Dissemination of Innovation:
The Will to Change an Organization

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"Absolutely amazing stuff. Social network maps like this provide a whole new view of the organization. How long will it take you to do this?" asked the Associate Medical Director.

"Excuse me?" I asked.

"Let's do it. What'll you need?"

I was confused. "You mean, collect this kind of data here to get a sense of what's going on? Or everything, the whole process, of collecting formative data, assessing priorities among caregivers, getting feedback on prototype interventions and revising them, and then intervening and following up? Or just a proposal?"

"Not a proposal. We need to move the needle. This could save us millions."

That's when it hit me. I work in an organization where there is a will to change: improvement, innovation, Plan Do Study Act, with emphasis on the *act*. The question, then, is whether it is a learning organization—a sign of greatness—or just an innovative organization—a sign of being good at core objectives. Collectively, do we listen? Do we communicate across departments, facilities, and regions to transfer successful practices? Do we document experiences to pass on the knowledge gained for those who follow us? These simple questions reflect the pathways and qualities and persistence of innovation dis-semination of mutual understanding and two-way communication, not just a one-way transmission of information. Dissemination occurs when the state of the art—what practitioners do—affects the state of the science—what researchers do, and vice versa. Organizational dissemination is fundamentally a learning process.

Getting From Good to Great

Innovative organizations can excel in their core mission. Large, complex organizations with solid consistent performance often have the resources to be innovative. But they often fail to capture what they already know, share it internally, support implementation, and thus capitalize by learning from within.[1] It takes a learning organization to be great.

Too often, dissemination is a one-way transmission: create a Web site, award a local success, give a talk. These are passive approaches that rely on the assumption that *evidence of effect* is sufficient to propel innovations into broad use across organizations and among organizations. This faulty assumption is one of several common missteps in attempts to spread successful practices (see Sidebar: Top Ten Dissemination Mistakes in Organizational Change). Worthy innovations can take decades to spread whereas ineffective innovations diffuse rapidly and sustain.[2] The knowledge that is most critical for reproducing effective results can be the most difficult to communicate.[3] Technology is rarely an answer in and of itself to the challenges of organizational learning.[4] Lastly, organizations can be remarkably adept at not learning from past mistakes.[5]

Innovation, and even more so, dissemination, is naturally political. Innovation is political because an innovation supplants or supplements existing expectations and behaviors, and because personal and organizational identities are associated, sometimes strongly so, with innovations.[6] The implementing team must trust the team that is the source of the innovation.[7] How will our adoption of an innovation from afar reflect on us? Will we be seen as mere imitators? Is the source of the intervention someone or some unit we want to be seen as copying? Wouldn't it reflect better on our unit if we created an intervention ourselves? Can ideas from afar really work in our clinic, with our staff, our physicians, and our patients?

The Innovative Organization

Having an innovation or practice that is worthy of replication and spread is the critical initial criterion for dissemination. Discovery,

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originality of thought, creativity, and breakthrough insights do not just happen. Organizational conditions must be supportive of inventive activity. The psychologic conditions that lead to creative work, hard work paired with enthusiasm,[8] are made possible by social conditions inside organizations that can affect the likelihood and quality of innovative work.[9] Find a physician or nurse who is self-indulged in work[10] and you have the basis for inventive activity.

Innovation needn't always be thought of as a prelude to dissemination. Some innovations can be effective and efficient, yet are poor candidates for dissemination; suited to a few sites but not for most or even many. Successfully transferring an effective practice to just one site can be formidable enough.[11] Moreover, the objectives of inventive activity may not extend beyond an initial site or a couple sites.

American universities bear certain similarities to integrated health care systems. Each employs highly skilled experts who have high degrees of autonomy in determining what they will do. Each type of organization is complex, with many units grouped by specialty. Hierarchy in both types of organization is rather flat with units only loosely coupled.[12] Both physicians and faculty can be more normatively tied to their specialization and its professional societies than they are to their employer. But because universities rarely call on the knowledge of their faculty to improve organizational quality, service, or efficiency, the individual innovativeness of their faculties does not cumulate into their organizations likewise being innovative.

Medical organizations, including multispecialty group practices, are similar to universities in structure, though not in function or culture. An HMO may look like a university on paper, but successful HMOs are more highly attuned and responsive to their market both in terms of consumers and competitors than are successful universities. For example, Kaiser Permanente is a very progressive organization, which is neither good nor bad; it is an accu-

Top Ten Dissemination Mistakes in Organizational Change

1. Assume that evidence matters in the decision making of potential adopters.

Interventions of unknown effectiveness and of known ineffectiveness often spread while effective interventions do not. Evidence is most important to only a subset of early adopters and is most often used by them to reject interventions. *Solution*: Emphasize other variables in the communication of innovations such as compatibility, cost, and simplicity.

2. Substitute our perceptions for those of potential adopters.

Inadequate and poorly performed formative evaluation is common as experts in the intervention topical domain engage in dissemination. *Solution*: Seek out and listen to representative potential adopters to learn wants, information sources, advice-seeking behaviors, and reactions to prototype interventions.

3. Use intervention creators as intervention communicators.

Although the creators of interventions are sometimes effective communicators, the opposite condition is much more common. *Solution*: Enable access to the experts, but rely on others who will elicit attention and information seeking by potential adopters.

4. Introduce interventions before they are ready.

Interventions are often shown as they are created and tested. Viewers often perceive uncertainty and complexity as a result. *Solution*: Publicize interventions only after clear results with messages that elicit positive reactions from potential adopters.

5. Assume that information will influence decision making.

Information is necessary and can be sufficient for adoption decisions about inconsequential innovations, but for consequential interventions that imply changes in organizational routines or individual behaviors, influence is typically required. *Solution*: Pair information resources with social influence in an overall dissemination strategy.

6. Confuse authority with influence.

People in positions of authority may be regarded as influential, but often this is not the case. *Solution*: Gather data about who among potential adopters is sought out for advice; intervene with them to propel dissemination.

7. Allow the first to adopt (innovators) to self-select into dissemination efforts.

The first to adopt often do so for counter-normative reasons and their low social status can become associated with an intervention. *Solution*: Learn the relational structure that ties together potential adopters so that influential members can be identified and recruited.

8. Fail to distinguish among change agents, authority figures, opinion leaders, and innovation champions.

It is unusual for the same persons to effectively play multiple roles in dissemination into and within communities and complex organizations. *Solution*: Use formative evaluation to determine the functions that different persons are able to fulfill.

9. Select demonstration sites on criteria of motivation and capacity.

Criteria of interest and ability make sense when effective implementation is the only objective. But spread relies on the perceptions by others of initial adopters. *Solution*: Consider which sites will positively influence other sites when selecting demonstration sites.

10. Advocate single interventions as the solution to a problem.

Potential adopters differ by clientele, setting, resources, etc, so one intervention is unlikely to fit all. *Solution*: Communicate a cluster of evidence-based practices so that potential adopters can get closer to a best fit of intervention to organization prior to adaptation.

rate description of a will within the organization to try new things.

Can an organization suffer from being progressive? Can the will to try new things, to celebrate new care models and new information systems and new commitments to customers and compliance and error reduction and responsiveness and coding protocols negatively affect an organization? Although many changes are desirable, not all will outperform existing organizational ways for getting work done.

An organization good at innovation needn't share what works and why, but becoming great at organizational learning means precisely this.

On Becoming a Learning Organization

What would it take to prompt the internist or surgeon to look first within the organization for ways to improve? How can learning by sharing come to characterize who we are?

A disseminative organization must decrease the varied individual costs associated with implementation of a new practice or intervention, including research, evaluation, customization, and monitoring.[13] Caregivers are already overburdened.[14] The tacit ways that effective practices have been applied with success at an initial practice site must be made explicit.[15] Each practice site is, in fact, unique and thus has the potential for creative adaptation and improvement over the initial demonstrated outcomes.[16] The creation of generalizable dissemination tools and guides must be readily available so that the adopters and implementers see their value and can easily apply them (an example can be seen at: www.research-practice.org[17]). When done well, resistance is decreased.[18] Learning by sharing is the means; uniformity and improved efficiency is the potential result.

Conclusion

The perspective to organizational change outlined here requires a high degree of certainty that an effective practice, based on demonstrated or potential *robustness,* will work in diverse settings. This perspective requires support for local units from leadership, local and national. Local implementers need to know the causal components responsible for desirable observed outcomes.[19] They must see how similar groups or units have successfully adapted the practice.[20] This approach requires trust that a set of new, proven practices warrants consideration; trust that clinicians are capable and well positioned to improve quality, service, and affordability. This balance of support and trust between central administration and local offices and clinics is the sweet spot of organizational change. It's where change isn't just for the sake of change, but rather for the improvement of the organization and the lives of our patients. ❖

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