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Voice is not enough: A multilevel model of how frontline voice can reach implementation

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Issue: When frontline employees' voice is not heard and their ideas are not implemented, patient care is negatively impacted, and frontline employees are more likely to experience burnout and less likely to engage in subsequent change efforts.

Critical Theoretical Analysis: Theory about what happens to voiced ideas during the critical stage after employees voice and before performance outcomes are measured is nascent. We draw on research from organizational behavior, human resource management, and health care management to develop a multilevel model encompassing practices and processes at the individual, team, managerial, and organizational levels that, together, provide a nuanced picture of how voiced ideas reach implementation.

Insight/Advance: We offer a multilevel understanding of the practices and processes through which voice leads to implementation; illuminate the importance of thinking temporally about voice to better understand the complex dynamics required for voiced ideas to reach implementation; and highlight factors that help ideas reach implementation, including voicers' personal and interpersonal tactics with colleagues and managers, as well as senior leaders modeling and explaining norms and making voice-related processes and practices transparent.

Practice Implications: Our model provides evidence-based strategies for bolstering rejected or ignored ideas, including how voicers (re)articulate ideas, whom they enlist to advance ideas, how they engage peers and managers to improve conditions for intentional experimentation, and how they take advantage of listening structures and other formal mechanisms for voice. Our model also highlights how senior leaders can make change processes and priorities explicit and transparent.

Key words: Coalitions, employee voice, implementation, listening, voice cultivation

Frontline employee voice is increasingly seen as vital in health care environments, and this attention often misses the primary purpose of voice: improving organizational functioning. If voice is raised but lost before it reaches implementation, then the value of voice is greatly diminished, reducing the likelihood of much needed improvements in care delivery. Research on frontline employee voice in health care has found that employees raise issues that are deemed critically important by employees and their managers and that might otherwise go unnoticed (Jung et al., 2023; Tucker et al., 2008). When specific instances of voice are received as intended and otherwise supported toward implementation, as with "good catch logs" that capture close calls with medical harm, patient safety improves (Edmondson, 2018; see Singer & Vogus, 2013, for more general benefits of voicing on safety in health care). In contrast, when otherwise promising ideas are rejected, misunderstood, or ignored, errors and harm can result (Cosby & Croskerry, 2004). However, initiatives encouraging health care employees to voice their concerns and suggestions have seen limited success (e.g., Jones et al., 2021). Frontline employees may be voicing their concerns and ideas for safety and process improvement, but if they are not heard, patient care is negatively impacted and frontline employees are more likely to experience burnout and less likely to engage in change efforts (Kerrissey et al., 2022). Being heard is especially difficult in health care organizations because of complex organizational structures, occupational hierarchy, power dynamics, and communication barriers (e.g., Lichtenstein et al., 2004; Morrow et al., 2016). It is therefore essential to develop theory and inform practice regarding how to support employee voice to reach implementation for the benefit of patients, staff, and organizations.

Employee voice is defined as "ideas, opinions, suggestions, or alternative approaches directed to a specific target inside or outside the organization with the intent to change an objectionable state of affairs and to improve the current functioning of the organization, group, or individual" (Bashshur & Oc, 2015, p. 1531). Research in organizational behavior

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and health care management has identified individual, group, managerial, and organizational antecedents that encourage frontline employees to voice (e.g., Detert & Burris, 2007; Nembhard et al., 2015). This work has also examined how voice is framed, whom it targets, how receivers perceived it, and when employees are rewarded or punished for voicing (e.g., Burris, 2012; Liang et al., 2012). There has also been a great deal of work tying the impact of employee voice to individual, group, and organizational outcomes (see Bashshur & Oc, 2015, for a review). However, theory about what happens to voiced ideas during the critical stage after employees voice and before outcomes are measured is nascent (Morrison, 2023). Two recent articles have explored this area. Satterstrom et al. (2021) followed ideas from frontline employees and patients from the moment an idea was voiced to when it was implemented, allowing them to identify a set of team-level practices and processes through which ideas reached implementation despite initial rejection. Bain et al. (2021) examined how coworkers could amplify a voiced idea to enhance the idea's status, as well as the status of the voicer and the coworker. Together, these articles suggest that a collective and dynamic process is involved in helping ideas reach implementation.

Building on this work on voice, we draw on research, primarily conducted in health care contexts, from the fields of organizational behavior, human resource management, and health care management to map what is currently known about how voiced ideas can be supported to reach implementation. In doing so, we develop a multilevel model encompassing practices and processes at the individual, team, managerial, and organizational levels that together provide a more comprehensive picture of how voiced ideas reach implementation (see Figure 1). Our model makes three contributions. First, we illuminate the importance of thinking temporally about voice to better understand the complex dynamics required for voiced ideas to reach implementation. Doing so shows how voicing is not enough for addressing problems and creating improvements in organizations. Second, we offer a multilevel understanding of the practices and processes through which voice leads (or fails to lead) to implementation. Third, our resulting model highlights processual and structural dynamics: how voicers are limited in their ability to implement change without colleagues and managers, as well as the critical role of senior leaders in providing a roadmap for voiced ideas by transparently communicating organizational culture and priorities.

Theoretical Analysis

Voice: Its Antecedents and Benefits

Antecedents that encourage voice. Researchers have invested a great deal in understanding voice antecedents at the individual, group, and organizational levels (Morrison, 2023; Nembhard et al., 2015). This work has been especially important for health care organizations where failing to speak up has been found to inhibit needed innovation (Nembhard et al., 2009) and safety (Vogus et al., 2010).

At the level of the individual voicer, researchers have found that traits (e.g., conscientiousness), perceptions (e.g., self-perceived status), work role characteristics (e.g., tenure), and an individual's relationship with their organization (e.g., organizational identification, organizational obligation, organizational support) all affect the likelihood of voicing (see Morrison, 2023, for a recent review). Perceptions of psychological safety by individual members of an organization or team—an individual's understanding of the consequences for taking interpersonal risk—affect an employee's willingness to voice (Detert & Burris, 2007). In particular, work by Liang et al. (2012) found that feeling psychologically safe was related to employees engaging in riskier prohibitive voice (i.e., expressions of concern about actions that may harm

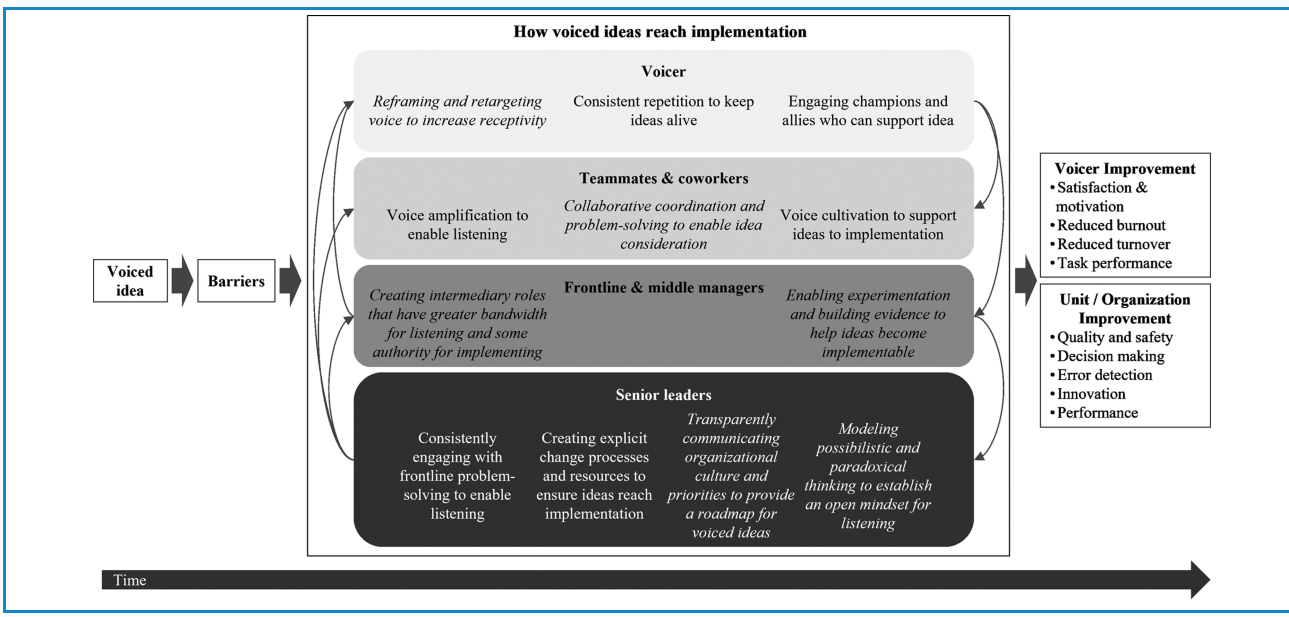

Figure 1. Multilevel processes for sustaining employee voice to reach implementation over time. Italicized items in the figure draw upon research that is relevant but has not directly examined ways to support voice. Standard font items have directly examined ways to support voice.

their organization), compared to promotive voice (i.e., expressions of new ideas that may improve their organization). However, many studies of health care organizations find that efforts to voice are not enough and that health care workers often report being ignored or disrespected after voicing, leading them to abandon otherwise constructive ideas or choose silence (e.g., Lainidi et al., 2023; Morrow et al., 2016).

At the team level, psychological safety has been found to underpin voice (Edmondson, 1999). That is, when team members feel they can propose ideas and solutions in a nonjudgmental climate, voice follows. Manager actions enabling psychological safety include exhibiting openness (Detert & Burris, 2007), approachability (Milliken et al., 2003), sharing feedback they have received (Coutifaris & Grant, 2021), and demonstrating a willingness to take action (Edmondson, 2003). More recent work suggests voice results when coworkers extend respect and engage in perspective taking (Ng et al., 2021). Many of the interventions in health care that have yielded both voicing behavior and safety improvements focus on training the entire team in teamwork and communication (e.g., Gupta et al., 2015; Savage et al., 2017).

In large, hierarchical health systems, frontline and middle managers play crucial, yet distinct roles in enabling voice. Prior research on voice tends to focus on frontline managers and employees, but research on issue selling emphasizes that its effectiveness depends on the target and context, meaning issue selling and by extension voicing should also take into account different managerial levels (Ashford et al., 2017). Even if frontline employees have limited access to middle managers or senior leaders, their managerial behavior and beliefs impact organizational policies, practices, and culture, all of which affect employees' willingness to voice.

Research has also identified antecedents of voice at the organizational level. Nembhard et al. (2015) found that work design (e.g., responsibility for representing others), organizational culture (e.g., shared values of collaboration), organizational structures (e.g., agendas with transparent voice protocols), and access to data (e.g., benchmarking data) positively influenced employee voice in health care organizations. Research in human resource management discusses formal organizational structures for employee voice often emanating from unions, collective bargaining agreements, and corresponding governmental regulations (Wilkinson et al., 2013, 2018). Voice also results from empowering (e.g., employee autonomy; Boxall et al., 2019) and commitment-based (e.g., training and development) practices that foster trust, cooperation, and shared language that helps employees contribute uniquely held information (Collins & Smith, 2006).

Benefits of employee voice. Research in health care management and organizational behavior has found that frontline employees' engagement with voice benefits the organization, team, and individuals' work. Health care organizations where employees report they can voice also demonstrate higher levels of quality improvement and safety (Robbins & McAlearney, 2020), higher quality organizational decision-making and swifter error detection (Morrison & Milliken, 2000), and more effective and efficient implementation of new practices (Edmondson, 2003), compared to organizations where employees do not report such a climate. Frontline voice is argued to produce these benefits through new, often critical, information and insights that may not have been salient to others, especially professionals and leaders less connected to frontline operations. Voicing can also provide benefits to frontline employees, including increased satisfaction and motivation and reduced emotional exhaustion and turnover intentions (Morrison, 2023). In addition, research in human resource management sees voice as a beneficial precursor to employee participation and employee dignity (Wilkinson et al., 2018).

The research above provides guidance on how to facilitate employee voice to create positive outcomes. However, research also shows that once employees voice, their ideas face many barriers, so only a small fraction of proposed ideas make it to implementation. Although some voiced ideas are rejected or ignored because they are infeasible or inappropriate for the situation, past research accounting for idea quality has shown that even many verifiably "good ideas" still face barriers to implementation in organizational settings (Satterstrom et al., 2021). To overcome these barriers, ideas need to be supported by both the voicer, other actors in the organization, and organizational processes to reach implementation.

There can also be value in thoughtfully rejecting a voiced idea. When the idea is considered and reasoning is provided for the rejection, the employee who voiced the idea and those who heard it have the opportunity to learn from the feedback and decide whether to stop, start anew with a different idea, or continue to push forward with their existing idea. We focus on the latter, on how ideas are kept alive and reach implementation. In Figure 1 and in the sections below, we first outline barriers to employee voice and the underlying reasons for these barriers. We then highlight what voicers themselves can do to move their ideas forward, pulling from existing studies of voice, champions, and issue selling. Next, we turn to the literatures on voice and teams to generate insights into how and when teammates and coworkers can support voiced ideas. Then, we draw upon research on organizational change to propose how frontline and middle managers can (structurally) support voiced ideas. Finally, we discuss how senior leaders can support employee voice by systematically engaging with all levels of the organization to reduce barriers and to provide pathways and guidance to implementation.

Though our model shows the different levels of analysis separately and sequentially, we draw from past research that suggests that there is a cyclically recursive relationship within and between levels such that the "repeated process can lead over time to the amplification or diminishment of certain outcomes" (Cloutier & Langley, 2020; Satterstrom et al., 2021). In Figure 1, this is depicted by the arrows down the right side of the figure illustrating how voicers enlist teammates and coworkers, frontline and middle managers, and senior leaders. On the left side of the figure, the cyclical recursive relationship is depicted by the arrows showing how senior leaders set the context for frontline and middle managers, teammates, coworkers, and voicers through their actions, their communication, their investments, and their thought processes. Similarly, frontline and middle managers

also create roles and structures for voicers that help develop and refine ideas to make them implementable. More specifically, senior leaders communicating organizational culture and priorities inform whether a voicer continues bringing up a particular idea and how they do so. Such communication from senior leaders also shapes the actions team members and managers take to amplify or legitimize the idea by helping frame it to match the stated organizational priorities. Our model provides a starting point for additional research on sustaining voice that examines these cross-level interactions and dynamics. Figure 1 also reflects a temporal sequence within each level. For example, to overcome barriers, voicers try to increase receptivity; they then reinforce and repeat ideas to sustain awareness and interest before enlisting champions and allies to garner support for implementation. Illustrating the temporal sequence suggests future research to test these ideas and further refine how voicers can best take voiced ideas to implementation (and how other roles can support this process).

Barriers to Employee Voice

Despite their multifaceted potential benefits, voiced ideas often face barriers to implementation. Research by Satterstrom et al. (2021) found that of the more than 200 ideas voiced by frontline staff and patients they followed, most ideas were rejected or ignored in the moment; just 49 ideas lived on to reach implementation, 41–74 weeks after the idea was first proposed. There were four common reasons for why these ideas were initially rejected. The first was that receivers often did not believe the idea was important or feasible. Specifically, employees' ideas were not perceived as aligned with managerial, organizational, or industry priorities and therefore were considered a low priority. This could be because frontline employees were unaware of priorities or because frontline employees—especially front desk staff, medical assistants (MAs), and nurses—did not know how they should frame their ideas to highlight their alignment with organizational priorities. Moreover, receivers—be they coworkers or managers—often lacked awareness of the work other roles were capable of performing, leading them to erroneously perceive an idea as infeasible. A second common reason for rejection was a lack of understanding of the work or problems that other roles experienced, which was often because of the siloed nature of work in health care clinics. Moreover, employees also lacked shared language and priorities across professions, making it difficult to present ideas in ways that are clearly understood by people in other roles (see Malloy et al., 2009, for more evidence from health care contexts). Third, receivers did not want to remove or delegate work that higher-power roles felt was theirs. Fourth, receivers did not want to add work that was not welcomed by higher-power roles. Underlying these last two barriers is that those in authority may feel defensive or simply lack the resources or authority to enact the voiced change (Fast et al., 2014).

What Voicers Can Do

Reframing and retargeting voice to increase receptivity. Applying management research on voice and social influence to navigate health care contexts suggests ways that voicers can overcome power- and hierarchy-based barriers: by reframing their idea to increase the likelihood that receivers hear and constructively engage with their ideas or shifting their voice target. For instance, ideas are more likely to be accepted in the moment if they are framed as supportive or promotive (i.e., building on existing practice), are expressed in a manner that engages with the receiver rather than directly challenges them, signal the voicer's commitment to the organization and the connection of the idea to organizational interests, and target receivers who have the ability and willingness to make change (Burris, 2012; Burris et al., 2022; Li et al., 2017; Liang et al., 2012). Social influence tactics, from engaging in dialogue to creating a sense of felt obligation or a need for reciprocity with the receiver, and using more vivid and identifiable language, may also help voicers be more persuasive when reengaging with receivers (Cialdini & Goldstein, 2004).

Consistent repetition of voice to keep ideas alive. For a reframed idea to reach implementation, employees may need to continue to bring up the idea over time. De Dreu and De Vries' (1997) work on minority dissent ("publicly advocating and pursuing beliefs, attitudes, ideas, procedures, and policies that go against the 'spirit of the times' and challenge the status quo" [p. 72]) finds that being persistent and consistent in voicing helps recipients not only hear the idea but also shift their thinking into a more active and systematic mode. This suggests that seeing a voiced idea that has met resistance through to implementation requires ongoing and repeated voicing rather than a one-off instance of voice. Similarly, interventions on speaking up in health care point to the effectiveness of assertiveness and persistence in overcoming hierarchies and differences in communication styles to ensure that voiced concerns about safety are more easily heard (Leonard et al., 2004).

Engaging champions and allies who can support ideas via issue selling and collective action. Another way that frontline employees can overcome barriers to implementation of their voiced ideas is by identifying and recruiting influential individuals who have the legitimacy and the competence to follow through with the request (e.g., Burris et al., 2022), which in health care may mean bypassing their frontline manager and instead seeking out middle managers (Pappas et al., 2004). Related research on innovation finds that "champions" may come from within or outside the organization and help ideas reach implementation (Howell & Boies, 2004). Champions can do so because they "convey confidence and enthusiasm about the innovation; enlist the support and involvement of key stakeholders; and persist in the face of adversity" (Howell, 2005, p. 108). Middle manager or senior manager champions are better positioned than frontline employees and frontline managers to know how to engage in issue selling, framing voiced ideas to align with organizational priorities, and ensuring these ideas are included in senior leaders' agendas. Manager champions can also encourage their peers and subordinates to consider the idea through backchannels—publicly

supporting the idea to ensure it is not quickly dismissed by frontline managers—and continue to advocate for the ideas as they are refined, tested, and implemented (Ashford et al., 2017; Howell & Boies, 2004). Although managers may be reluctant to spend the time and social capital to champion frontline ideas, they might also experience benefits. Championing is a form of public endorsement, and as such, managers may experience a status boost from being seen as prosocial and concerned with the well-being of the organization and its employees (Bain et al., 2021).

Employees voicing ideas can also support their implementation by engaging others who may want to take collective action. That can mean encouraging champions and allies to meet and discuss their grievances and solutions in what Kellogg (2009) refers to as relational spaces ("areas of isolation, interaction, and inclusion that allow middle-manager reformers and subordinate employees to develop a cross-position collective for change" [p. 657]) to build hope, trust, and group identity around the desired change. In studying the work intensification of MAs during the adoption of new clinical support technology in their electronic medical record, Kellogg (2022) found that MAs were able to ally with managers to voice their concerns and come up with solutions to better pace their work; these MAs also allied with doctors leading the technological change who supported the MAs' solutions by socially sanctioning other doctors who did not follow them.

Extending research on how middle managers sell their ideas about strategy to senior leadership provides suggestions for the way relational coalitions could also support employee voice. For example, middle managers ("the sellers") use coalitions to "help assess the objectivity of sellers' opinions, provide emotional support, give additional input and suggestions, and help to build awareness of the issue…[a coalition] also allows sellers to pool resources and share lessons" (Ashford et al., 2017, p. 92). In addition to efforts to unionize, other forms of collective action to help frontline employee voice be implemented in health care organizations include protests (for adequate personal protective equipment during COVID-19; Jeffrey, 2020) and strikes (for better staffing ratios to ensure patient safety; Adams, 2023).

What Teammates and Coworkers Can Do

Engaging in voice amplification to enable listening.

Peers can help others listen by building on each other's ideas through processes of voice amplification in which a coworker publicly endorsed another person's contribution, with attribution to that person (Bain et al., 2021). Experimentally, Bain et al. (2021) found that ideas were rated as higher quality when they were amplified than when they were not amplified, regardless of how they were framed or the voicer's gender. They also found the voicer whose idea was amplified and the coworker who amplified the voice gained higher status in their work groups. Thus, organizational research suggests that public bolstering ideas by peers/coworkers may enable ideas to be carefully (re)assessed, even ideas that might have been overlooked initially.

Collaborative coordination and problem-solving to enable idea consideration.

Related research on groups and teams engaging in collaborative coordination and problem-solving processes on a regular basis—relational coordination, mindful organizing, and formalized problem-solving methods—has been shown to build on ideas, particularly those that aim to improve care quality and safety. Specifically, research on relational coordination in health care shows ideas that are consistently communicated with accuracy, timeliness in a problem-focused way, and mutual respect produce greater efficiency and quality outcomes (Gittell et al., 2000). Research on cross-boundary teamwork addressing chronic disease has shown that shared emphasis on problems as jointly faced and solutions as requiring coproduction can help draw attention to ideas that might otherwise lose steam (Kerrissey et al., 2021). Research on mindful organizing in hospital nursing units suggests errors are better managed when nurses take even weak signals of threats seriously; question their own assumptions about their work; and defer to expertise with the problem at hand, including to those with lower formal status (Vogus & Iacobucci, 2016). Formalized problem-solving processes (e.g., root cause analysis) also provide a common language that fosters deeper engagement with problems and solicits a broader array of perspectives (MacDuffie, 1997) that can be applied to help elaborate voiced ideas.

Engaging in voice cultivation to support ideas to implementation.

Teammates and coworkers can help revive voiced ideas that are initially rejected or sustain ideas that are languishing. Satterstrom et al. (2021) identified a set of voice cultivation processes that helped voiced ideas—most of which were initially rejected—to reach implementation in a study of successful and failed ideas voiced in a health care team over 2 years. They found that it was important to look beyond the voicer–receiver dyad to ideas voiced publicly in teams because these ideas prompted a collective, interactional process through which team members who initially heard the ideas were able to bolster them for months until they reached implementation. They articulated five pathways: (a) allyship, in which a voiced idea is kept alive by team members who repeatedly legitimize the idea over time; (b) persistence, in which the voiced idea is kept alive through the persistence of the original voicer with support from others who help develop the idea; (c) co-crafting, in which the idea is kept alive by collectively crafting the idea with both those giving up and those taking on work, so that higher-power members accept giving up ownership of work they had not wanted to delegate; (d) problematizing, in which the voiced idea is kept alive by raising specific issues with the idea, creating an opening for team members to develop collective solutions that gain the support of higher-power members; and (e) catalyzing, in which a voiced idea gains new life after being stalled when a new shock occurs that is connected to the idea and acts as a catalyst for reviving it. Using a mix of cultivation practices (e.g., amplifying, developing, issue raising, exemplifying, legitimizing) that best addressed the barriers each idea faced was particularly effective.

What Frontline and Middle Managers Can Do

Creating intermediary roles that have greater bandwidth for listening and some authority for developing and implementing ideas. Managers in health care organizations are in a difficult position with demanding day-to-day responsibilities and expectations while playing key roles in carrying out change, while lacking formal power and status (e.g., Birken et al., 2018; McConville & Holder, 1999). They are often responsible for implementing top-down changes and so may not have the bandwidth or power to listen to and act upon bottom-up ideas and concerns. Middle managers, such as medical directors, nurse managers, and operation managers, may be able to create new intermediary roles that bridge the frontline and managers (e.g., Kellogg et al., 2021) and create more capacity for listening to and developing new ideas (Hofmann et al., 2009). Creating these new roles can help overcome a key barrier to implementing voiced ideas—limited managerial time and attention—by ensuring that someone who is familiar with the work, with access to some amount of training, with exposure to managerial priorities, and with some authority can help frontline personnel create day-to-day changes to their work routines. As such, these roles reduce demands on managers and can enable more experimentation with voiced ideas that may benefit the organization, team, and individual by growing employee engagement and their sense of efficacy.

Enabling experimentation and building evidence to help ideas become implementable. Other managerial actions, such as enabling local experimentation, can help keep employee ideas alive. Local experimentation refers to providing resources, physical spaces, and time for employees to develop, test, and show evidence of their ideas such that they can become implementable changes (Bucher & Langley, 2016). From many studies of multidisciplinary frontline health care teams tasked with using plan–do–study–act cycles, lean, or human-centered design approaches to respond to external demands (e.g., Atkinson et al., 2022), we know that frontline employees can generate and implement ideas. By extension, managers could allow employees to use these approaches, carving out small pockets of time for individuals or small groups of employees to collect data, conduct small experiments, or prototype their own ideas alongside their day-to-day work to demonstrate whether their voiced idea could benefit their work and the clinic (Atkinson et al., 2022). Middle managers, including quality improvement managers, can help frontline employees frame the problems and opportunities they see in light of existing grants or organizational priorities to garner resources that can further support this work. Although it is easier to provide time and resources when there are organizational norms in place (e.g., a learning laboratory), managers can create local improvement norms to help sustain voiced ideas.

What Senior Leaders Can Do

Consistently engaging with frontline problem-solving to enable listening and keep ideas alive. Willingness to consider the possibility of new ideas is a critical first step for senior leaders' support of frontline ideas. The second step is consistent exposure to and engagement with frontline employees, their context, and their ideas. Efforts, such as "Leadership WalkRounds" in which hospital senior executives (e.g., CEO) conduct regular rounds (i.e., weekly or biweekly) to surface "concerns or defects related to patient safety" and transfer these issues to an operations committee responsible for instituting change, led to significant increases in safety climate scores (Frankel et al., 2008, p. 2053). These WalkRounds help ensure executives understand voiced concerns and ideas regarding an array of issues frontline staff are experiencing, including communication, equipment and supplies, technology, and workflows, among many others. It also provides a foundation for senior leaders to respond to the issues raised. Several leading organizations have expanded this idea to "tiered daily huddles" and "interdisciplinary executive rounding" (Kline & McNett, 2019; Mihaljevic, 2020). For example, Cleveland Clinic has a series of brief (15 minutes or less) huddles each day that start with frontline managers and staff and then managers and directors, culminating with the CEO. Twenty-five thousand employees engage in one of six tiers of huddles—structured conversations with standard agendas that track and review action items to identify and address challenges—with information moving up the hierarchy at every tier. These tiered huddles intend to improve "daily insight into our operations and empower caregivers and teams at all levels to identify and solve problems on a daily basis" (Mihaljevic, 2020, p. 1050). Tiered huddles present another structured approach, supplemented with coaching, that helps transmit voiced ideas to senior leaders and provides a context that overcomes discomfort with engaging voiced ideas and discussing problems openly, which fosters other forms of voice like safety event reporting and enables reductions in patient harm.

Creating explicit change processes and resources to ensure ideas reach implementation. Another critical step in senior leaders' support of frontline ideas includes using formalized structures to create conditions for realizing ideas. For example, innovation contests in health care organizations emulate open innovation, whereby idea generation and selection processes are open to any and all interested individuals (Jeppesen & Lakhani, 2010). Contests and other voice systems can offer a transparent mechanism that helps voicers feel heard and brings their ideas to the implementation stage. In such contests, all members of the organization are invited to propose ideas, vote on ideas, and see which ideas are selected for investment. Formalized approaches like contests can increase employees' motivation to participate, their understanding of the types of problems and ideas other employees have, and their acceptance of selected ideas (Jung et al., 2020). Innovation contests are increasingly used in health care organizations to ensure ideas that are raised and widely supported by other employees can quickly be implemented with fewer barriers than ideas that are raised in other ways (Jung et al., 2022). Another benefit of structures like innovation contests is that they have frontline employees, who are closest to the work, vote on proposed ideas and indicate which voiced ideas should be prioritized,

rather than exclusively or primarily relying on managers who may be less reliable judges (Berg, 2016). Formal channels for proposing and evaluating change-oriented ideas also provide clear feedback to all participants regarding their idea and other ideas selected to move forward to implementation, which can spur continued participation (Piezunka & Dahlander, 2019). In addition to this feedback, the public nature of innovation contests may provide opportunities for keeping nonwinning ideas alive by mobilizing those who did support them.

Although every health care organization may not be positioned to carry out formal innovation contests, their features could be readily replicated: soliciting ideas, publicly considering ideas, applying clear selection criteria, and transparently sharing information regarding support offered to voicers and their ideas. Senior leaders play a key role in creating and sustaining widespread norms around transparent evaluation and investment in employee ideas to enable coworkers, frontline managers, and middle managers to bolster frontline employees' voiced ideas.

Transparently communicating organizational culture and priorities to provide a roadmap for voiced ideas to implementation. Senior leaders shape an organization's culture in response to the external (e.g., regulatory) and internal (e.g., diversity) demands facing it, manifesting the mission, vision, and goals that set the organization's direction and priorities. When organizational values, priorities, and constraints are consistently and openly communicated, they are likely to be better understood by frontline employees and their ally peers and managers. In such an environment, voiced ideas can be crafted in ways that directly tie to organizational priorities and are thus more likely to be resonant (Ashford et al., 2017).

Senior leaders can also accelerate the implementation of voiced ideas by proactively providing employees with strategies for navigating the organization culturally and politically. For example, Kellogg (2011) finds that aligning change-oriented ideas with organizational priorities and having toolkits to navigate the culture (e.g., frames, identities, and tactics) resulted in ideas successfully reaching implementation. However, Kellogg (2011) also finds that it often took months to years for these frontline changemakers and their middle management supporters to hone their toolkits on how to push for change, thus necessitating more directive action from senior leaders.

Modeling possibilistic and paradoxical thinking to establish an open mindset for listening. While walking the floors, creating proactive process to collect and consider ideas, and communicating change processes and priorities is critical, senior leaders may also need to use and model thought processes that illustrate how to keep ideas alive. Research on culture suggests that, in addition to artifacts and espoused beliefs and values, employees' underlying assumptions play a significant role in maintaining the status quo (Schein, 2016). It is therefore not surprising multiprong approaches that shift thought processes would be needed to create space and support for new ideas from the frontline. For example, in response to seemingly intractable industry challenges, Grimes and Vogus (2021) describe possibilistic thinking—a willingness to question existing assumptions and resist the temptation to reject ideas because they are not likely to come to fruition immediately—as a way leaders may help keep voiced ideas alive, even ideas that are radically new or disruptive. Smith and Tushman (2005) describe how senior leaders embrace paradox, which can also extend to deepening consideration (or reconsideration) of voiced ideas. Leaders with a paradox mindset can differentiate and integrate ideas that propose incremental changes, build on existing ideas (exploitation) with those that pursue fundamentally new directions (exploration), and identify ways to structurally support exploitation and exploration. These mindsets suggest ways in which senior health care leaders can reconcile divergent understandings across professions or organizational subcultures to help voiced ideas overcome resistance, bringing them closer to implementation (Kan & Parry, 2004).

What All Receivers Can Do

Listening to understand and support voicers. For any receiver to effectively support a voiced idea or concern, they must listen to understand the voicers' perspectives and provide social–emotional support (Yip & Fisher, 2022). Effective listening can be difficult for receivers who may not always understand whether a voiced idea is a request to be heard, a request for permission, or a request for support. A shared understanding of the voicer's intent is needed for appropriate follow-on action to address underlying issues and to ensure a positive affective experience for the voicer to ensure they continue voicing in the future. Research on listener's experience suggests that, though there are many barriers to listening (e.g., cognitive load), being empathetic, engaging in mental exertion to focus on and interpret the message, being open, paraphrasing, and asking questions are directly or indirectly related to listening to understand (for a review, see Yip & Fisher, 2022). Similarly, socioemotional support via listening helps the voicer feel reassured, understood, confirmed, less anonymous, and more psychologically safe and engaged. However, research on interruptions (Rivera-Rodriguez & Karsh, 2010) and relational work practices (Gittell et al., 2010) in health care organizations finds receivers—in particular managers—need to supplement individual, interpersonal efforts with listening structures and systems that help channel and operationalize voiced ideas. These structures might include outlets like town halls and time-limited listening sessions, supported by idea repositories. These structures also reduce the demands (e.g., cognitive, emotional) on employees for keeping voiced ideas alive until they are translated into practices or processes that can be implemented (Vogus & Sutcliffe, 2007).

Theoretical Implications

There has been considerable attention and investment in promoting and enabling frontline voice in health care. However, there has not been comparable attention to ensuring employee voice is translated into organizational change.

The absence of a holistic understanding of how voiced ideas result (or do not result) in implementation provides insight into why voice may not produce the intended benefits (Montgomery et al., 2023) and why health care innovation persistently lags (Nembhard et al., 2009). We address this considerable gap by integrating disparate strands of organizational research into a model that illuminates the recursive processes through which voiced ideas reach implementation, even when initially rejected. Specifically, we home in on what the voicer can do to ensure their proposed change is heard by making use of forums and people and then tailoring the approach to the recipient of the voice. In other words, our model provides a process-based, multilevel understanding of how specific conditions (e.g., practices and structures), dynamics (e.g., behaviors and processes), and actors (e.g., voicers, their teammates and coworkers, and managers and leaders at different levels in the organization) can build pathways for voiced ideas to reach implementation and create organizational change. It suggests that the level of the receiver matters and so pushes voice researchers to further differentiate between frontline managers, middle managers, and senior leaders who may have different abilities, resources, and responsibilities for opening spaces (e.g., frontline and middle managers creating space for experimentation) and creating conditions (e.g., senior leaders' modeling of possibilistic and paradoxical mindsets) for bolstering ideas to reach implementation. We also point to the unique and insufficiently examined role of senior leaders through both their modeling of cultural norms and expectations and their work establishing transparent policies and practices (e.g., innovation contests), which play an especially important role in keeping voiced ideas alive and helping them reach implementation.

Our model highlights the importance of grounding behaviors, tactics, and structures that bolster voice in ways that are attentive and responsive to local barriers and sources of rejection. Some approaches may work better for ideas that are rejected because they do not seem feasible (e.g., voicers and allies can use voice cultivation tactics such as legitimizing), that have mixed support among managers (e.g., champions can share cultural and political toolkits), or that frontline managers lack time to consider them (e.g., middle managers can create intermediate roles). Voicers and allies can combine these multilevel approaches to help voicers feel heard and ideas stay alive, especially when good ideas face a variety of barriers.

Our multilevel model provides a basis for future research on bridging voice to implementation. Researchers can examine the relationships detailed in our model and illustrated in Figure 1. Qualitative research that follows the longitudinal processes of voiced ideas and the conditions under which they reach implementation would be useful, especially if this research is able to observe and document the pathways associated with different barriers that ideas face and how the different levels support or undermine each other. Future work can also explore the feedback loops associated with voiced ideas and attempts to implement them—we suspect that these feedback processes will involve the evolution of the voiced ideas and the barriers they face over time. The temporal nature of support would also make an interesting area of investigation because we know that voicers and allies can help craft windows of opportunity for change over time (e.g., Reay et al., 2006). Further research could also integrate extensive work on organizational change with support for voiced ideas (e.g., Stouten et al., 2018), emphasizing the dual bottom-up and top-down strategies that may be needed to support voiced ideas as they create change. Although there is a great deal of work on the risks of voicing on the voicer, future research could look at the risk of supporting voice for team members, coworkers, and frontline and middle managers in health care. From the voicers' perspective, managers have the power and resources to consider and enact change; however, our research in health care suggests that frontline and middle managers often lack formal power and insight into change processes in their complex, bureaucratic organizations. Future research should also consider the emotional dynamics that have received less attention in prior research. Researchers could build on work on compassion and emotional dynamics that have identified a set of behaviors, structures, and practices organizations can engage in to ensure employees feel heard and supported (McClelland & Vogus, 2021) to investigate how emotion generally and prosocial emotions (e.g., compassion) help sustain voice. In addition, more research is needed on the role of differences in national health care systems and national culture in shaping voice and keeping voice alive. Studying systems outside the United States will likely reveal important variation in multiple aspects of our multilevel integration of health care, human resources, and organizational behavior research. These variations could pertain to the interpersonal and relational processes of voice (Morrison, 2023) in that in national cultures with greater power distance, the support and championing of voiced ideas by leaders and managers become even more important, and efforts to keep voiced ideas alive are more tied to those with higher formal status and power. In addition, when national health systems have more formalized voice mechanisms because of governmental involvement and/or more widespread unionization, navigating the range of formal policies and procedures for making change happen becomes a more important source of support from peers, managers, and senior leaders (Wilkinson et al., 2018). There is also considerable opportunity to further explore potential behaviors, practices, and structures that bolster voice to implementation in voice-adjacent literatures. For example, research on "taking charge" and job crafting identifies additional personal strategies and organizational practices that can help enable voicers to make changes to their work and organizations (Morrison & Phelps, 1999; Wrzesniewski & Dutton, 2001).

Our model also highlights the need for further exploration of the many facets of voice. Broadly speaking, we focus on promotive voice, but there are additional features of voice evident in our theorizing that merit further exploration to add more process nuance. Prior research (and our model) suggests that the content of the voiced idea (e.g., acute safety concern, process improvement, incivility; Keller et al., 2020; Noort et al., 2019), its valence (e.g., negative or positive; Liang et al., 2012), the expression of the idea (e.g., tied to organizational priorities, persistent advocacy; Ashford et al., 2017),

the target (e.g., peer, manager, senior leader; Burris et al., 2022; Detert et al., 2013; Liu et al., 2013), and the voicer's relationship with the target affect the likelihood of getting to implementation and the risk that the voicer takes on in speaking up. In addition, work on "voice systems"—structures in organizations that "shape and channel participation" through institutional and human elements—provides models for understanding employee voice, including the *degree* to which employees are able to influence managerial decision-making, the hierarchical *level* of the voice recipient, the *range* an idea can take from local work practices to strategic considerations, and the *form* voice takes from occurring on the job or through formal channels (Wilkinson et al., 2018, p. 712). Additional work could use these voice systems to explore the impact of voicer approaches on implementation. Which approaches are better for bolstering ideas about local tasks compared to ideas that seek to enhance cross-disciplinary processes or impact organizational strategies? Which level of actor is needed to bolster an idea—are certain ideas better bolstered by the voicer, by their teammates, by coalitions, by middle managers, by innovation contests, or by a mix of the above? It is also critical to better understand how these approaches dynamically respond and adapt to emergent barriers that voicers and voiced ideas face, whether those be lack of time, resources, demographic characteristics of the voicer, perceived threat by authority figures, or organizational policies and practices that impede voiced ideas from reaching implementation and creating change. This work suggests expanding the focus of voice research to not only consider more actors when studying voice but also take a more processual and longitudinal look at voice pathways and dynamics.

Practical Implications

Our model has practical implications for senior leaders, managers, and frontline staff interested in turning voiced ideas into implementable change. Our model details a set of evidence-based strategies for bolstering (initially) rejected or ignored ideas through how voicers (re)articulate ideas and who they enlist to help advance them (e.g., collective action), make use of peers (e.g., voice cultivation), enlist managers to help create better conditions for intentional experimentation (e.g., intermediary roles), and take advantage of listening structures and other formal mechanisms (e.g., tiered huddles) and how senior leaders can make change processes and cultural norms explicit and transparent. If the steps for navigating organizational processes and approaches to change are not well-known, organizations and their leaders would be well served to establish them and/or make them clearer and more transparent. Bolstering voice to implementation is all the more pressing in light of the current health care workforce crisis, as organizations may be well served to not only consider supporting and implementing evidence-based best practices that employees perceive as additional work and can lead to employee burnout (National Academies of Sciences, Engineering, and Medicine, 2019), but also supporting and implementing employee ideas that reflect frontline priorities. We have seen organizations frustrate and disappoint their employees by oversoliciting their voice—aggressively asking for frontline input in meetings and surveys on how to make things better—and then rejecting their suggestions or failing to follow up. Our model suggests organizations would be better served using that time and space to create pathways for voice to reach implementation. The benefits that employees experience from feeling heard (Kerrissey et al., 2022) may not persist if employees are then made to engage in change efforts, even in support of their own ideas, without adequate resources.

Researchers and practitioners alike have an opportunity to develop and refine theories, tools, and practices to help realize ideas from frontline staff—those closest to the work and those most at risk of burnout—so that patients, employees, and organizations sustainably reap the benefits of voice.

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