for improvements in the care operations.”	Value cannot be determined solely from one perspective. The nature of the medical condition of psychosis entails that patients themselves are not always capable of presenting value judgments. Value needs to be measured in a broader perspective than today’s system enables. The cost side of the value equation in VBHC needs to be recognized more.
<i>A value-based taxonomy of improvement approaches in healthcare</i>	Expert interviews (3, open-ended) Semi-structured interviews (17, staff & managers) (NB: one expert interview now treated as semi-structured) Key informant interviews	“To construct a taxonomy supporting the management of parallel improvement approaches in healthcare.”	A taxonomy is presented based on the dimensions of “organizational focus” and “view on value”. Value can be viewed as processes and/or outcomes. Professionals tend to focus more solely on outcomes than managers and developers. A taxonomy can facilitate dialogue around IAs, between managers and professionals. A taxonomy can support managers theoretical understanding of IAs and guide combination of IAs into a coherent management model.
<i>Value-based healthcare translated: A complementary view of implementation</i>	Field notes, group interviews, and documentation from the longitudinal action research project	“To investigate how a translation theory perspective can inform CFIR, in order to increase understanding of the complex process of putting MIs into practice.”	Strength of evidence is not as applicable for VBHC, as for medical and technical innovations. The adaptability of VBHC can be more emphasized and inspired by the concept of interpretative flexibility and pragmatic ambiguity. The implementation of VBHC can better be seen as a process of contextualization (that is, iterative and emerging translations) than a pre-planned process and subsequent execution.

5. Discussion

The appended papers demonstrate three central aspects of putting IAs to practice that align with the perspectives described by Pettigrew (1987) for studies of strategic change: content, context, and process (as shown in Figure 5.1). The first paper focuses on the concept of value as a core element in the *content* of VBHC, displaying the ambiguity of the concept that can increase complexity. The second paper concerns the healthcare *context* – in which multiple IAs and logics are present when VBHC is implemented – and suggests that different IAs can be combined into a coherent management model at local level. The third paper addresses the *process* of how VBHC is put into practice, promoting the view that IAs are translated (rather than instrumentally implemented) into context and that ambiguity must not only increase complexity, but can facilitate the translation (Giroux, 2006). Marshall et al. (2017, p. 581) analogously stated that *“the literature describes how what people do (intervention), how they do it (implementation) and the wider environment (context) are interdependent and some people are suggesting that the traditional differentiation between this classic triad is no longer helpful.”* Hence, the following discussion aim to integrate these three aspects.

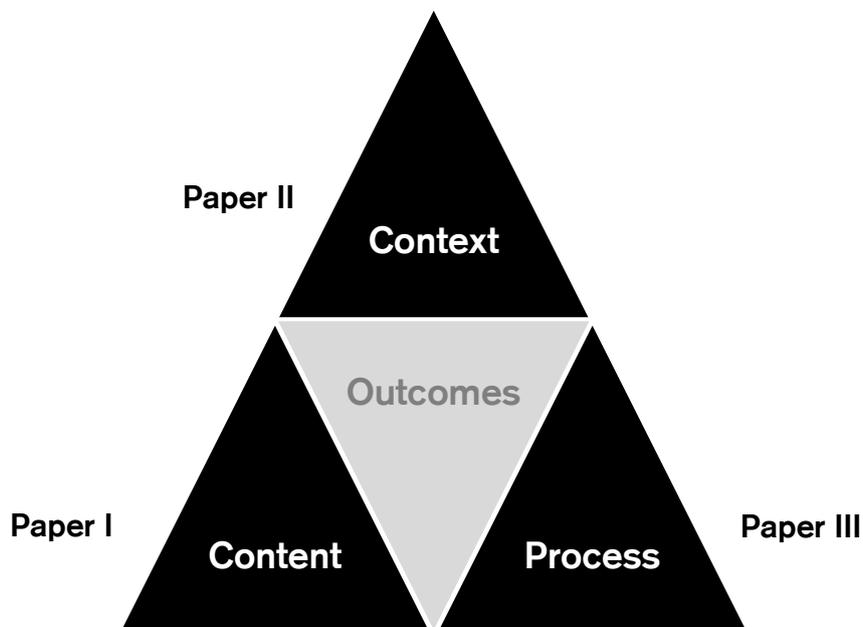


Figure 5.1 – Papers in relation to the framework for analysis and discussion.

Overall, this thesis is concerned with the issue of how to improve the value outcomes of healthcare organizations by use of IAs, when applications of IAs in many cases have failed to deliver the promised results (Fältholm and Jansson, 2008; Ham, 2003; Hellman et al., 2015; Plesner et al., 2013; van der Wiele et al., 2006). Put together, the studies describe a process in which there is a local management model (Birkinshaw and Goddard, 2009) in place, built up by elements from different IAs (and other management theories, which are outside the scope of this thesis). To this management model, a new IA is introduced for reasons such as external pressure (e.g., Elg et al., 2011) or internal demand for improvements (e.g., Madsen, 2015). When the IA is brought into the organization it goes through a series of translations (Czarniawska and Sevón, 1996; Latour, 1986) – that is, a contextualization (Røvik, 2008) – in which its content is adapted due to contextual factors (for example, internal and external demands, technical and organizational constraints, and preferences of involved individuals). The result is an updated local management model that is expanded or modified with elements from the new IA (and possibly from other sources, if additional elements were incorporated during the contextualization). If successful, the updated management model is now better suited than before to help the organization achieve its operational goals (expressed in terms of, for example, improved value outcomes, increased efficiency, or higher quality). Looking at the narrower perspective of a delimited part of an organization, for which one manager or management team is responsible, an IA (perhaps already modified from its original description) is introduced and a single translation process is conducted of the IA into the local management model. A model of the translation process is presented in Figure 5.2, showing the contextual pressure that “funnels down” (that is, narrows and transforms) the content of the IA, as described by Røvik (2008), affecting the content of the management model.

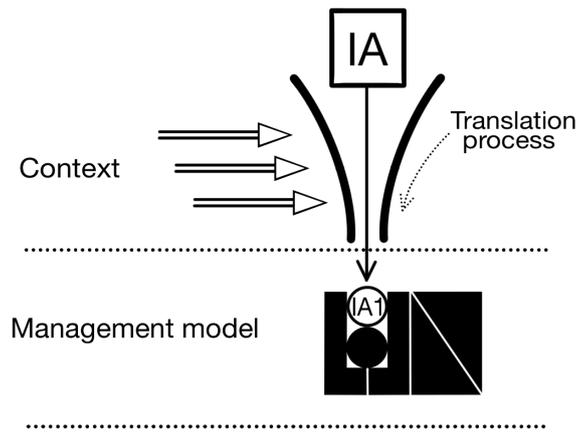


Figure 5.2 – Model of how an IA is “funneled down” in the process of translation, to fit into the existing local management model. The (inner and outer) context exerts a pressure that affects the content (shown as the altered shape) of the IA during the translation process.

Moreover, as both the inner and outer contexts (Pettigrew, 1987) change over time, the management model must also develop over time. Hence, there is a rationale for new IAs to be introduced periodically and thus for the phenomenon of management fashions (Abrahamson, 1996; Clark, 2004). To further improve operations and outcomes, or even just to keep up with the times changing, organizations must strive for continuous improvements; one way of doing this can be to translate new IAs into the management model, as illustrated in Figure 5.3, showing a Model of Improvement Approaches Translation and Transformation (MIATT).

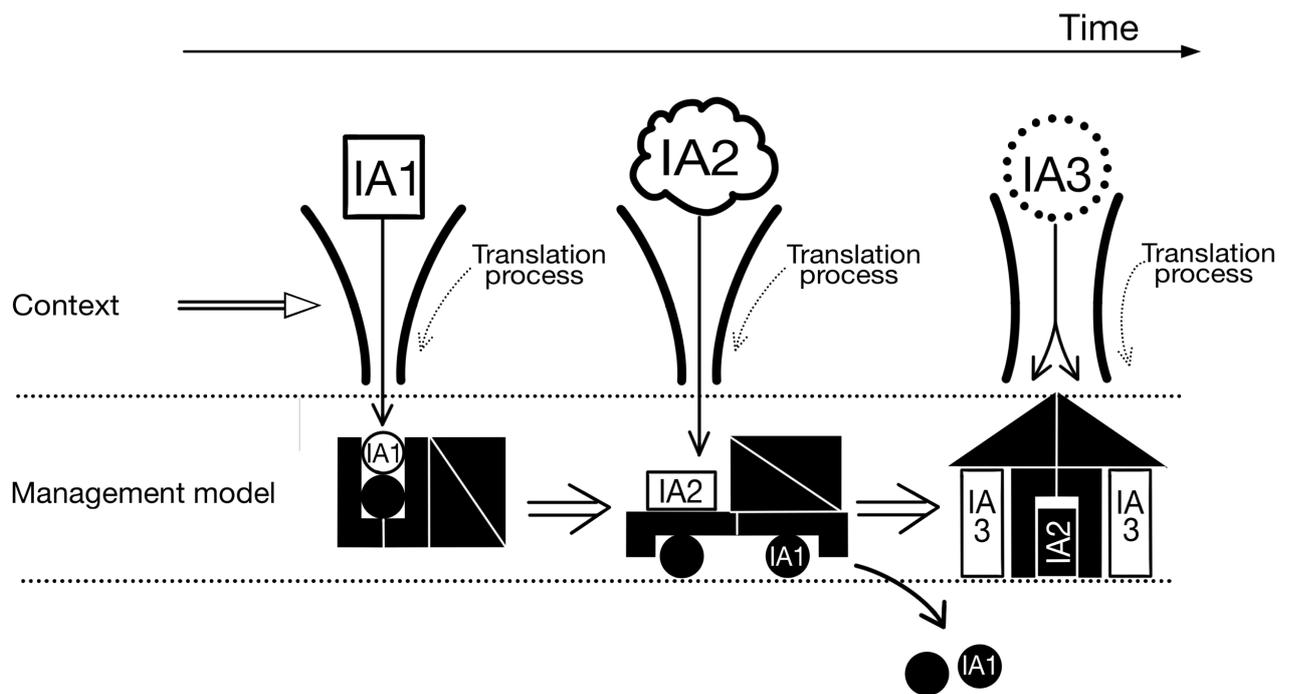


Figure 5.3 – Model of Improvement Approaches Translation and Transformation (MIATT). The illustrative model show how different IAs are translated and transformed at different points in time, to fill niches in the local management model, which is continuously developed by adding, removing, and rearranging elements, to fit the changing needs of the organization. New IAs (white), presented with a clearer or fuzzier content, are reshaped (that is, the content is transformed and/or clarified) in a context-dependent translation process and inserted into the management model. Over time, they fuse into fully integrated parts (black) of the management model. But as the management model continues to evolve, IAs and other elements can be removed in favor of new IAs.

By embracing the content, context, process, and also a perspective of development over time to stay fit to achieve high value outcomes, MIATT corresponds to all of the research questions of this thesis. Next, the MIATT is discussed in relation to each research question.

RQ1: How can translation theory provide guidance for use of IAs in local contexts?

As proposed in Paper 3, in some aspects translation theory (e.g., Czarniawska and Sevón, 1996; Røvik, 2008, 2011) provides a theoretical lens that is more helpful than more traditional views on implementation (as condensed in CFIR (Damschroder et al., 2009)) in terms of understanding and guiding the process of introducing IAs to local contexts. Based on the MIATT (see Figure 5.3) it can also be argued that managers must continuously develop their management model (Birkinshaw and Goddard, 2009) to

include new techniques, priorities, or even just vocabulary, in order to meet the ever-changing challenges that any organization encounters. Hence, managers can view existing and emerging IAs as a smorgasbord from which they can pick and choose IAs that they believe can bring improvements or just profile their organizations as modern even though only small changes are intended (Benders and Verlaar, 2003). On the other hand, making such seemingly rational choices *“is most applicable to explaining adoption in conditions of low uncertainty, which are comparatively rare in management”* (Sturdy, 2004, p. 158). Hence, improving the management model by rational additions of IAs – seen as complete and fixed solutions – is not a viable view. Instead, Røvik (2008) argued that *translator competence* is needed in order to succeed in implementing new concepts, stating that *“it seems like one is often not conscious enough that ideas as a rule have to be translated to concrete local versions to be useful at all”* (p. 277, translated from Swedish). Hence, the present thesis supports the view that it is fruitful to see IAs as moldable sets of practices and tools, whose ambiguity (Giroux, 2006) even serves as an asset when translating them into a unique and tailored management model, consisting of (elements from) different IAs (as described in Paper 2). If this view is adopted, managers can see themselves as having more freedom of action and seize the power they actually have in this process. This is particularly important as managers are often obligated by higher authorities to adopt certain AIs (Elg et al., 2011), which was also an experience from practice before the onset of the research project.

RQ2: In what ways can the ambiguity in the value concept hinder or support translation of IAs?

The appended papers display differing views on ambiguity. The first paper illustrates the complexities that arise with ambiguity of a concept, whereas the third paper emphasizes the usefulness of ambiguity and promotes the notion of pragmatic ambiguity (Giroux, 2006). Seen by the more traditional lens of CFIR, *complexity* includes a number of IA characteristics and ambiguity can be seen to increase the complexity by raising the *“number of choices presented at decision points”* (Damschroder et al., 2009, p. 7), since different possible interpretations of a concept can be made and can lead to even more possible different choices. Thus, the ambiguity can hinder the implementation of IAs. However, as implied in the research question, if IAs are seen to be translated rather than implemented, ambiguity can be handled pragmatically to allow for more courses of action and avoid potentially paralyzing conflicts in understandings and priorities

(Giroux, 2006). Also, Benders and van Veen (2001, p. 49) stressed that the efficacy of an IA is dependent on *“the way the concept is interpreted and enacted in the setting ... and thus cannot without further ado be attributed to the concept itself”*, and uses the term *interpretative viability* (Ortmann, 1995) for the conceptual ambiguity that allows room for interpretation. Consequently, ambiguity can be seen both to hinder and support translation of IAs, but the present thesis supports the view of Giroux (2006), implying that ambiguity is more of an asset than a hindrance.

RQ3: How can coexisting IAs be handled in the translation process?

As suggested in Paper 2, different IAs can be seen to fill different niches in a management model based on different characteristics of the IA. The MIATT further suggests that IAs are not to be seen as fixed entities, and that elements from multiple IAs can be combined to coexist. This phenomenon is also recognized by Røvik (2008, p. 184), who stated that *“The typical ideal modern organization ... is often a multi-standard organization, that is it is designed under the influence of [several contemporary streams of ideas]”* and further argued that *“The typical multi-standard organization is often a large modern business that routinely pick up, incorporate, and manage to live with many different popular organizational ideas, which have often been adopted in rather disparate ways from different parts of their contexts. And what is even more important: without this being perceived as a particularly problematic either by those on the inside or the outside of the organization.”* (ibid. p. 188. Translated from Swedish).

Hence, if multi-standard organizations are seen as the norm, management of coexisting IAs is the normal situation, even though IAs may be presented as distinct and comprehensive solutions (e.g. Porter and Lee, 2013; Spear, 2005). This assumption is supported by the present thesis, and is also illustrated in Paper 2, where an interviewed manager stated that:

“PCC provides a sympathetic view on ‘What’s my role in the care of this person?’ ... One needs to work with the improvement instruments that Lean provides, and one needs to be able to do a clear follow-up, which is where I think VBHC enters.”

Also, Paper 1 found that although participants in the study knew very little about the details of the VBHC concept, they were generally enthusiastic about it. Hence, when

managers shape and use their management models they may handle different IAs strategically to gain acceptance and enthusiasm among different stakeholder groups based on their preunderstandings and experiences from the organization. That is, elements from different IAs can be targeted for different groups of employees or subordinate managers, and labels of IAs (such as VBHC, Person-Centered Care, and Lean) – as opposed to adopted elements (such as practices and tools) – can be kept (as was the case in Paper 3) or removed (as elaborated on by, for example, Heusinkveld and Benders (2012)). However, Røvik (2008) also claimed that even though multi-standard organizations are ubiquitous, all ideas (such as IAs) do not necessarily fit well together. Hence, the fit with both organizational context and coexisting IAs must be considered in translations of new IAs.

In sum, this thesis provide support for the view that inherently ambiguous IAs are better seen as translated than instrumentally implemented (Røvik, 2008). Further, it can also be argued that the recognition of coexistence of IAs – which is an obvious fact for many practitioners – has not been given adequate attention in the field of healthcare improvement. Hence, this thesis contributes by combining healthcare improvement and translation with the notion of management models (Birkinshaw and Goddard, 2009), providing a model that allows for a dynamic view of how IAs can be handled in healthcare management.

Obviously, healthcare management cannot be reduced to one schematic model. For example, IAs are only one type of ideas that influence healthcare management and not all improvement activities use input from a pre-defined IA. Also, the empirical material presented in this thesis is too small to make any definite claims. Hence, the MIATT need to be tested for other IAs and in other contexts, preferably over extended periods in time to study developments in management models. Types of ideas other than IAs (even when broadly defined) should also be studied to further develop the MIATT into a more comprehensive framework for management models in healthcare, and the processes involved in developing such.

6. Conclusions

This thesis sought to provide support for an active translation process of improvement approaches to local healthcare settings. The appended papers indicate that Pettigrew's (1987) three analytical categories for strategic change – content, context, and process – are also relevant for investigation into translations of IAs. Based on the three papers, a model was proposed for how IAs are funneled down through a context-dependent process of translation to complete or modify the content of the local management model (Birkinshaw and Goddard, 2009). Recognizing this more dynamic view on the application of IAs to local settings implies that managers seeking to improve operations and value outcomes could benefit from actively analyzing their inner and outer contexts and constructing their local management models to fill the niches deemed necessary for accomplishing the goals of the time being. Also, seen in a larger perspective, iterative translations of IAs at different hierarchical levels in an organization give rise to the phenomenon of contextualization (Røvik, 2008), which further amplifies the transformation of IAs.

In sum, considering all three research questions, both practitioners and scholars can benefit from viewing IAs not as fixed entities that can be implemented or studied separately, but as moldable elements that are dependent on the context. Proposedly, the chances of achieving improved value outcomes from adoption of IAs depend on the context and the fit with other, coexisting, approaches. Hence, managers need to understand and actively consider their contexts, preexisting perceptions of IAs among staff and other stakeholders, and established IAs. Scholars, in turn, need to carefully consider the contexts and preceding IAs when conducting research focused on evaluation of new IAs, as other scholars have argued (e.g. Lega et al., 2013). The MIATT (see Figure 5.3) can be used to design future research projects and help identify important factors in translations of IAs that need to be considered to interpret and understand events and outcomes. Combining the notion of iterative translations in a contextualization process with the notion of management models in multi-standard organizations is a contribution that may help both managers and scholars to grasp the complexity of healthcare management.

7. Future research

Taking the suggestions made in this thesis one step further, this final section presents four potentially fruitful paths for future research.

First, one interpretation of the indicated implications of this thesis is that translating and transforming IAs is something exclusively positive, since the resulting management model may be tailored into just that what is needed for each organization at the time. However, this notion might not be the only side of the matter. If an IA is transformed to ignorance (but still carrying its original label) – what problems does that entail? Will different stakeholders expect certain elements to exist? And what effects will it have when they discover that that is not the case? Further, is it worth the trouble of implementing a predefined IA if a (almost) new concept is created along the path of translation? These issues could be studied, for example, in a qualitative multiple case study of different organizations implementing the same IA but with different views on the implementation process.

Second, the longitudinal case that constituted the empirical base for this thesis continues, and elements of VBHC can now be seen to have been incorporated in the management model of the Department of Psychotic Disorders. A spin-off project from the implementation of VBHC attempts to introduce the principles of *value logics*, as described by Stabell and Fjeldstad (1998) and Christensen et al. (2009), in combination with elements from *standardized care plans* (e.g. Olsson et al., 2009) into the management model, with the aim that elaborating the logic of how value is created can be used to delineate and improve operational processes to further increase value outcomes. This attempt would be suitable for a continuation of this thesis and would preferably be designed as a mixed-methods study with quantitative data on efficiency or productivity, combined with qualitative data on the translation of value logics and standardized care plans and the reception of the modified management model. Such a study could show what a practical application of value logics can look like and to examine if it seems to have an effect on outcomes. A result that contributes conceptually to the theories of value logics could be a development of one or several of the formerly proposed logics. For practitioners, this could provide more hands-on guidance for ways

to disentangle operations adhering to different value logics, as proposed by several authors (e.g. Bohmer, 2009; Christensen et al., 2009).

Third, the concept of management models in relation to healthcare could be investigated further. Since healthcare organizations have been argued to be particularly complex to manage (Mintzberg, 2002), it would be interesting to elaborate on more dimensions to management models than what was originally described by Birkinshaw and Goddard (2009) (see Section 2.2). For example, is it possible to simultaneously use different principles for motivating different groups of employees in an organization, and in that case *how*? And, relating to the idea above, how can processes adhering to different value logics be coordinated in coexistence? Is coordination of different logics an additional logic of special importance in healthcare settings? A study approaching these issues could be designed as a multiple case study, either inductively identifying aspects that managers find important in building up their management models, or deductively investigating the relevance of a theoretically derived model.

Fourth, one possible path would be towards a more explicit action research project, where the point of departure could be the aim to increase the value outcomes of my own organization. The specific actions to be taken and theories to be used would then have to emerge during the course of the project, in direct joint cooperation with other individuals (organization members and potentially patients or other stakeholders). Areas of interest could include how data on patient interventions and outcomes could be presented in order to be of practical use for professionals and for patients themselves, or how work satisfaction among employees and managers could be improved. Also, the present thesis has only been concerned with how to make use of externally developed IAs that are brought into an organization. This approach could potentially include innovation of new, local IAs (that may spread to other contexts).

8. References

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