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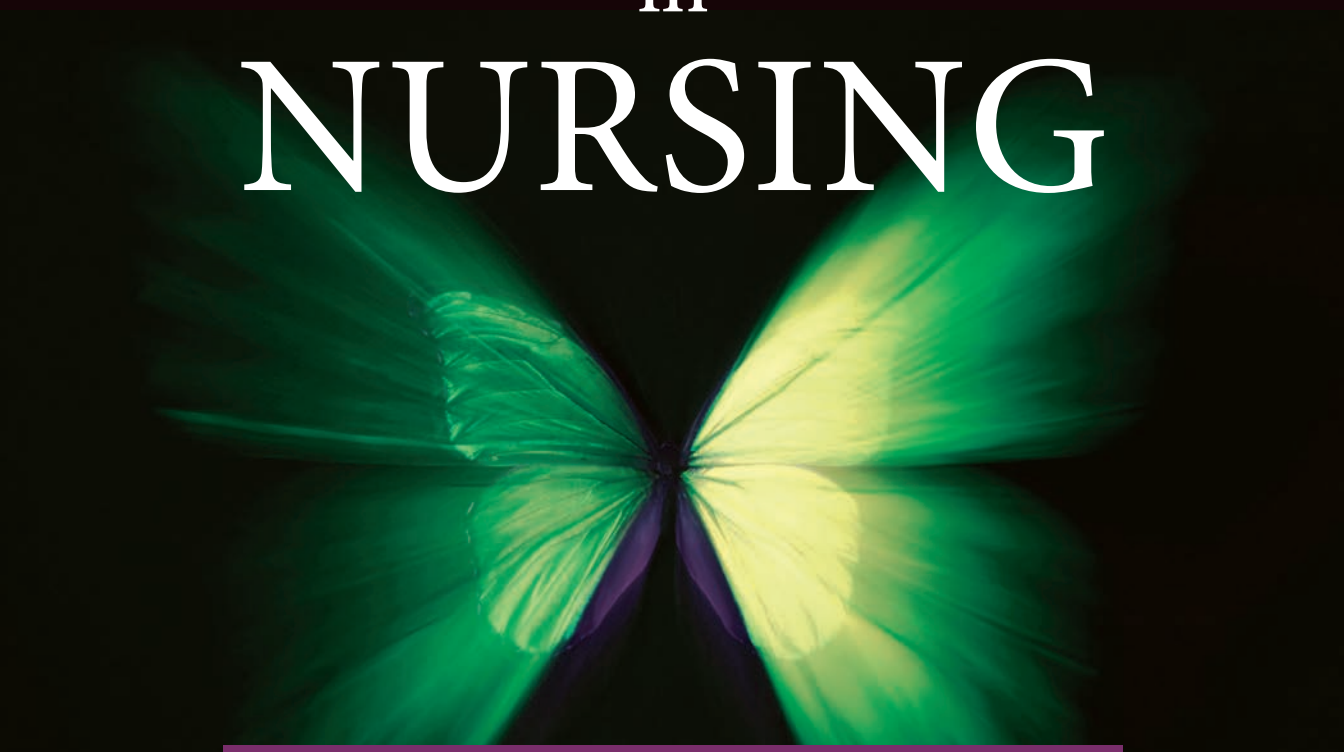

From Expert Clinician to Influential Leader

Marion E. Broome
Elaine Sorensen Marshall
EDITORS

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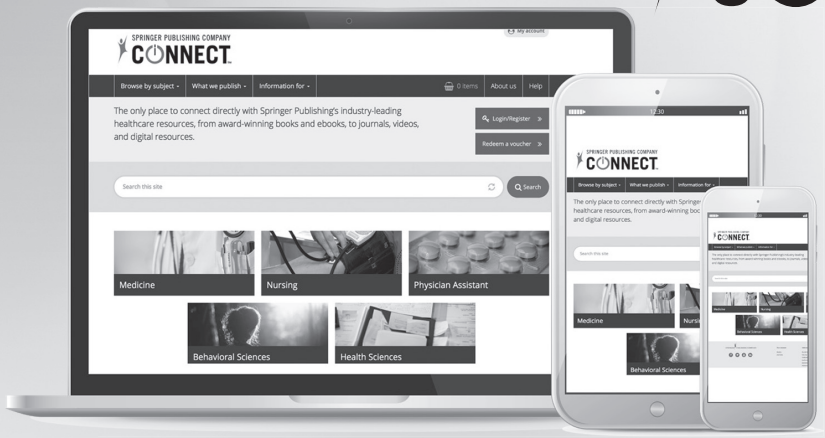

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Elaine Sorensen Marshall, PhD, RN, FAAN, is former Castella Distinguished Professor and chair of the Department of Health Restoration and Care Systems Management at the University of Texas Health Science Center School of Nursing, San Antonio, Texas; former professor and Bulloch Endowed Chair at the School of Nursing at Georgia Southern University, Statesboro, Georgia; and professor and dean emerita of the College of Nursing at Brigham Young University, Provo, Utah. She has served in national elected and appointed leadership positions for the American Association of Colleges of Nursing, the American Association for the History of Nursing (AAHN), and the Western Institute of Nursing (WIN). Dr. Marshall has published two books and more than 50 articles and book chapters. She received the New Professional Book Award from the National Council on Family Relations, the Lavinia Dock Award from the AAHN, and the Jo Eleanor Elliott Leadership Award from the WIN.

TRANSFORMATIONAL LEADERSHIP IN NURSING

From Expert Clinician to Influential Leader

Third Edition

Marion E. Broome, PhD, RN, FAAN
Elaine Sorensen Marshall, PhD, RN, FAAN

Editors

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FOREWORD

I am so pleased to be writing the foreword for the third edition of *Transformational Leadership in Nursing: From Expert Clinician to Influential Leader*. As a seasoned health services nurse leader, I know much about the complexities and challenges of healthcare delivery, and I appreciate the importance of effective leadership in advancing excellence in this important domain.

This book provides readers with a vibrant and up-to-date view of these complexities and challenges. It imparts a plethora of knowledge, both theoretical and empirical, that positions readers to develop their own effectiveness as people and leaders so that they can ultimately positively influence healthcare delivery in the future. This book is perfectly geared toward nurses who are interested in becoming more effective and more influential people and leaders as they carry out their professional roles in healthcare delivery.

When I first read the second edition of *Transformational Leadership*, I knew immediately that this was the book I would use to teach nurses to be effective leaders. I recently transitioned from my health services role to teaching DNP students full time. I was designing the leadership course for a new DNP program and looking for just the right book. When I found the second edition, I was immediately taken with the usefulness of the entire book. Every chapter was filled with the content I knew I needed to prioritize for our new course.

When I reached out to Marion Broome and Elaine Marshall about my interest in knowing if a third edition would be coming out soon, I was so delighted to hear that, in fact, the plan for that was well underway. Both Marion and Elaine have incredible depth in their own expertise and experience in leading in the academic setting. They could not be better suited to be editors for this important text. That was evident to me as I read the second edition.

In this current edition, a comprehensive overview of leadership theory sets the stage in the first chapter, but it does not stop there. The book encourages readers to personalize the knowledge imparted in the book to their unique characters and roles in the healthcare setting. This book is written with application in mind. It highlights key challenges that leaders face and provides ideas and strategies based in evidence that can guide their planning, implementing, and evaluating tactics and strategies to ensure excellence in all they do. There are personal vignettes, cases, reflective questions, and a robust set of references for even further exploration.

What is most valuable about this particular nursing leadership book is that it addresses the current healthcare system. It is rich with what is real today. In this new third edition, several chapters were revised to add or update key priorities within healthcare delivery today. For instance, a chapter on the design, implementation, and evaluation of innovative practice models is provided. Additionally, the growth of population health initiatives and the importance of recognizing, improving, and innovating care delivery across the continuum are fully addressed. Information technology, use of machine learning, and the possibilities of future technology for personalizing and guiding care are also addressed. Nurse faculty, nursing students, practicing nurses, and APRNs alike will find this third edition extremely helpful in their quest to improve care delivery while improving their own effectiveness as people, nurses, and leaders.

The authors use the term *transformational* as less about ascribing to a particular leadership theory and more about helping transform practice settings and people who work in them through recognition of the benefits of diversity, by encouragement of creativity, innovation, and professional development. They also stress how important it is to recognize the importance of standards, policies, guidelines, recognition, governance, regulations, structures, and processes that ensure that excellence is always present.

The authors also advance the idea that leadership is personal, it is a lifelong journey, and it is about serving others and self with compassion, humility, and kindness. That said, the book emphasizes execution and outcomes. In this way, *Transformational Leadership in Nursing: From Expert Clinician to Influential Leader* is very practical but also philosophical and clearly provides readers with a set of values, principles, and evidence by which to start down the road of making a tremendous difference in people's lives.

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PREFACE

This book is for nurse leaders of the future. It speaks to clinicians who are experts in patient care and are now on a path toward leadership. Several clinician leaders offer their insights in their chapters, while other scenarios and examples drawn from practice are placed throughout the book. This book is offered as a resource as you embark on your own journey toward transformational leadership. You are needed to lead in the setting where you practice: from a solo practice clinic in the community to the most complex healthcare system. From an isolated rural community to an urban health sciences center, it is clear that nurse leaders like yourself are needed to forge new and innovative models of care that can meet the challenges of patients and families with whom we work. If you are reading this book, you are likely already prepared for clinical practice. You may be an expert in patient care, you may work as a manager in administration, or you may teach clinical nursing. Your challenge now is to enhance your skills and stature to become an influential leader. If that "becoming" is not a transforming experience, it will not be enough to prepare you to lead in a future of enormous challenges. The future of healthcare in the United States and throughout the world requires leaders who are transformational in the best and broadest sense. It requires a thoughtful, robust sense of self as a leader. It requires an intellectual, practical, and spiritual commitment to improve clinical practice and lead others toward their own transformation in their professional journey. It requires courage, knowledge, and a foundation in clinical practice. It requires an interdisciplinary fluency and ability to listen, understand, and influence others across a variety of disciplines. Transformational leadership requires vision and creativity!

Many who use this book are students in programs of study for a clinical practice doctorate, for example, the DNP. A decade ago, the DNP emerged as the credential for leaders in clinical practice. The *DNP Essentials* and the position statement on the DNP of the American Association of Colleges of Nursing (AACN, 2004) called for a "transformational change in the education required for professional nurses who will practice at the most advanced level of nursing" (AACN, 2006, p. 4) and "enhanced leadership skills to strengthen practice and health care delivery" (AACN, 2006, p. 5). Such transformational leaders focus not only on settings of direct patient care but also on healthcare for entire

communities. The 2020 version of the DNP Essentials is being developed as we send this book to press. But the core values of doctoral education—knowledge translation, leadership, and practice excellence—serve as core concepts in this book.

This work is neither a comprehensive encyclopedia for healthcare leadership nor a traditional text in nursing management. Rather, its purpose is to identify some key issues related to leadership development and contexts for transformational leaders in healthcare. The book is meant to introduce you, as a clinical expert, to important issues in your own aspirations toward becoming a leader. It is offered as a text and supplement to your own study of the literature, experts, and important experiences in the transition to leadership. It is meant to accompany and guide you to more focused current literature and experts on a variety of issues that healthcare leaders face. It is an aid to launch or guide you on your own journey to become a leader.

You will read about transformational leadership, which needs some clarification. Although there are some formal theories and definitions of transformational leadership, this work refers to the concept in its best and broadest sense without adhering only to a specific theoretical perspective. This book is heavily referenced not only to provide citation but also to lead you to a vast range of literature—both seminal and contemporary.

In this third edition, we have made some changes to update the messages for present-day and future readers. We provide more opportunities for students of leadership to access contemporary thinking of leaders from a variety of fields through links to TED Talks, blogs, and other media. Because a global view of healthcare is essential to today's leader, global perspectives have been added throughout the book. The focus on the context of complex healthcare organizations has been sharpened, with attention given to current legislation and concepts such as the Quadruple Aim to increase access, decrease costs, and improve quality; seamless care delivery; and competencies of the American Organization of Nurse Executives. There is also increased attention to national patient safety benchmarks, issues in health disparities, workforce issues, and patient and consumer satisfaction. We have invited experts to contribute on important issues of interprofessional collaboration, creating and shaping diverse environments for care, healthcare economics, and other significant areas of leadership development.

The messages of this book are to be taken personally. Your journey toward transformational leadership is a deeply personal one, and it requires courage and creativity. Throughout the book, we provide cases of "Leadership Action" for you to read about and see how nurses just like you played to their strengths, sought out mentors, and solved complex problems. Finally, you will find discussion questions and occasional personal stories and opportunities to guide your own personal reflection. We hope you enjoy reading this text and using

what content and activities resonate with you as you continue your leadership journey!

Marion E. Broome
Elaine Sorensen Marshall

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PART I

CONTEXTS FOR TRANSFORMATIONAL LEADERSHIP

CHAPTER 1

Frameworks for Becoming a Transformational Leader

Elaine Sorensen Marshall and Marion E. Broome

A leader takes people where they want to go.
A great leader takes people where they don't necessarily want to go but ought to be.

—Rosalynn Carter

OBJECTIVES

- *To consider the challenges facing today's leaders in healthcare systems and the need for leaders who can transform these challenges into opportunities*
- *To review foundational historical and theoretical contexts for leadership*
- *To discuss the evolution and envisioned role of doctorally prepared nurses in healthcare systems and how they can exert positive influence as leaders within these systems*
- *To explore theoretical contexts in the discipline of leadership to guide transformational leadership*
- *To use activities within this book to develop leadership skills, assess current and preferred future environments to make a difference, and shape the future of nursing and healthcare*

HEALTHCARE ENVIRONMENTS: OPPORTUNITIES FOR NURSE LEADERS

The world needs visionary, effective, and wise leaders. Never has this statement been truer than it is in the world of healthcare today. Leadership matters. It matters in every organization, not only for nurses to thrive in their careers but for them to advance effective healthcare for society. The current state and pace of healthcare change continue to create unprecedented challenges for individuals, families, and communities of the nation and the world. Healthcare continues to grow more

complex, corporate, costly, and expansive. In the United States, we face urgent problems of system complexity, financial instability, and poor distribution of resources; shortages of clinicians and provider expertise; issues of patient safety; and controversy about who will pay for what, at what level of quality, and at what cost for services (Institute of Medicine, 2010; Siwicki, 2017). Furthermore, leaders face a host of health problems and disparities, such as greater incidence of chronic illnesses, comorbidities, new epidemics of infectious diseases and opioid use, and growing numbers of vulnerable, underserved, and aging populations. Important issues of artificial intelligence, cybersecurity, disaster preparedness, drug prices, and patient experiences add further challenges to today's leaders (Siwicki, 2017). Meanwhile, society impatiently waits with waning confidence in the current healthcare system. Dialogue becomes more strident, and positions become more polarized in legislatures, the federal government, among private insurers, and within health systems themselves. Where are the transformational leaders who can take us through these turbulent times?

The healthcare professions of past decades focused on clinical practice and educational preparation for practice (Broome, 2019). Society demanded clinical experts to master the burgeoning body of knowledge, research, clinical information, and skill sets. Nurses, physicians, and other health professionals across disciplines responded to that challenge, as they became highly specialized clinical experts. They devoted years of learning and practice to achieve clinical excellence. Despite years of intermittent shortages, the nursing profession continued to provide registered nurses at the bedside, advanced clinical specialists who worked in acute care settings providing and managing care for patients, APRNs who practiced in primary care to provide health promotion and management of chronic conditions, and administrators who led health systems through difficult demands of society. These professionals effectively met healthcare needs for thousands of individuals and families. If you are reading this book, you are among those nursing professionals who have made major contributions to care delivery. The profession and society will continue to need expert clinicians like you.

The context of health and healthcare has changed dramatically in the past decade. We now recognize that patients spend most of their time living with their illness outside clinics and inpatient units. Our care delivery models of the past heavily focused on highly technical inpatient settings. Care is now, more than ever, expanded into the community and the homes of patients. Our need now is for leaders who can work within and across systems and settings. Your clinical expertise, whether it is in direct patient care, clinical education, research, or administration, is needed as a foundation for your emerging leadership in changing healthcare environments. We need nurse leaders who can draw from their roots in clinical practice to collaborate with leaders in other disciplines, with policy makers, and with members of the community to create new solutions to the problems facing all of us, to improve quality of life, to transform healthcare systems, and to inspire the next generation of leaders.

REFLECTION QUESTIONS

1. Think about your current practice environment. Is it organized in such a way that patients and staff feel safe, cared for, and able to express problems?
2. Are you ready to think of your practice in a different way?
3. What are the areas in your practice where you notice a need for a new kind of leadership?
4. What new challenges do you face in your practice?

Preparation at the highest level of practice must include preparation for leadership. The world needs expert clinicians to become transformational leaders. The world needs you to become a leader to transform healthcare for the next generation.

HERITAGE AND LEGACY: HISTORICAL PERSPECTIVES ON LEADERS IN NURSING

The story of modern Western nursing began with little noted but great leaders, and it traditionally starts with Florence Nightingale. Although her contributions are not usually described from a purely leadership perspective, the inspiration and effectiveness of her leadership have been celebrated for over 150 years. Her work in Scutari, Turkey, designing safer healthcare environments and hospital structures, training nurses, and using epidemiological data to improve health, can only be described as "transformational." The list of other transformational leaders in the history of nursing practice is daunting, including some who are unrecognized today. Well-known charismatic leaders in nursing of the 19th century include Clara Barton, who founded the American Red Cross; Dorothea Dix, who championed advocacy for patients and prisoners and who ruled her staff nurses with an iron fist; and, perhaps, even Walt Whitman, the celebrated poet who was a volunteer nurse during the American Civil War.

Best-known and revered models in our heritage of leadership in nursing include the handful of women in North America at the dawn of the 20th century who are credited with the vision of professional nursing: Isabel Hampton, Mary Adelaide Nutting, Lavinia Lloyd Dock, and Lillian Wald (see Keeling, Hehman, & Kirchgessner, 2018 for a comprehensive history of nursing).

- Hampton led nurse training at Johns Hopkins in Baltimore and was the first president of what became the American Nurses Association. "Her vision of nursing . . . required a transformation of . . . accepted norms. [Her work] demonstrated her ability to effectively lead change and inspire others toward her cause" (Keeling et al., 2018).

- Nutting was Hampton's student at Johns Hopkins and was among the first visionaries to foresee academic nursing education, rather than apprentice nurse training solely in hospitals. She led efforts to develop the first university nursing programs at the Teachers College of Columbia University and to secure funding for such programs (Gosline, 2004).
- Dock was a strong woman who was involved in many "firsts" that influenced the profession for years. She firmly believed in self-governance for nurses and called for them to unite and stand together to achieve professional status. She was among the founders of the Society for Superintendents of Training Schools for Nurses, which later became the National League for Nursing (2019), and an author of one of the first textbooks for nurses and history of nursing. She encouraged nurses and all women to become educated, to engage in social issues, and to expand their views internationally (Lewenson, 1996). She was known as a "militant suffragist" and champion for a broad range of social reforms, always fighting valiantly for nurses' right to self-governance and for women's right to vote.
- Wald, who modeled the notion of independent practice a century before it became a regulatory issue, founded the first independent public health nursing practice at Henry Street in New York. She not only devoted her life to caring for the poor people of the Henry Street tenements but also was the first to offer clinical experience in public health to nursing students. She worked for the rights of immigrants, for women's right to vote, for ethnic minorities, and for the establishment of the federal Children's Bureau (Brown, 2014).

Many other leaders of the 20th century valiantly promoted the development of the profession of nursing. Among them was Mary Elizabeth Carnegie, who established one of the first baccalaureate programs in nursing in 1943 at Virginia's Hampton University (American Association for the History of Nursing, 2018). She became the first African American nurse to be elected to a board of directors of a state nurses association (Florida). She was on the editorial staff of the *American Journal of Nursing*, was senior editor of *Nursing Outlook*, and the first editor of *Nursing Research*. Carnegie was a president of the American Academy of Nursing and was awarded eight honorary doctorates over the course of her career. Her legacy of leadership included making the contributions of African American nurses visible in the professional literature (see Carnegie, 2000).

Ildaura Murillo-Rohde was a Panamanian American nurse, academic, and organizational administrator. She came to the United States in 1945 and studied at Columbia University. She was the first Hispanic nurse awarded a PhD from New York University. Her specialty was psychiatric–mental health nursing, and she was an outstanding advocate for mental health needs of Hispanics. Murillo-Rohde was an associate dean at the University of Washington and the first Hispanic dean at New York University. She founded the National Association of Spanish-Speaking Spanish-Surnamed Nurses in 1975 and served as its first

president. She was named a living legend in the American Academy of Nursing (National Association of Hispanic Nurses, 2019).

Modern leadership for advanced practice in the mid-20th century ultimately led to the development of the DNP degree. The vision, courage, and leadership qualities of Loretta Ford and Henry Silver at the University of Colorado are evident in their pioneer work in establishing the first nurse practitioner program in the United States in 1965. By the 1990s, preparation for advanced nursing practice had moved to the master's degree. Now, in the face of increasing complexity of healthcare, trends among other healthcare disciplines toward doctoral preparation, and the urgent need for knowledge workers and wise leaders, the practice doctorate is becoming the required preparation for advanced practice nursing.

Today's healthcare leaders inherit courage, vision, and grit that must not be disregarded. We stand on the shoulders of valiant nursing leaders of the past who left a foundation that cries for study of its meaning and legacy for leadership today. They were visionary champions for causes that were only dreams in their time but today are essential. They dared to think beyond the habits and traditions of the time. These leaders were *truly transformational.* You are among the pioneer leaders to move healthcare forward to better serve society.

REFLECTION QUESTIONS

Lurking in the archives of your own institution, community, or state are the stories of other exemplary leaders in nursing and healthcare.

1. Who were/are they?
2. How have they changed healthcare?
3. What can you/we learn from them?

FOUNDATIONAL THEORIES OF LEADERSHIP

Although the theme of this book is transformational leadership, it is important to understand that the purpose, content, and principles of this book are not confined to the tenets of a specific theory of transformational leadership. To become a full citizen of the discipline, it is important that the transformational leader in healthcare understands the history, culture, and theoretical language of the science and practice of the discipline of leadership. Here we explore several leadership frameworks of the past and present with the expectation that some might resonate with you in your own career.

The popularity of any particular theory for leadership may wax or wane, but some leadership principles are timeless. Any truly transformational leader will have a solid foundation of understanding of the value of a theoretical approach to leadership in practice.

The first principle for leadership is that leaders be grounded in a set of ethics or core values that guide human behaviors and actions. No matter how brilliant the strategy or how productive the actions, if leaders do not hold the trust and act in the best interests of those they serve, they are not competent. Leaders in today's healthcare and academic settings deal with a variety of ethical issues and must ground themselves in values that enable them to lead with grace and effectiveness. Nurse leaders have a responsibility to shape ethical cultures (Broome, 2015) using the knowledge of ethical standards in the discipline (American Nurses Association, 2015) and expert guidelines (Johns Hopkins Berman Institute of Bioethics, 2014). More than a decade ago, Yoder-Wise and Kowalski (2006, p. 62) outlined the following principles for ethical leadership: respect for others, beneficence (promoting good), veracity (telling the truth), fidelity (keeping promises), nonmaleficence (doing no harm), justice (treating others fairly), and autonomy (having and promoting personal freedom and the right to choose). Such principles continue to be reflected in leadership today.

Historical Overview of Leadership Theories

It is beyond the scope of this text to provide a comprehensive history of leadership theories. A brief review is offered to give a sense of how traditional theories continue to influence leaders. Early management theories were developed during the industrial revolution and, thus, reflect the factory environment of worker productivity. Such theories included classic and scientific management theory that emphasized formal processes of the organization rather than the characteristics or behaviors of the individual. Primary concepts included hierarchical lines of authority, chain-of-command decision-making, division of labor, and rules and regulations. Such theories were originated by early 20th-century industrial thinkers such as Max Weber, Frederick W. Taylor, F. W. Mooney, and Henri Fayol. Approaches focused on organization and processes. They included time-and-motion studies, mechanisms, and bureaucracy. Advantages of such theories were clear organizational boundaries and efficiency. Disadvantages included rigid rules, slow decision-making, authoritarianism, and bureaucracy (Garrison, Morgan, & Johnson, 2004).

Behavioral and Trait Theories

In the mid-20th century, management focus turned away from the organization and moved toward people within the organization. Theories that emerged may be referred to as behavioral or trait theories. Even with a new focus on people rather than organizations, early behavioral theories promoted linear thinking, compartmentalization, functional work, process orientation, clear

and fixed job requirements, and predictable effects (Capra, 1997; Cook, 2001; Wheatley, 1994).

WORKER STYLE THEORIES

Other early behavioral theories moved the focus from people, or even leaders themselves, to an emphasis on the *concept* of leadership. Thus, the ideas of leadership styles emerged. Styles were considered people based, task based, or a combination of both. Such styles include authoritarian, democratic, and laissez-faire (Lewin, Lippitt, & White, 1939). Leaders were expected to determine objectives, initiate action, and coordinate the efforts of workers. These early theories set the stage for modern theories of management by objectives (Williams, 2017).

Problems with behavior or style theories are related to the issue of context. For example, in the heat of a crisis, such as pandemic influenza, which style is most effective? Theory X or Theory Y? Do the styles describe all aspects of the personality, character, motivation, or behavior of the leader? Do the behavioral styles account for all situations? Which, if any, style is uniquely applicable to leaders in healthcare? Another important question is, "Do all individuals respond to certain styles or do followers require some tailoring or combination of styles?"

LEADER TRAIT THEORIES

Current trait theories seem, in some respects, to return to an old "great person" approach as they target the intellectual, emotional, physical, and personal characteristics of the leader. Trait theories propose that desirable characteristics of successful leaders may be learned or developed. Trait theories continue to be popular. Just pass by a bookstore in any airport to find shelves full of business or leadership self-help books based on some list of qualities, behaviors, or habits marketed for success. The notion of successful leadership traits cannot be denied, but the science of predicting optimal traits under differing circumstances has still not matured.

Emotional intelligence is increasingly recognized as an important characteristic of effective and successful leaders. It may be considered here among trait theories. It includes self-awareness, self-management of emotions, empathy, and effective communication and relationship management. These characteristics allow leaders to deal with the daily challenges in healthcare organizations by understanding how they respond to stress, how to regulate emotions such as anger and resentment, and how to make decisions and communicate their rationale to others. Since Goleman's original work on emotional intelligence in 1995, his work continues to influence leaders in many areas, with growing use in nursing and medicine (see Carragher & Gormley, 2017; Goleman, Boyatzis, & McKee, 2002; Heckemann, Schols, & Halfens, 2015; Johnson, 2015; Lewis, Neville, & Ashkanasy, 2017).

See Table 1.1 for examples of behavioral and trait theories over time.

TABLE 1.1 Examples of Behavioral and Trait Theories for Leadership

THEORY	MAJOR PRECEPTS	CONTRIBUTIONS TO OUR KNOWLEDGE ABOUT LEADERSHIP
Theory X Theory Y (McGregor, 2006) Theory Z (Ouchi, 1981)	Theory X is a directive style, wherein the leader makes decisions, gives directions, and expects compliance. Follower productivity is related to incentives and punishments. Theory Y is a participative style, wherein the leader seeks consensus. Followers focus on quality and productivity and are rewarded for problem-solving. The theory Z leader promotes employee–follower well-being on and off the job to promote high morale, satisfaction, stable personnel employment, and high productivity.	The leader is a motivator and role model for follower behavior.
Leadership attributes (Gardner, 1989)	Leadership attributes include physical vitality and stamina, intelligence and action-oriented judgment, eagerness to accept responsibility, task competence, understanding of followers and their needs, skill in dealing with people, need for achievement, capacity to motivate people, courage and resolution, trustworthiness, decisiveness, self-confidence, assertiveness, and adaptability.	This promotes less "theory," with associated concepts and propositions, and more "lists" of preferred characteristics or activities.
Eight habits (Covey, 1989, 2004)	Eight habits of successful leaders: • Be proactive and take goal-directed action rather than reacting to circumstances • Begin with the end in mind—goal oriented • Put first things first—distinguish important versus urgent • Think win–win—negotiate to mutually benefit • Seek first to understand, then to be understood—listen • Synergize—engage in activities that amplify most effective aspects of all leadership habits	The first seven habits codified commonsense principles in a national bestseller of the popular business literature. Later Covey added the eighth habit of "finding your voice."

(*continued*)

TABLE 1.1 Examples of Behavioral and Trait Theories for Leadership (*continued*)

THEORY	MAJOR PRECEPTS	CONTRIBUTIONS TO OUR KNOWLEDGE ABOUT LEADERSHIP
	• Sharpen the saw—attend to personal maintenance and renewal • Find and express your voice in vision, discipline, passion, conscience	
Leadership attributes (Shirey, 2006, 2009, 2017)	Leadership attributes: genuineness, trustworthiness, reliability, compassion, believability	Provides another list of commonsense effective characteristics.
Leadership competencies (American Organization of Nurse Executives, 2005)	Leadership competencies: • Communication and relationship-building • Knowledge of the healthcare environment • Leadership • Professionalism • Business skills	Provides a list of specific skills related to nursing leadership.

Situation/Contingency and Constituent Relationship Theories

Situational theories grew largely as a reaction to trait theories, proposing the opposite premise that the characteristics of the situation, rather than personal traits of the person, produced the leader (see Table 1.2). Theorists called for a repertoire of leadership traits or styles and defined the appropriate style for specific types of situations. Building on the work of Lewin et al. (1939), situational theory would propose that authoritarian leadership may be required in a time of crisis, a democratic style in situations for team or consensus building, and laissez-faire style in traditional single-purpose, well-established organizations.

REFLECTION QUESTIONS

1. What do you think are ideal conditions under which one learns successful leadership traits?
2. What leadership traits might be needed in a leader of a state public health department? Are these similar to those needed by the chief nursing officer of a large hospital system? If different, which ones are needed and why?
3. What leadership traits do you think would be most predictive of effectiveness in a particular role?
4. Which theory best "fits" your perception of effective leadership?

TABLE 1.2 Examples of Situational and Constituent Interaction Theories for Leadership

THEORY	MAJOR PRECEPTS	CONTRIBUTIONS TO OUR KNOWLEDGE ABOUT LEADERSHIP
Path–goal theory (House, 1971)	Leader responds to follower motives in working relationships. Leader identifies and removes barriers, gives support and direction, secures resources, and facilitates goal or task achievement of followers. Leader focuses on followers' needs for affiliation and control by promoting clarity of expectations and supportive structure. Describes transactional leader behaviors as achievement oriented, directive, participative, or suppressive. These are connected to environmental and follower factors or situations.	Leader influences followers' perceptions of work and goals and creates paths to attain these goals and expectancies for goal attainment.
Situational leadership theory (Hersey & Blanchard, 1977; Hersey, Blanchard, & Johnson, 2008)	Four leadership styles and associated situations: • Telling, or giving direction • Selling, or participatory coaching • Participating, or sharing decision-making • Delegating, or assigning responsibility for task or goal achievement	Expands scenario in which leadership occurs to include follower and situational needs.
Leader in context of quanta and chaos theory (Porter-O'Grady & Malloch, 2011)	Recognition of phenomena of disequilibrium, disorganization, or chaos to lead a natural course to new orders. Constant change is a way of being. Leadership and organizations can thrive on the paradox that order can emerge from disorder. Principles: • Partnership • Accountability • Equity • Ownership	Application of "New Age" theories from physics to leadership. Allowance for phenomena beyond the control of the leader to evolve and emerge.

(*continued*)

TABLE 1.2 Examples of Situational and Constituent Interaction Theories for Leadership (*continued*)

THEORY	MAJOR PRECEPTS	CONTRIBUTIONS TO OUR KNOWLEDGE ABOUT LEADERSHIP
Emotional intelligence (Goleman et al., 2002)	Monitoring of emotional perceptions of self and others. Domains: • Self-awareness • Self-management • Social awareness • Relationship management Five steps to advance as leader: • Identify "ideal self" • Identify "real self" • Create a plan to build on strengths • Practice the plan • Develop trust and encourage others	Expands concepts of social–emotional aspects of human relationships to complement traditional business management/leadership competencies.
Servant leadership (Van Dierendonck, 2011)	Leader's motivation is to serve and meet the needs of others. Rather than directing followers, the leader inspires, motivates, influences, and empowers. Ten characteristics: • Humility • Empathy through framing questions • Authenticity • Awareness • User of persuasion • Interpersonal stewardship • Foresight • Provide distraction • Commitment to the growth of people • Co-builder of learning/working communities	Servant leaders combine their motivation to lead with a need to serve others.

Thus, the leader would adjust behaviors according to circumstances of worker experience, maturity, and motivation. Less-motivated workers would require a directive task focus, and highly motivated workers would require a focus on support and relationships. See Table 1.2 for examples of situational and constituent theories.

Situational/contingency theories represented attempts to consider both the leader and the situation. However, studies over the past few decades were most often done in typical American, middle-class, male organizations with little regard for situations or styles that considered gender, culture, political climate, or specific types of organizations such as those of healthcare. Relationship-based theories, which evolved more recently, paved the way for more transformational theories in the 21st century that are believed to be critical to the success of any organization and leader. They also expanded thinking to incorporate the notion that engaged followers are an essential part of any leader's effectiveness.

WHAT IS TRANSFORMATIONAL LEADERSHIP?

As you thought about your answers to the earlier reflection questions, did you think of certain individuals who were more effective than others as leaders in your own experience? Or did you ask yourself some basic questions such as, "What is leadership?" or "Who are the leaders we need?" Leadership is one of those difficult concepts that is sometimes readily identified but never easily defined. Simply put, leadership is the discipline and art of guiding, directing, motivating, and inspiring a group or organization toward the achievement of common goals. It includes the engaging and management of people, information, and resources. It requires energy, commitment, communication, creativity, and credibility. It demands the wise use of power. Leadership has been defined by many people over the years.

Leadership is the ability to guide others, whether they are colleagues, peers, clients, or patients, toward desired outcomes. A leader uses good judgment, wise decision-making, knowledge, intuitive wisdom, and compassionate sensitivity to the human condition—to suffering, pain, illness, anxiety, and grief. A nursing leader is engaged and professional and acts as an advocate for health and dignity.

You might also ask at this point, "But what does a leader *do*?" Leaders "are people who have a clear idea of what they want to achieve and why" (Doyle & Smith, 2009, p. 1). They are usually identified by a title or position and are often associated with a particular organization—but not always. Leaders are the resource for confidence, assurance, and guidance. Renowned leadership guru Peter Drucker (2011) listed the following things leaders must *do* to be effective:

- Ask what needs to be done.
- Ask what is right for the enterprise.
- Develop action plans.
- Take responsibility for decisions.
- Take responsibility for communicating.
- Focus on opportunities, not problems.
- Run productive meetings.
- Think and say "we" not "I."

These are pragmatic but highly effective strategies to motivate others, improve the organization, and empower followers to achieve excellence. Not a single item on the list is easy or straightforward, but each provokes thinking and action. All can be learned behaviors if one is open to that learning.

Leaders are seldom born, made, or found by luck, but rather they emerge when preparation, character, experience, and circumstance come together at a time of need. Those leaders build on strong leadership characteristics they always had. Leaders are most often ordinary people demonstrating extraordinary courage, skill, and "spirit to make a significant difference" (Kouzes & Posner, 2007, p. xiv).

So, you can prepare yourself and learn to be a leader. That is one reason you seek additional education. Others in your environment can and will support, coach, and mentor you as you learn to know yourself and your strengths, try on new behaviors, and own your future. The purpose of this book is to help you as an advanced clinician to prepare to become a transformational leader.

Transformational Leadership

Simply defined, transformational leadership is a process through which leaders influence others by changing the understanding of others of what is important (Broome, 2013). An operative word here is *process*. It is not just a list of attributes or characteristics but a dynamic and ever-evolving style that is focused on self, others, the situation, and the larger context. Transformational leaders inspire others to achieve what might be considered extraordinary results. Leaders and followers engage with each other, raise each other, and inspire each other. Transformational leadership includes value systems, emotional intelligence, and attention to each individual's spiritual side. It connects with the very soul of the organization and honors its humanity. It raises "human conduct and ethical aspirations of both the leader and the led and, thus has a transforming effect on both" (Burns, 1978, pp. 4, 20). Transformational leaders are energetic, committed, visionary, and inspiring. They are role models for trust. Their leadership is based on commitment to shared values. For over a decade, nurses have discussed the need for transformational leaders. Where and how leadership is truly "transformational" in nursing and healthcare may still not be clear, but there is no question that such leadership is much needed.

The original concept and foundational theory for transformational leadership are attributed to James MacGregor Burns, who proposed the idea in 1978. Other leadership scholars continue to build on the principle. Bass (1985) developed the concept of a continuum between transactional and transformational leadership. As noted earlier, Goleman further advanced the perspective to include aspects of emotional intelligence, such as self-awareness, self-management, social awareness, and relationship management (Goleman et al., 2002; Heckemann et al., 2015). Bass, Avolio, and Jung (2010) created an instrument to measure transformational leadership, and many studies have

been conducted in diverse settings and disciplines to examine leadership among various groups. Since this book does not embrace a sole theoretical perspective, transformational leadership is considered here in its best and broadest sense, as a context and backdrop for leadership development.

Components of Transformational Leadership

Though we refer to transformational leadership in its broadest sense, without strict adherence to a specific theoretical framework, it is important to recognize and review the foundational seminal work on the concept. Some of the core concepts of transformational leadership, as developed by theorists Burns and Bass (Bass, 1985, 1990; Bass, Avolio, Jung, & Berson, 2003; Bass et al., 2010; Bass & Riggio, 2006; Burns, 1978), are outlined in the following paragraphs.

CHARISMA OR IDEALIZED INFLUENCE

A transformational leader is a role model of values and aspirations for followers. He or she inspires trust and commitment to a cause. Charisma refers to the ability to inspire a vision. Unlike the individual with narcissistic charisma, who focuses on self, the person with charisma of idealized influence finds effectiveness stemming from a strong belief in others. Charisma is the ability to influence others, to inspire not only a willingness to follow, but also an expectation of success, an anticipation of becoming part of something greater than self. Charismatic leaders know who they are and where the organizational unit they are leading has the potential to go. They have themes and personal mantras in their lives. One leader keeps a file called "Dream" that holds ideas about future opportunities, or another keeps a hand-drawn diagram of her "Tree of Life" showing the roots, trunk, and branches of her life and future. Charismatic leaders, grounded in a commitment to values, influence others to make a positive difference in the world. Healthcare needs such leaders. Indeed, one study demonstrated higher satisfaction and greater happiness among workers who follow a charismatic leader (Erez, Misangyi, Johnson, LePine, & Halverson, 2008). On the other hand, other researchers found that leaders too high in charisma may be less effective because they are not able to engage in operational demands. Their conclusion was that too little charisma brings less strategic thinking and behavior, while too much may not get the job done (Vergauwe, Wille, Hofmans, Kaiser, & DeFruyt, 2018).

Charismatic leaders often emerge in times of crisis. They exhibit personal qualities that draw people to believe and follow them. If they are wise, they inspire followers in a synergistic manner that provides safety, direction, beliefs, and actions that exceed the expectations of either follower or leader.

To be charismatic does not mean to be flamboyant. Indeed, the most successful leaders "blend extreme personal humility with intense professional will" they are often "self-effacing individuals who display the fierce resolve

to do whatever needs to be done to make the [organization] great" (Collins, 2001, p. 21). In their early seminal study of 28 elite companies (i.e., those who moved from "good to great"), Collins and colleagues found that level 5 (transformational) leaders channeled their ego away from themselves to the larger goal of building a great company. They were ambitious—but more for their organization than for themselves. One charismatic leader shared, "I want to look out from my porch at one of the greatest companies in the world someday and be able to say, 'I used to work here'" (Collins, 2001, p. 26). Collins also later confirmed that the steady commitment to move forward, such as "turning a flywheel," creates momentum toward success for the entire enterprise (Collins, 2019).

Charisma may refer to a quality of authenticity, transparency, and trust that draws others to you to share the vision and the will to work toward the goal. Kouzes and Posner (2012) noted that such leaders may be ordinary people who accomplish extraordinary results by being role models, being examples, and leading by behavior that authentically reflects the behaviors expected of and admired by others.

INSPIRATION AND VISION

Transformational leaders also create a compelling vision of a desired future. Kouzes and Posner (2007, p. 17) explained, "Every organization, every social movement, begins with a dream. The dream or vision is the force that invents the future." Thompson (2019) outlined how successful leaders create a shared vision: Be clear about the desired destination, dream big, communicate a strong purpose, and set strategic goals. Transformational leaders influence others by high expectations with a sight toward the desired future. They set standards and instill others with optimism, a sense of meaning, and commitment to a dream, goal, or cause. They extend a sense of purpose and purposeful meaning that provides the energy to achieve goals. They inspire from a foundation of truth.

INTELLECTUAL STIMULATION

The transformational leader is a broadly educated, well-informed individual who looks at old problems in new ways. He or she challenges boundaries, promotes creativity, and applies a range of disciplines, ideas, and approaches to find solutions. This involves fearlessness and risk-taking. The transformational leader in healthcare reads broadly, takes lessons from many disciplines beyond clinical practice, and engages as an interested citizen in public discourse on a full range of topics. Such a leader may find strategies from the arts and literature, humanities, business, or other sciences. He or she consults experts from a variety of fields and settings to weigh in on complex problems faced by the organization. Such leaders ask questions. Asking questions about problems, large and small, allows leaders to understand the landscape in which the

problem "lives," and they can pull together teams to work on the problem and encourage, expect, and nurture independent and critical thinking. The transformational leader assumes that people are willing and eager to learn and test new ideas.

INDIVIDUAL CONSIDERATION

The transformational leader has a kind of humility that looks beyond self to the mission of the organization and the value of the work of others as individuals. He or she uses many professional skills including listening, coaching, empathy, support, and recognition of the contributions of followers. The transformational leader enables others to act toward a shared vision. The effective leader recognizes and promotes the contributions of others and creates a culture of sharing, celebration, and unity within the entire team. Who gets the credit is less important than how team members affirm each other's work.

Transformational leaders effectively build on these characteristics and integrate principles from a variety of leadership theories and pragmatic approaches to advance, enhance, and expand clinical expertise from a focus on direct individual patient care to a focus on the care of groups, aggregates, and entire populations in a variety of environments. They consider the individual and the aggregate at once.

Recently, in addition to a plethora of reviews about transformational leadership and leadership in general, there have been some studies on how leaders in nursing demonstrate transformative leadership and influence followers. Fischer (2016) found transformational leadership in nursing to include "high-performing teams and improved patient care," but it is not considered to be a set of skills or competencies that can be taught. Masood and Afsar (2017) found a relationship between transformational leadership and innovative work behavior when combined with knowledge sharing of best practices and mistakes. Lin, Maclennan, Hunt, and Cox (2015) identified a relationship between transformational leadership and nurse job satisfaction and organizational commitment. Yet, we know little beyond the description of actions of such leaders (Broome, 2013; Disch, 2017a; Disch, Edwardson, & Adwan, 2004; Giddens, 2018). Hutchinson and Jackson (2013) confirmed that there is little applicable research or critical review of transformational leadership in nursing literature. We still know little about how transformational leadership works, or what it ultimately means to followers and patients. Such research and role models must emerge from the next generation of leaders. It is your job to envision and articulate the prototypes for transformational leadership in healthcare for the future or to test their effectiveness. The transformational leader must make a conscious decision to lead. Often, competent nurses are given opportunities to supervise or manage, but successful leaders choose to lead. And some individuals find they learn a great deal very quickly and go on to build on that experience and become transformational leaders, while others find the emotional costs and

BOX 1.1 LEADERSHIP IN ACTION: PERSONAL REFLECTION ON LEADERSHIP

Elaine Sorensen Marshall, PhD, RN, FAAN

I remember the first "official" day I was required to be a leader. I had been out of nursing school for less than a year, working at a job I loved as a staff nurse on a medical–surgical unit in a large flagship hospital. The nurse manager, then referred to as the team leader, called in sick. One by one, calls to all the other usual suspects to take her place were in vain. The house supervisor came to me and said, "You are *it* today. You are in charge. I will be available if you need anything." I was left in charge of a unit staff of one other registered nurse, two practical nurses with more bedside experience than I had in years of life, two nursing assistants, and 22 very sick patients. My heart raced simultaneously with the surge of excitement and panic. I will not violate privacy regulations here to tell you all the near-death adventures that day, but I can say that it was probably not the ideal first step on a path toward transformational leadership. I did learn, almost immediately, what worked and what did not work to inspire or influence others. Eventually, over a lifetime, I gained knowledge, insight, and experience as a transformational leader, but I always return to that summer day when I learned the "sink or swim" theory of leadership. I learned that my heart was in the right place, that I wanted to care for others, that I had some innate abilities to influence others for good, that I was a natural goal setter, that I had fairly good judgment in making decisions, and that others trusted me. But I had no specific knowledge of how to lead, no preparation for leadership, no coach or mentor, little confidence, and not much insight on organization of resources to meet what came next. I knew only that I was in a situation that needed a leader, and on that day, I was recruited and stepped up to it.

Since that day, I have had the benefit of advanced education, professional leadership training, and years of experience in academic leadership. I have led teams in private and public settings as well as a large academic health center. My joy has been to help others to grow and watch them flourish.

BOX 1.2 LEADERSHIP IN ACTION: PERSONAL REFLECTION ON LEADERSHIP

Marion E. Broome, PhD, RN, FAAN

I spent my early career learning how to be a competent nurse, then nursing educator, and then nurse researcher—always focused on improving the care of children and their families. Twelve years after I graduated with my BSN, and 2 years after completing my PhD, I assumed my first administrative role, as an associate dean for research. For the first time in my nursing career I found myself on the

(*continued*)

BOX 1.2 LEADERSHIP IN ACTION: PERSONAL REFLECTION ON LEADERSHIP (*continued*)

"side" of hearing the complaints, issues, and needs of nurses in the organization, in this case related to support for faculty research development. I must admit I was not entirely prepared for the responsibility of "fixing the problems" the faculty brought to me. However, once I began to reframe the issues—as problems to be solved, systems to be put in place so faculty could be successful—and honed my listening skills to focus intently on what a person was really asking for, my enthusiasm for the job increased. I began to see myself as a problem solver and someone who needed to have a vision for how things could be. To my amazement, I enjoyed solving problems, and I enjoyed thinking about how to make the systems we had in place work better. I also learned quickly that while you could tell others their issue was solved, it was not until they actually worked with the office (to submit a grant, to develop an institutional review board [IRB] proposal, or to hire personnel), and things went smoothly, that they became true believers. It seemed so easy (and fun). For me, the real satisfaction of leadership was seeing others be able to achieve their goals with the least amount of hassle and the most amount of perceived support. Then they could dream bigger and better and move the whole organization ahead!

time investment of leadership not to be congruent with where they see themselves making a contribution. In Boxes 1.1 and 1.2 we share our personal leadership stories.

MANAGEMENT AND LEADERSHIP: IS THERE REALLY A DIFFERENCE?

In their zeal to promote charismatic transformational leadership, some writers make unfortunate distinctions between managers and leaders, as though managers are undesirable, and leaders are more effective across all situations. Jennings, Scalzi, Rodgers, and Keane (2007) reviewed the literature to find a growing lack of discrimination between nursing leadership and management competencies.

Traditionally, managers are thought to control and maintain processes with a focus on the short term, relying on authority rather than influence, while leaders are visionary, insightful, and influential. Managers minimize risk, and leaders maximize opportunity. In reality, most leaders will tell you it is important to know enough about processes in one's organization to be able to decide what new directions to take and how to assess the efficiencies of a unit to preserve or redirect resources. It is likely a matter of balance between the two sets of competencies of manager or leader that is crucial to master.

Transformational leadership theorists refer to the manager style as transactional leadership (Bass et al., 2010). Transactional leaders primarily motivate others by systems of rewards and punishments. Their power lies largely in the authority of their position. A manager may be referred to as the "laissez-faire" supervisor who provides little direction or motivation for change, leaving most decision-making to the followers. Transformational leaders, on the other hand, develop, innovate, focus on developing others, inspire and create trust, and hold a long-term, big-picture, futuristic view.

The reality is that anyone in charge of a group of people working toward effective goal achievement needs the wisdom to develop and use the qualities of both manager and leader in different situations. Williamson (2017, p. 4) asserted that "nurses are called to leadership" regardless of the position title of leader or manager. Thus, the terms *manager* and *leader* may be used interchangeably, as appropriate, in this book, not for lack of precision, but with the view that the characteristics of each are needed in effective leadership. Effective leaders (and managers) rely on a broad repertoire of style, rather than specialization of techniques. And neither should rely on their position to motivate or reward others. You must be able to distinguish when incentive/punishment motivation is needed versus when charismatic inspiration will achieve the desired results, or even when "well enough" is left alone. The next generation of leaders will be required to blend techniques of artistic management and wise leadership, all "on the run," in a rapidly changing healthcare environment (Bolman & Deal, 2013). Indeed, early studies of military platoons in combat (the ultimate fast-paced and stressful environment) showed both transformational and transactional leadership to be positively related to group cohesion and performance (Bass et al., 2003). Researchers have compared the effects of transformational leadership with other leadership styles and have found high correlations among all styles with organizational outcomes, employee satisfaction, and change management (Fischer, 2016; Lin et al., 2015; Molero, Cuadrado, Navas, & Morales, 2007), confirming the idea that a variety of leadership styles and approaches can be effective in differing roles and circumstances (Burke, 2017).

ROLE OF THE DNP IN ORGANIZATIONAL AND COMPLEX SYSTEMS LEADERSHIP

You have taken a step toward assuming leadership for the profession by pursuing the DNP degree. From the beginning of the development of the degree, leadership development has been a high priority (Lenz, 2005). Indeed, the need for leaders prepared in advanced clinical practice was a precipitating factor in the earliest discussions of the DNP. Since the inception of the DNP, leadership roles have been studied and promoted as essential to healthcare practice and education (see Gosselin, Dalton, & Penne, 2015; Malloch, 2017; Morgan & Tarbi,

2016; Smith, Hallowell, & Lloyd-Fitzgerald, 2018; Tyczkowski & Reilly, 2017; Walker & Polancich, 2015;). Broome (2012) proposed that doctorally prepared nurses will bring unique expertise to several areas, including innovative educational approaches, patient management knowledge and expertise, theoretical expertise, research methods expertise (both qualitative and quantitative), statistical and analytical expertise, and political awareness. They will also open doors to new roles and positions to gain entry to care for specific patient populations at the highest levels.

When leaders in nursing education developed DNP programs in the early part of the 21st century, we joined other practice disciplines, such as medicine, optometry, pharmacy, physical therapy, and audiology, which had elevated their practices and leadership by preparing practitioners with the highest professional academic degree. The American Association of Colleges of Nursing (2004, 2015) affirmed the fundamental need for DNP-prepared leaders, noting that "the knowledge required to provide leadership in the discipline of nursing is so complex and rapidly changing that additional or doctoral level education was needed."

One of the competencies listed in the *Essentials of Doctoral Education for Advanced Nursing Practice* (*DNP Essentials*) (American Association of Colleges of Nursing, 2006, p. 10) is "Organizational and systems leadership for quality improvement and systems thinking." Specifically, DNP graduates should be prepared to:

- Develop and evaluate care delivery approaches that meet the current and future needs of patient populations based on scientific findings in nursing and other clinical sciences, as well as organizational, political, and economic sciences.
- Ensure accountability for the quality of healthcare and patient safety for populations with whom they work.
- Use advanced communication skills/processes to lead quality improvement and patient safety initiatives in healthcare systems.
- Employ principles of business, finance, economics, and health policy to develop and implement effective plans for practice-level and/or system-wide practice initiatives that will improve the quality of care delivery.
- Develop and/or monitor budgets for practice initiatives.
- Analyze the cost-effectiveness of practice initiatives accounting for risk and improvement of healthcare outcomes.
- Demonstrate sensitivity to diverse organizational cultures and populations, including patients and providers.
- Develop and/or evaluate effective strategies for managing the ethical dilemmas inherent in patient care, the healthcare organization, and research. (American Association of Colleges of Nursing [AACN], 2006, pp. 10–11)

Although early in its development, the DNP was met with controversy within the discipline of nursing (see Chase & Pruitt, 2006; Dracup, Cronenwett, Meleis, & Benner, 2005; Joachim, 2008; Otterness, 2006; Webber, 2008). Some leaders proclaimed that "the question facing the nursing community is no longer whether the practice doctorate is 'future or fringe'" (Marion et al., 2003), but rather how do we move forward together (O'Sullivan, Carter, Marion, Pohl, & Werner, 2005). As of 2017, there were 135 PhD programs in nursing with enrollment of 4,698 (AACN, 2017). As of 2018, there were 348 DNP programs with enrollment of 32,678 (AACN, 2018). Clearly, the DNP degree has been embraced by many nurses in practice who want to take their careers as practitioners to a new level and provide leadership and expertise to shape care delivery. Clearly, new models of care are needed, designed by nurses prepared at the highest levels of practice and education (see Mason, Martsolf, Sloan, Villarruel, & Sullivan, 2019). Graduates of DNP programs are fulfilling the hope for a new, more effective advanced practitioner and healthcare leader.

Taken together, the complexity of healthcare systems, emphasis on evidence-based practice and information management to improve patient outcomes, information explosions in science, advances in technology, and a new world of ethical issues only amplify the need for new leadership grounded in expert clinical practice. It is the hope of the profession that the DNP-prepared leader will offer the highest level of practice expertise and have the skills to translate knowledge into evidence, as well as practice-based evidence into better outcomes for patients and families (Zaccagnini & White, 2017). As a DNP-prepared leader, you will be expected to guide and inspire organizational systems, quality improvement, systems and analytical evaluations, and policy development and translation, and to forge intra- and interdisciplinary collaborations to improve patient health outcomes (Broome, 2012). Much of this important work is done in context and collaboration with interprofessional teams. We elaborate more on this later, but at the outset of considering yourself a leader, it is critical to understand the style, dynamics, and climate of interprofessional collaboration (Agreli, Peduzzi, & Bailey, 2017; Disch, 2017b) and team-based care.

Prepared at the highest level of practice, you will understand the broad perspective of resource management in a sociopolitical environment to influence policy decisions and use your influence to lead teams to develop and test new care models. There is every reason to hope that you will be able to invent systems of care yet unknown that will strengthen, correct, and transform healthcare systems as we know them today. You will work with teams from various disciplines and various levels of preparation and backgrounds even in nursing. The success of teamwork is the goal and responsibility of the transformational leader. Transformational leaders in nursing include those with preparation at a variety of levels.

ROLE OF THE PhD-PREPARED NURSE IN PRACTICE AND LEADERSHIP

Many hospitals throughout the United States, especially those in academic health centers, employ nurses prepared with the Doctor of Philosophy (PhD) degree to lead various sectors of the enterprise, including education, professional development, and research. PhD-prepared nurses are also most commonly employed in academic institutions. You might ask, "What is the difference between the two degrees and their preparation? How will we work together?" The PhD is not a professional degree but rather the highest research-focused academic degree given across a variety of disciplines. The PhD program and degree require the student to understand the philosophy of science and the nature of knowledge, and to master, extend, and generate knowledge for the discipline through research.

PhD programs provide graduates with an understanding of the environment within which nurses practice and prepare graduates to advance the science of the discipline (Broome & Fairman, 2018). The core of the PhD program is an understanding of nursing and the development of competencies to expand science that supports the discipline and practice of nursing (AACN, 2010). Since the mid-1990s, hospitals and health systems have employed nurse scientists to engage in the development and testing of interventions designed to improve patient outcomes. In addition, these nurses collaborate with researchers in other practice disciplines to develop and evaluate evidence-based initiatives to improve care delivery. DNP- and PhD-prepared nurses will find themselves as collaborative team members or leaders of teams to develop, test, and translate knowledge that has the potential to improve patient outcomes (Broome, 2012; Gilbert, Von Ah, & Broome, 2017). The complementary in-depth skill base of both fields of study can maximize effectiveness and efficiency of any initiative.

BRINGING THE PERSPECTIVE OF DOCTORALLY PREPARED NURSES TO ENHANCE LEADERSHIP: ENVISIONING NEW ROLES

The professional background of the advanced clinician provides the unique opportunity for new eyes to examine the leadership tradition, including the vision of new roles for the leader and others. We cannot tell you what new roles you will envision or be expected to fill. We can only help you prepare to invent and lead in those roles. You must be fearless and creative to envision the role. If you reach deep into your own knowledge and find the courage to step out of old habits, you will design and fulfill models that will work.

To become a transformational leader requires both theoretical and conceptual understanding of the real-world practice of leadership. It is beyond the scope of this book to explore the range of theories for nursing. Rather, we have focused on a broader scope of theories for leadership. Leadership is a discipline

in itself, with a body of knowledge, theories, culture, and practice expertise. By learning from theories and principles of leadership, then applying vision and courage, you will become a citizen of the community of leaders who will solve the problems of the future.

One of your major challenges as an advanced clinician and leader at the organizational level will be to shift the perspective of care from the individual patient to that of entire populations of patients, professionals, peers, and other stakeholders. Your world will broaden. This means you must learn new skills—especially the ability to "zoom in and zoom out" (Kanter, 2011) in the face of challenges. The ability to zoom out cannot be overestimated.

Evidence is mounting that links the influence of transformational leaders to both improved nursing practice at the bedside and positive patient outcomes in the aggregate (see Lin et al., 2015; Masood & Afsar, 2017). There continues to be a need for more research and practice results in this area, particularly those aimed at examining how effective leaders influence both patient and staff outcomes.

The expertise of the advanced clinician in the position of organizational leader offers a treasure trove of perspective, professional and personal knowledge, and in-the-trenches experience that is frequently missing in healthcare today. For example, in settings where the chief executive officer is not a clinician, it is often the chief nursing officer who provides the insight, experience, and model for clinical leadership. Clinical expertise brings context, credibility, and a dose of reality to a leadership position. So, many areas of healthcare will benefit from the clinical leadership roles yet to be invented.

Such roles are currently needed to achieve the quadruple aim of increased access to care, improved quality, decreased cost, and work meaning (Sikka, Morath, & Leape, 2015). New leaders are needed in such clinical areas as child

REFLECTION QUESTIONS

1. What are your goals and dreams as a DNP-prepared leader?
2. What are your greatest concerns about assuming the "mantle" of leader? What resources can you take advantage of now and in the near future to address those concerns?
3. Identify your own goals and strengths. Consult any of the numerous free strength aptitude tests online. Then respond to the following:
   a. What are your greatest strengths?
   b. How can you use these strengths in the practice setting?
   c. How will they be useful to you while in this graduate program?
4. Interview a nurse executive in your setting who hires nurses into advanced practice roles. What does he or she think is a good fit in the organization for the skill set of a DNP graduate?

health and risk reduction for chronic conditions, transitions of aging, symptom management, and palliative and end-of-life care. They are needed in settings of primary and acute care, as well as community and home care. We need leaders for new kinds of comprehensive preventive screening centers, immigrant health, Internet and telehealthcare, and other settings and practice areas yet to be imagined. In the environment of fast-paced complex systems, the bold and creative expert clinician will invent the new roles needed to lead care teams, patient groups, public interest groups, and organizations that may better manage challenges, solve problems, and take advantages of opportunities.

BECOMING A TRANSFORMATIONAL LEADER

As noted, transformational leadership is increasingly the focus of empirical study among healthcare organizations. For instance, one study examined the relationships among transformational leadership, knowledge management, and quality improvement initiatives among various departments in 370 hospitals in all 50 states. Results demonstrated that transformational leadership and quality management improve knowledge management. Researchers concluded that transformational leadership skills among healthcare executives promote effective knowledge of management initiatives that enhance quality improvement programs. Furthermore, the integration of transformational leadership, knowledge management, and quality improvement was closely associated with organizational and patient outcomes, including patient safety (Gowen, Henagan, & McFadden, 2009). The idea of transformational theories sometimes refers to a group of several different approaches that focus on "positive constructs such as hope, resiliency, efficacy, optimism, happiness, and well-being as they apply to organizations" (Avolio, Walumbwa, & Weber, 2009, p. 423), rather than on traditional models, some of which focus on deficit reduction, or working on what is wrong with a leader. Currently, transformative leaders are the best hope for mobilizing intellectual and social capital within their organizations to not only improve outcomes for patients but to enhance working environments for professional nurses (Gilbert et al., 2017).

From an empirical and theoretical perspective, evidence for the effectiveness of transformational theories remains to be demonstrated. Such theories continue to secure a major place in contemporary literature on leadership. There seems to be a hunger in society for the positive hope and promise of the transformational leader. The discipline of nursing offers a welcome laboratory to test the promise of transformational leadership. Nursing practice is grounded in concepts of caring and altruism; it already attracts people motivated toward self-actualization, achievement, and helping; and it embraces tenets of holism (Jackson, Clements, Averill, & Zimbro, 2009). Such principles are highly consistent with those of transformational leadership.

We have moved from the industrial era to an age of information, with the explosion of knowledge of facts and complexity of systems. You were likely trained as a clinician to meet the challenges of simply keeping up with growing information. Futurists predict with hope that the next generation will be the age of wisdom. What will be needed next are vision and wisdom regarding how to best employ information, resources, and people to meet healthcare needs within complex systems. Leadership can be learned and practiced, and you are in the right time and place to do it. Critical clinical skills and judgment, amplified and enriched by thoughtful, wise decision-making and leadership, are what are most needed now.

The challenge of the next decade for nurse leaders is to create an empirical foundation of evidence for best practices in leadership in complex healthcare organizations. Malloch and Melnyk (2013) described competencies and challenges for executive leaders. Their competencies include:

- Evidence-driven consciousness
- Cross-generation communication competence
- Innovation leadership expertise
- Work–life balance
- Commitment to lifelong learning
- Transdisciplinary teamwork and inspiring teams
- Management of dynamic time pressures
- Shaping policy

Leaders with such competencies promote nursing practice but must also invite interprofessional engagement in the bigger picture of healthcare. Perhaps the initiative of the advanced clinician in the organizational leadership role will launch that discovery. It is especially important to note that a working theory, empirically tested and specific to clinical leadership in complex healthcare systems, is yet to be developed, discovered, or invented.

Many impressive theories explain or guide leadership of people and organizations, but few have included the environment or setting as much more than an artifact or a backdrop, implying that context may not be relevant. As a healthcare provider, you know that the context of healthcare is uniquely challenging and complex. The innovative leader can think in terms of multiprofessional caregivers, patients, community, and context from a systems perspective. He or she understands not only leadership theory but also theories of complexity and complex adaptive systems. The new transformational leader will design new environments and systems for care—some we have not dared to imagine. Perhaps, theories of the past will be revised or proven altogether irrelevant. The world is waiting for your creativity to care for those in need, and to inspire other leaders to come together in new ways of thinking and practice. Transformational leaders of the future will see the world with a new vision, break old rules, discover or create new rules, and thrive in the paradoxes of

complexity. Innovation requires the space for creativity and the courage to be wrong. Mistakes teach as much as success. The truth is, there is often no right or wrong but, rather, change, diversity, and helping people come together to solve problems and help others.

Innovation is a paradox that requires a willingness to learn all you can, bring your clinical experience to bear, and then eagerly suspend previous learning and experience to welcome new ideas, recognize a different point of view, embrace chaos, winnow what must remain and what must change, and set a new course. These are not easy things to do, but leaders must encourage those in their environment to ask questions and seek out new and different solutions to challenges that present themselves over and over in healthcare.

THE PATH FORWARD IN THIS BOOK

The chapters that follow expose you to information and learning activities, media (see Box 1.3), cases, and sharing of expertise from key leaders in the field. You will learn about healthcare as a context in which the transformative leader must not just adapt but must lead others to shape a preferred future. We discuss current theoretical perspectives about change management, chaos, and complex organizations. We consider contemporary challenges related to technology, quality and safety, healthcare workforce issues, and consumer and provider satisfaction. And we note other issues related to success in achieving the quadruple aim of increasing access, decreasing cost, increasing quality, and finding meaning in the work of healthcare, with the goal of improving the health status of all. We share our knowledge and experiences about our own leadership journeys and how important it is to understand oneself as a leader.

You will learn how finance models influence care models, the importance of economics to healthcare (Platt, Kwasky, MacDonald, & Spetz, 2019), and understand how financial complexities and solutions are part of the work of the successful leader. We also discuss the importance of intra- and interprofessional team growth and management to help achieve an organization's goals, as well as how leaders can influence teamwork. Creating and shaping environments in which diversity is not just valued but embraced and used to maximize all individuals' contributions is the focus of one chapter and truly the primary job of any transformative leader. We close with the view forward for your career and provide some guidance for you to consider as you work with others outside of professional provider contexts, including boards of trustees, community boards, and policy makers. In sum, we hope this book serves you as you begin your next leadership journey. The authors and editors of this book have provided you with their best knowledge and wisdom about leadership, an overview of the evidence to support leadership development, and opportunities to reflect on where you have been, where you are now, and where you hope to be in the future.

BOX 1.3 NEW MEDIA: LEADERSHIP

TED Talks

Drew Dudley. "Everyday Leadership." https://www.ted.com/talks/drew_dudley_everyday_leadership

Roselinde Torres, PhD. "What It Takes to Be a Great Leader." https://www.ted.com/talks/roselinde_torres_what_it_takes_to_be_a_great_leader?language=en

Blogs

Big Is the New Small: Scott Williams addresses solution-based (vs. problem-seeking) focus. He uses thinking from a variety of disciplines.

Healthcare Leadership Blog #hcldr: Joe Babaian brings in guest bloggers and provides minitutorials on relevant topics in healthcare.

Podcasts

Leadership Development News: Drs. Cathy Greenberg and Reily Nadler. July 8, 2018. "Encore: Leadership in Healthcare: Challenges for the Future."

Dose of Leadership: Richard Rierson (#331). December 8, 2017. "Being a Leader, Not Just an Achiever."

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CHAPTER 2

Transformational Leadership: Complexity, Change, and Strategic Planning

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Change will not come if we wait for some other person or some other time. We are the ones we've been waiting for. We are the change that we seek.

—Barack Obama

OBJECTIVES

- *To describe how concepts in complexity and complex adaptive systems theories explain the context of today's healthcare environment*
- *To discuss how the individual leader takes a systems perspective to manage complexity*
- *To apply precepts of change theory to a case of implementation of a new model of care in a particular setting*
- *To describe the steps of strategic planning and how to mobilize talented individuals and teams to move initiatives through a system responding to continual change and new demands*
- *To identify why it is important to communicate to and engage others in the organization to a strategic plan*

INTRODUCTION

Effective leadership is rarely learned, developed, enacted, or evaluated outside the dynamic environment in which one works and leads. Although a context in which one could lead can be constructed, that is rarely the situation in which most contemporary leaders must learn to function. Instead, most of us inherit an environment that we are expected to grow and improve. We are called to enhance effectiveness and develop a work culture that supports the functioning of all members of the organization. Therefore, as a transformational leader, you

must acquire an ability to understand and function effectively within the realities of the context and environment in which you work.

Contemporary healthcare systems that survive and thrive in today's society continue to evolve and change (Box 2.1). Individuals in leadership positions are expected to help others assume new roles and models for doing their work, maintain high levels of employee satisfaction, and motivate others to "do their best"—even when it is not always clear what "best" would look like (Romley, Goldman, & Sood, 2015). And they must do this in an even more constrained financial market. The new jargon is all too familiar: *complexity*, *cost-effectiveness*, *change*, *value*, *employee engagement*, and *populations*. But what do these terms mean for the next generation of leaders?

These concepts all refer to context. In the past, the context of care was simple. It referred to *settings*, such as hospital, clinic, or home—all with simple linear and hierarchical models for care of the sick. Now the boundaries among these settings have blurred, and it is the transitions of what happens to patients (and providers) between and among such settings for which leaders are responsible. Now, and for the foreseeable future, context is everything. Organizational context is the circumstance of your work as a leader. Context refers to the multifaceted culture and climate, background, domain, and terrain of care delivery. It is more than just the setting or environment, although it includes those. It comprises all systemic, physical, social, emotional, professional, informal, and formal aspects of care. The context for leadership has become as challenging as any aspect of leadership itself.

BOX 2.1 NEW MEDIA RESOURCES: CHANGE IN HEALTHCARE

TED Talks

Dave Isay. "Everyone Around You Has a Story the World Needs to Hear." https://www.ted.com/talks/dave_isay_everyone_around_you_has_a_story_the_world_needs_to_hear?language=en

Daniel Kraft, MD. "The Pharmacy of the Future? Personalized Pills, 3D Printed at Home." https://www.ted.com/talks/daniel_kraft_the_pharmacy_of_the_future_personalized_pills_3d_printed_at_home

Twitter

Eric Dishman (@ericdishman): He does healthcare research for Intel and studies how new technology can solve big problems in the system for the sick and the aging.

Blogs

Center for Creative Leadership: https://www.ccl.org/blog/

Health Affairs and Policy: https://www.healthaffairs.org/blog

Beyond physical, social, or professional context, the context of our very thinking is challenged. The easy things have been done. Healthcare problems are complex. Our old ways of thinking will not bring us to solutions. We must have the courage to think in new ways.

COMPLEXITY IN HEALTHCARE SYSTEMS

Nearly every discussion of current issues and contexts in healthcare begins with mention of the complexity of the problems we face and solutions we must implement. Complexity has become the introduction, the theoretical explanation, and the metaphor for the current and future state of healthcare. Consequently, complex adaptive systems, engagement of employees, and patients/customers are discussed in so many situations that they have become the catch phrases of the industry, with little general agreement on definitions and even less precision of application. Nevertheless, the references to complex states and issues continue to prevail, and it is difficult to argue that complexity has no real influence on how we work and lead. Thus, it is helpful for any leader to have a basic awareness of such approaches to thinking about and practicing in a new world of healthcare. Space is not adequate in this book to provide the quick-and-easy comprehensive discourse on chaos and complexity theory often desired by the emerging leader. The concepts cross a wide range of disciplines in their meanings and applications. Many of the ideas have been applied to areas as divergent as biology and art. Further, application of such theories to the daily practice of a leader can be daunting. Nevertheless, the complexity should not intimidate you as a leader. These are topics that should be studied from a range of authors and perspectives. It is precisely because they are often discussed in areas far distant from healthcare that such theories provide an excellent opportunity for learning and practice for innovation in thinking and leading.

Chaos, Quanta, and Complexity Theory

Complexity science is applicable across many fields, including biology, physics, mathematics, economics, sociology, management, and healthcare disciplines and systems. It examines the nature and process of multiple interacting components of systems and the subsequent emergence of order and/or change (Wall, 2013). Complexity science applies to living systems, examining the unpredictable, disorderly, nonlinear, and uncontrollable way of phenomena. Importantly, leaders must understand that complex systems are in fact integrated and often predictable and support "emergence through novel behavior," wisdom, and wise use of disruptive innovations (Pesut, 2008b, p. 123, 2019; Pesut & Thompson, 2018).

Complexity science focuses on the interacting elements of systems, seeking to identify principles and processes that explain how order emerges from change within the systems. Change is desirable and a natural way of being, which demands action. Key principles of change management are transparency,

engagement, communication, support, training, feedback, and value (Hayes, 2018). Systems often have relationships among entities within them that reflect a high degree of systemic interdependence, which leads to nonlinear dynamics and outcomes (Goldstein, Hazy, & Lichtenstein, 2010). So, it is essential to understand how healthcare complexity and change affect everyone within the organization, from the CEO to providers, professional staff, and patients.

Theory of Complex Adaptive Systems

The theory of complex adaptive systems, as one aspect of complexity science, adds a dimension that describes the ability of organizations to adapt in an ever-changing environment (Goldstein et al., 2010). This adaptability drives new and creative solutions to problems within the system. Complexity is the result of patterns of interactions that are a result of the ever-changing demands on the system, as well as the attempts of individuals and teams in the system to derive and test partial solutions to problems. When these partial solutions can be harnessed and individuals with different perspectives brought together to examine the problem from all angles, a synergistic effect often occurs that results in a creative approach to address necessary changes and produce desired outcomes.

Most analysts of the contemporary healthcare scene mention complexity when referring to the complicated nature of all the structures, settings, and individuals. The term *healthcare system* has a variety of meanings itself. It may refer to the entire healthcare industry, including structures, processes, and personnel, or it may refer to a single hospital, ambulatory center, freestanding ED building, several hospitals under one organizational umbrella, or a system within any of those entities. Some may argue that although healthcare is complicated, it may not be the best example of a complex adaptive system. A complex adaptive system is characterized by flexibility and patterns of emerging change as opposed to predetermined change based on hierarchical or central control.

All clinicans can enumerate a long list of areas in healthcare that persist in their linear, hierarchical paradigm and approaches to solving problems. They can also point to numerous evolutions in the care delivery model close to the point of service that are clearly adaptations to complex new regulations, compensation structures, or patient demographics that have mandated change for the organization to survive. Complexity frameworks offer models to frame the issues in the current realities of healthcare toward a hopeful transformation to a better future. Indeed, some of the current problems of healthcare may relate to the challenging transition from traditional thinking to a complexity perspective.

There are several key characteristics of complex systems (Stroebel et al., 2005; Strumberg & Martin, 2013). They include the following:

- Emergence happens; behaviors, patterns, and order develop as a result of nonlinear patterns of relationships and interactions among the elements or units of the organization.

- Relationships are short range or interchanged from within a unit or near neighbors in a matrix of networks within the larger whole. The units, or parts, cannot contain, determine, or control the whole. Relationships are nonlinear, seldom cause-and-effect, and contain feedback loops.
- Feedback from those within the system may be dampening (negative) or amplifying (positive), and a small stimulus may have a large powerful effect or none at all.
- Boundaries are open; energy and information constantly cross boundaries and create constant change.
- Coevolution is a "process of mutual transformation" for both smaller units and the larger organizational environment.

The "fitness landscape" is how an organization fits within an independent/dependent interaction with other agents, units, or organizations. Table 2.1 contains examples of these characteristics within the healthcare arena.

TABLE 2.1 Characteristics of Complex Adaptive Systems With Examples in Healthcare Systems

CHARACTERISTICS OF COMPLEX ORGANIZATIONS	HEALTHCARE EXAMPLE
Emergence	Outpatient clinic systems have components each serving patients with different care needs and illness states. They require similar communication and monitoring systems across settings, providers, patients, and families.
Relationships: Nonlinear, short range, within a matrix	Nurses on patient care units must interact with numerous people at various levels, including patients, families, other nurses, physicians, laboratory personnel, administrative staff, and so on, on a daily basis.
Feedback loops	A small change in task of one role within a patient care model in one department can reverberate across departments and must be acknowledged, communicated, and integrated.
Open boundaries	Continual changes in regulations governing care and systems improvements require flexible and evolving policies developed with a diversity of input from stakeholders (e.g., providers, patients).
Mutual transformation of units across system	Two small community hospitals merge with an academic health center hospital. Units within each original organization must change as an emerging new system and culture replaces the original individual organizations.

The role of the leader in this system is to interact within the system in such a way that those interactions help others to understand how they are expected to relate to other units or agents within the system in the future—all with the goal of creating solutions to complex problems arising in the system (Strumberg & Martin, 2013).

NURSE LEADERS WITHIN COMPLEX HEALTHCARE SYSTEMS

Many ingrained cultural aspects of large complex healthcare systems may originate in their history as hospitals. American hospitals are laden with history and cultural stories. Throughout most of the 20th century, hospitals were powerful symbols of progress and modern society's affinity for science, technical procedures, and efficiency. In midcentury Western cities, the edifice of the hospital served as a sort of temple in the center of the community where people came as disciples of the art and science of medicine and submitted to its secular–divine authority. Hospitals and healthcare systems are now much more corporate and extend well beyond the traditional bricks and mortar of one building.

The concept of disruptive innovation is important to consider in leading in an environment of complexity (Christensen, Raynor, & McDonald, 2015; Fuller & Hansen, 2019). Leading within a complex healthcare organization requires an individual to be committed to learning, being flexible, and focusing on supporting others in their jobs and industries and how "the business of healthcare" works. Leaders must be facile with issues of disruptive innovations in healthcare, competition, changes in payment models used in care delivery across settings, regulations, and social determinants of health as those factors together influence the effectiveness of the care delivery system. Boston-Fleischhauer (2016, p. 487) pointed out that in healthcare leadership, "the ultimate goal of disruptive innovation is to ensure that care innovations are aligned with changing consumer and payer expectations, while ensuring safety, reliability, and cost-effectiveness." A foresightful leader anticipates and develops effective disruptive innovations for the organization (Pesut, 2019).

The current focus on healthcare reform has revealed the growing trend toward integrated healthcare systems with boundaries that span emergency and acute care, chronic care management, primary care, and population care management. The evidence to support the effectiveness of this model of integration is yet to be determined. An integrated system may be the answer in one sector, but likely not the only solution for all healthcare (Strumberg & Martin, 2013). Generally, integrated systems link a variety of services and systems, potentially increasing value and quality through seamless care across transitions and reducing costs. Such systems are becoming increasingly competitive in a social environment that demands improved safety, quality, and values-based clinical performance. And all providers will be expected to

develop new competencies to thrive in the world of an integrated care model (Delany, Robinson, & Chafetz, 2013).

It is clear that now is the time for nursing leaders to be prepared to take key leadership roles to the highest levels of such systems in the following areas:

- Ensuring quality and patient outcomes
- Promoting executive-level nursing leadership
- Empowering nurses' participation in clinical decision-making and organization of clinical care systems
- Supporting clinical advancement programs based on education, certification, and advanced preparation for all nurses
- Creating a culture in which collaborative relationships among members of the healthcare provider team are the norm
- Utilizing technological advances in clinical care and information systems (American Association of Colleges of Nursing [AACN], 2016)

The complex environment of healthcare must provoke the development of new strategies to guide professionals and patients through chaos and uncertainty. It requires a clear vision, a few simple rules, and the extension of freedom to support adaptation, evolution, and emergence.

We would argue that in contemporary health systems, nurse leaders must be skilled in creating environments in which nurses can care for patients across boundaries within and outside hospital walls. However, any change in care delivery models will produce some ripple effect across the settings in which the patient receives care. Such interactions among various groups of people or units form feedback loops that move the organization toward new landscapes of care. It is important to understand that such feedback loops are not conceptualized in the same way as feedback loops of traditional systems or leadership theories, where such loops serve to support homeostasis. Rather, feedback loops in complexity theory support communication within the larger organization, feeding new information and creative thinking throughout the organization. Interventions that restructure practice must focus on modifying peer group norms and expectations and provide feedback loops for providers that are based on the team's performance compared with others (Johnson & May, 2015).

Therefore, it is the nurse leader's job to interact with providers across settings and to be clear about expectations for linkages among and across various units. Proficient leaders can then influence optimal care delivery. Tradition-bound clinicians and leaders accustomed to predictable and controlled systems where change initiatives are based on top-down implementation of prescribed protocols or "best practices" will struggle with new expectations for organizational effectiveness.

Leaders of the next generation of nurses and other providers will embrace complexity and promote positive emergence. Sitterding and Broome (2015)

described the challenges inherent in contemporary healthcare in which clinicians are continually bombarded with information and changing expectations and conditions, all of which influence care delivery with potential consequences for errors and omissions. In this environment they described a "new nurse." This nurse leader is expected to be a knowledge-worker managing competing demands within a very dynamic work environment whose architecture is not always configured in a way to reduce complexity. Such new leaders are expected to help nurses to manage the complexities of information overload. Leaders can do this by the following:

- Supporting nurses to tunnel their attention during high-risk or error-prone situations (e.g., medication administration)
- Reminding nurses to avoid relying on memory, but instead to use the tools in the environment to prompt memory (e.g., technology)
- Identifying and eliminating factors that increase fatigue and workload in caregivers at the point of care
- Determining which data points and information are critical for nurses to manage and which other data points would be more useful for others to manage

Complexity in the environments in which we work promotes the opportunity for integrated independent autonomy, accountability, and action to prevent (rather than cause) errors in real time. We must move beyond the idea that complexity promotes error. Rather, we need to use "tools" (root cause analysis, for example) to analyze the processes within delivery of care to understand what promotes opportunity for errors and how to reduce and correct them. Inherent in the challenges of complexity are opportunities for creativity and power to make critical immediate decisions and actions that change lives for the better. But seizing these opportunities requires personal integrity, accountability, commitment, and creative leadership.

REFLECTION QUESTIONS

1. Where do you see aspects of traditional versus complexity contexts where you work?
2. Think about your current work environment. Identify a recurring challenge in care delivery that results in frustration, increased cost, fragmented care, or potential for errors. Identify the various factors that influence every aspect of the situation (personnel, process, etc.).
3. Generate several solutions to the problem you have identified. Now choose one of those and map out what relationships would need to be explored, strengthened, or connected to begin to plan the implementation of your solution.

(*continued*)

REFLECTION QUESTIONS (*continued*)

4. Now, using a three-option system, rate how time-consuming (not at all, a little, a lot) that solution or connection would be. Assess how many other relationships would need to be included to gather information, generate ideas about factors impinging on the problem, and so on. Estimate how much energy, effort, and time might that analysis take.
5. Develop a plan to address one of the linkages that seem to be putting the most stress for the system and have the potential to produce errors in care.
6. As you examine your plan, where would you begin to address the challenge you have identified if you were the leader of the area in which the challenge presented itself?

TAKING AN ORGANIZATIONAL AND SYSTEMS PERSPECTIVE

Clinicians who are accustomed to focusing on the care of individual patients often find it a challenge to acquire a larger organization and system perspective. In many ways, it is like learning a new language or engaging in a new culture. To gain the perspective of the entire organization or system requires a different way of thinking about why things happen and what factors are associated with events. Systems thinking includes an emphasis on how people and processes are related, how they work, and how they are connected. As you have learned after completing the reflection exercise, rather than thinking of a procedure or problem in a one step-at-a-time linear fashion, organization or systems thinking considers multiple ideas, activities, and people connecting in a matrix of processes. Many dimensions are played out at the same time. Systems thinking often requires a conceptual rather than a linear view.

Systems thinking is the only hope to solve some of the most complex and entangled problems. Cipriano (2008, p. 6) explained why systems thinking is critical for leaders in current healthcare settings:

> A systems thinker sees how the parts of an organization interact and how effectively people are working together. . . . Expanded thinking allows us to…imagine ways of solving problems.

Systems thinking is not simply moving the focus from the individual patient to the unit, organization, or even the institution. It requires an ability to begin with the big picture and to live in the world of an entire system. Most scientists and clinicians have been socialized according to a Descartian reductionist approach to deductively see the parts of the whole. Systems thinking is based

on an opposite inductive idea that the parts are best understood, and problems are best solved as they relate to the whole system.

A system is a dynamic and complex whole. Porter-O'Grady et al. (Davidson, Weberg, Porter-O'Grady, & Malloch, 2017; Porter-O'Grady & Malloch, 2011, 2016) explained the difference between elements of the institution and the system as a whole by emphasizing that within institutions, most of the operational work is compartmentalized and organized vertically and distal from the administrators. To lead any one element, a leader must direct his or her vision from the whole to the part.

The leader who is a systems thinker understands that systems are about relationships, matrices of connections, community, and culture. It is often a challenging dance to lead both the individual at the point of service, who is focused on getting a discrete job/task done, and the larger system of connections and relationships related to the health, thriving, and future of the organization or constituency of organizations. It is also somewhat of an act of faith to understand that complex social systems self-organize within a context of chaos, and that sometimes this self-organization leads to additional problems.

There are multiple advantages to a systems view. Systems thinking facilitates the analysis of structures, patterns, and cycles rather than a series of isolated events. From this perspective, problem-solving becomes more systematic, and the solution to one problem can affect the solution to others within the system. To ensure that care is safe for patients using evidenced-based approaches to deliver the highest-quality care, nurse leaders must understand and use systems thinking. Not only does systems problem-solving show immediate or subsequent synergistic effects, but often, the positive effects are also long term rather than short lived. This can mean challenging boundaries despite existing power structures and working to improve processes to improve care (Stalter & Moto, 2018).

Facilitation of process improvement requires nurse leaders to work with others to change approaches to problems and issues. Drucker (2004, p. 59), in his classic approach to problem-solving, outlined eight practices that distinguish effective executives and enhance systems thinking. Such leaders see the big picture and take action from the perspective of entire systems. According to Drucker, the leader does the following:

- Asks, "What needs to be done?"
- Asks, "What is right for the enterprise?"
- Develops action plans
- Takes responsibility for decisions
- Takes responsibility for communicating
- Focuses on opportunities rather than problems
- Runs productive meetings
- Thinks and says "we" rather than "I"

This list of behaviors of executive leaders may seem simple. However, within complex systems, such behaviors require much intentional thought and planning.

COMPLEX ENVIRONMENTS AND MANAGING CHANGE

Living and Working in Changing Environments

Continual change in our work environments is a reality of life, but especially in healthcare today. Increasing pressures related to compensation for care, training, and support of healthcare providers, patients who present with complicated chronic illnesses, and increasing regulations—all produce continual change in how, where, and when care is delivered. It is a necessary way of life for leaders to learn how to help themselves and others to live effectively with continual change and to succeed in contexts of uncertainty and complexity. Effective change deeply affects the culture, structure, and processes in an organization. Change efforts can be planned or unplanned, tactical or strategic, and evolutionary or revolutionary.

We have left the industrial age and are now deep into an information and technology age. All the rules have changed. People over age 40 learned about sources of information in completely different ways from those under age 30 (digital natives), who grew up in the digital age. All information, and in some cases too much information, is always available within minutes. Sources of information are vast and highly accessible, and the range of choices has exploded. Just a couple of decades ago, who would have thought you might listen to music, access email, text, play a game, or even watch a movie on what was once your telephone. We have more avenues for more information than any individual can accommodate. Over two decades ago, Drucker (2000, p. 8) predicted:

> In a few hundred years, when the history of our time is written from a long-term perspective, it is likely that the most important event historians will see is not technology, not the Internet, not e-commerce. It is an unprecedented change in the human condition. For the first time—literally—substantial and rapidly growing numbers of people have choices. For the first time, they will have to manage themselves. And society is totally unprepared for it.

Twenty years later, Drucker's observations continue to be relevant. For example, given the shifts in healthcare, with much responsibility for self-management of chronic illness placed on individuals and families, it seems people still struggle with how to manage the deluge of and ever-changing information and their responsibility for self-care.

We are now seeing the outcomes and effects of that continual change and information overload on healthcare workers. Many observers thought multitasking was the answer to managing the overload, but evidence has made it clear that the human organism, while capable of multitasking, is not efficient or effective when doing so (Sitterding & Broome, 2015). In fact, information overload can lead to errors. This has major implications for how leaders lead. Change is constant, but some changes in the environment that the leader must initiate to improve outcomes are fast paced, abrupt, and disruptive. So, effective leaders must think not only about how change affects people, but also about how execution of change can make all the difference in their responses and performance.

Supporting Others During Change

Recent fiscal realities have brought unforeseen change to nursing employment, practice, and leadership. Like other major industries, hospitals and some other healthcare facilities have engaged in restructuring to manage costs (Hewner, Seo, Gothard, & Johnson, 2014; Tsai, Joynt, Wild, Orav, & Jha, 2015). Restructuring of care delivery models now include more diverse teams of care providers ranging from physicians to advanced practice nurses, baccalaureate-prepared nurses, and supportive care assistants. In a recent study (Pittman & Forrest, 2015) of the perceptions of leaders from 18 of the original 32 pioneer accountable care organizations, leaders believed that payment models were clearly affecting the roles of nurses in their organizations. These role changes required that teams of professional nurses and other nonprofessional, but well-trained, employees work together to provide care across settings. These roles will require new knowledge and skills for the professional nurse and nursing leader. For instance, in a recent Macy's Foundation report (Bodenheimer & Mason, 2016) on the role of registered nurses in primary care, new responsibilities are suggested for baccalaureate-prepared nurses regarding accountability for patient groups. This kind of role change produces stress for most individuals who must adapt and learn new ways of working with and providing care for their patients. As a leader you must be continually aware of, and responsive to, how others perceive change, and then you must provide strategies to support them. This new role will provide greater opportunities for the baccalaureate-prepared nurse to use assessment, clinical problem-solving, communication, and chronic illness management skills to manage care for groups of patients as part of a multidisciplinary care team (Bodenheimer & Mason, 2016).

Leading Change

Change means to transform or to become something different. To lead change is to generate and mobilize human talent and resources toward innovation and care improvement. Change can be described in terms of first order and second

order. First-order change is an adjustment within an existing structure, doing more or less of something, and is reversible. Second-order change, on the other hand, is transformational. It requires new ways of perceiving and doing things, new learning, and it is irreversible. The rules are different in second-order change. Such change requires new learning and creates a new story (Pesut, 2008a). Pesut further explained that problem-oriented change looks at what is wrong or why and how are we limited by the problem. An appreciative inquiry approach directs change toward identifying what is good, what is already working, what is desired, and what resources exist to achieve the desired result (Cooperrider, Whitney, & Stavros, 2008). Planned change often emerges from review of the meaning and relevancy of the organizational mission statement, from facing new systems or technology, and from recognition of the need for new ways of decision-making, practice, and policies.

Appreciative inquiry can be used to examine processes and interactions that continually produce tension for individuals in the workplace (Khan, Rivera, Manzano, & Fitzpatrick, 2018). For instance, using appreciative inquiry to identify existing strengths and positive interactions among staff that result in improved patient outcomes can positively change attitudes about the problems. This enables the participants to focus on addressing the gaps in care and solving the issues that result from these gaps by building on positive existing strengths of the team. In environments of change, effective leaders are early adapters of innovation. They are able to see change as an opportunity to learn and improve by using this creativity to approach old problems in new ways (Pesut, 2013). Leaders do not hand down mandates for change. Instead, they wisely identify needs or directions on the horizon. They engage others in ways that will elicit their participation, ideas about what is needed, and how they could go about making changes to improve the situation. This engagement can be one on one in informal conversations or in group settings in which all can feel comfortable sharing their ideas.

Change management experts believe that *how* change is led makes all the difference in the organization's ability to negotiate change. Powerful principles of leading change are reflected in Kotter's (2007) well-known eight steps for organizational transformation:

1. Establish a sense of urgency.
2. Form a powerful guiding coalition.
3. Create a vision.
4. Communicate the vision.
5. Empower others to act on that vision.
6. Plan for and create short-term wins.
7. Consolidate improvements and produce more change.
8. Institutionalize new approaches.

However, many leaders forget that if one step in the list is skipped (e.g., communicate the vision), then later efforts to regain momentum and the clarity

BOX 2.2 LEADERSHIP IN ACTION: IMPROVING END-OF-LIFE CARE FOR PATIENTS ON A SURGICAL ONCOLOGY UNIT

Mary S. is the director for surgical services. She has been a director for 4 years and has four units that report to her, including oncology surgical services. Members of the hospital system administration have been discussing a new model of care for two units in Mary's area. This new care model, called "An Integrated Learning Unit for Palliative Care," will be implemented in September. At that point, the 20 baccalaureate-prepared registered nurses will lead 10 teams that include three home care workers each, who will care for six to eight patients or families across both hospital and home care settings, 24 hours a day. The system expects to hire and train 20 new home care workers, who will work across the settings under the supervision of the professional nurses.

The unit manager, Sam W., MSN, just graduated with his degree in nursing administration in May. He first heard of this change in June after meeting with his director, Mary S. Mary's leadership style, as a rule, is transactional, and she expects her nurse managers to take charge of problems, come up with solutions, and present them to her for approval. In this case, she assures Sam he will do fine with implementing the change, saying, "You have just learned all the new ways of managing change and people." But she also reminds him that he has only 3 months to prepare his unit for the change, hire new home care workers, prepare the professional nurses to assume leadership of teams, and develop a plan to monitor and evaluate the effectiveness of the care delivery model on patient and family satisfaction and other outcomes, such as return of patients to the ED, rehospitalizations, or adverse events.

1. What should Sam think is "the sense of urgency" in this situation? What would be a reasonable approach to communicate the sense of urgency to others? How do you think staff on the unit might respond?
2. Who should Sam assemble to create the coalition that will help him guide the unit personnel through this dramatic change in their roles? What is the best size for this kind of coalition?
3. Who should be primarily responsible for creating and communicating the vision for the change? What might the outcome look like? How is the vision connected to the evaluation plan?
4. What specific strategies could Sam and the coalition members enact that would build a sense of empowerment in those working on the unit? What should they do first? Second? What might be some short-term "wins" for the employees that would encourage them?
5. When the hiring begins who should be involved? What kind of person do you think would be a "best fit" with the new model?
6. What kinds of criteria would you use to evaluate the effectiveness of the change model? The care model? The delivery of care and employee satisfaction?

and engagement of others will be very difficult. It is impossible to empower others to act on a vision for the outcomes of the change occurring if they are not clear what the vison or outcome will be. In Box 2.2, read about how one leader successfully implemented a scale change in her department.

Change can happen through power, by empowering others to engage and contribute to the change. It can happen through reason, by appealing to logic and rationales, and by education and re-education to provide knowledge and skills. Change also happens by altering structures and processes. The leader must identify which approach is the most appropriate. For example, if care providers *already know* information or have skills but feel powerless to make decisions, then development of education or training programs will not produce desired changes. Rather, individuals may need more independence, autonomy, and accountability in decision-making.

Change is a journey taken together with those with whom you work. Each change process is unique. And it is important to remember that as nimble as you or your organization may be, change usually takes longer than you expect.

Change, Reflective Adaptation, and Appreciative Inquiry

The effective leader understands that not all organizations are necessarily ready for, or even need, immediate transformation at any given moment. It is often wise to watch and wait. Sometimes, resistance to change can be so strong as to defeat even the most charismatic leader. Even if it is your perception that immediate change is needed, particularly in a new role, take some time for assessment—be the "chief listening officer" for a while. Sometimes, no action is better than the full court press, at least for an assessment phase. A sensitive systems thinker, especially in a new position, may be well advised to take time to simply observe the people and talk with them.

One of the most effective strategies to launch change used by the authors of this book is that of appreciative inquiry, introduced earlier. Once a challenge is identified and defined, it is helpful to engage the stakeholders who will guide the change in the four phases of appreciative inquiry that follow the first step, which is to define the situation (see Figure 2.1). AI builds on existing strength and success. It is based on the idea that those who focus on problems will continue to find and build on more problems, but organizations in which there is a sense of pride and appreciation will build on what is good or positive.

The model includes four concepts: defining, discovery, dream, design, and delivery, sometimes called the "5 Ds" (see Center for Appreciative Inquiry, 2019). Defining is necessary to identify and achieve a shared agreement on the situations and problem. Discovery represents the "positive core," based on the idea that in the heart of the organization something is working well. The dream concept invites imagination and envisioning of what can be better. Design means to

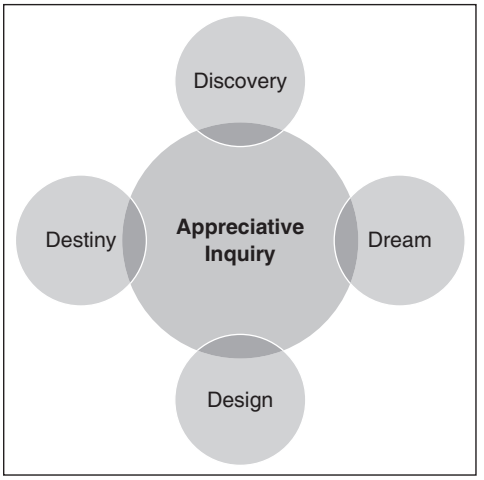

FIGURE 2.1 Stages of appreciative inquiry that follow defining.

Source: Adapted from Broome's visualization of concepts and Cooperrider, D., Whitney, D., & Stavros, J. (2008). *Appreciative inquiry handbook* (2nd ed.). Brunswick, OH: Crown Custom.

articulate the values, propositions, and plans of the desired future; and delivery means to act on the dream, to implement the plan, and to create "what will be" (Khan et al., 2018). This positive and constructive approach to working with groups to promote and implement change allows them to be highly involved in and identified with what the unit is doing well *now,* to identify the preferred future related to this challenge, to create a process and procedure for making the desired future a reality, and to engage in thinking about how to sustain the change and empower others.

The process of reflective adaptation is a helpful method to conceptualize and facilitate local change. Using the appreciative inquiry process can help others to adapt to a necessary change using a positive framework by structuring the conversations toward the mind-set, "What good do we do? What good can we create? What strengths do each of us bring to this need for a new approach?"

Although complexity and emergent change may be attractive and exciting for the new transformational leader, some planning, strategy, and a place for reflection must accompany change initiatives. Five guiding principles support a successful, reflective adaptation process:

- Vision, mission, and shared values are fundamental to guide ongoing change processes in a complex adaptive system.
- Creating time and space for learning and reflection is necessary for a complex system to adapt to and plan change.
- Some tension and discomfort are essential and normal during complex adaptive systems change.

- Improvement teams should include a variety of the system's agents with different perspectives of the system and its environment.
- System change requires supportive leadership that is actively involved in the change process, ensuring full participation from all members, and protecting time for reflection (Daly, Hill, & Jackson, 2014).

Using the reflective adaptive process, the leader uses the 5Ds or five core processes of appreciative inquiry (Center for Appreciative Inquiry, 2019). Instead of using a "fix it" model to solve problems, the first step in appreciative inquiry is to choose to ask a question that focuses on when things go well in the organization in a specific area, what does that "look like." Using stories of positive exemplars of when procedures resulted in positive outcomes, the group can identify and create a shared image of what "it could be." They then can innovate to reach the desired state of solution. In summary, the 5Ds are Definition, Discovery, Dream, Design, and Deliver.

Change as a Personal Challenge for the Leader

Realities in healthcare sometimes bring mandates for change and the requirement for you as a leader to move it forward. Any change can be stressful, as change requires that we let go of old behaviors and develop new ways of thinking and behaving.

It is important to manage your own time and stress when you find yourself in the midst of a big change initiative (whether you are creating the change or are the recipient of the change). Identify a confidant (often the best choice is someone outside of the organization who can be objective) who will support you through the challenges of your work. That person can help you to recognize the effects of your own leadership style on others during the change process. Stand strong to your own values and maintain the image of your change model in your mind, recognizing that your image of what should be likely will not be exactly what eventually evolves. Resist the temptation to either over control or "do all the work yourself." And think about how to do the following:

- Allow others to put their own marks on the initiative while you ensure that the change activities support the mission of the organization.
- Allow your team time and space to talk about the change and share their concerns.
- Identify and share early successes about positive coping and approaches.
- Remember that you are changing processes or products, not people or personalities.
- Build on strengths of individuals.
- Build in accountabilities and be careful to monitor the process at regular intervals.
- Stay close to and touch base often with those experiencing the change.

- Identify opportunities for learning for everyone and celebrate small and large accomplishments along the way.

Facing the uncertainty of change is a personal challenge, particularly if you are responsible for the lives and work of others. Although the temptation may be to resist or stall, often, the best way to find a sense of power or security is to simply step forward and engage yourself and others in change processes. Gilbert and Broome (2015) outlined several strategies to be used by nurse managers and clinical leaders expected to negotiate change. These are the following:

- Learn to let go of your need to control. This is risky as you must depend on others to accomplish the changes you think you want, and things may not occur on your timetable.
- Learn to be comfortable with life on the edge. This will require you to build on strong networks of relationships, communication channels, and trust in others both in and outside the organization.
- Get out of the data trap. Use your skills to identify which data are important to help participants to understand the situation. Communicate clearly how long-range goals are related to the data.
- Learn to help others reframe a situation that seems particularly threatening. Employ systems thinking.

Clinical leaders must develop a sense of timing and a willingness to engage in the rhythm of change processes. It requires anticipation, responsiveness, nimble action, and the willingness to lead others into a new reality. You can become the model of change for others and, thereby, communicate the invitation and urgency for transformation.

One of the most critical and least discussed aspects of change leadership is the fundamental principle of trust. Such trust is earned by consistent ethical behavior and clearly defined values. Regardless of our rhetoric on embracing complexity and relishing change as a way of life, usually change is difficult for people to accept. Subordinates often fear that change will "happen" to them, and there is sometimes an uneasy expectation that change will threaten control, autonomy, habit, or comfort. The wise leader who has grounded his or her leadership in relationships will be honest and transparent and help others to identify things they can control (i.e., care for individual patients or freedom to provide ideas about improvements). Such a leader will always consider perceptions and the dynamics of human relationships when launching change. Real change will happen only when everyone makes the decision to implement innovations. If people trust you as the leader, and you share a clear direction and vision and extend meaningful opportunity for input and contribution into the change planning and processes, followers will help to define the most effective path to improve quality as a matter of their own personal integrity and commitment to the mission of the organization.

REFLECTION QUESTIONS

1. How do you find yourself thinking and feeling in the midst of change in your organization? What are your biggest concerns?
2. What are your greatest strengths from which you draw in times of change?
3. Do you have a personal ritual (e.g., exercise, meditation, and reading) that you find useful in reducing your stress?
4. Can you identify two people outside the organization who can listen to your thoughts and feelings as you negotiate and support others during a major change?
5. How can you mobilize resources within the organization to help you support others (e.g., facilitators in human resources)?

Drawing on the Wisdom of All Experts During Change

Effective change does not happen within the purview of a solitary leader. In the position of a nurse leader, you have the freedom and opportunity to network with experts from all disciplines. The effective leader learns the language, reads the literature, and becomes interested and informed about the inside view of a vast variety of disciplines, both within and outside healthcare. Successful organizations owe their success to the dedication and inventiveness of their people. At the end of the day, our progress and success depend on each other—as peers, colleagues, subordinates, and strangers. We are all explorers in the new world of the future. We each must develop our own areas of expertise, respect the expertise of others, and acknowledge where we must come together when none of us has all the answers.

In the context of complex adaptive systems, do not confine your thinking to working only with people you know inside the organization or even by the usual professional networking. Furthermore, do not be limited to collaboration only with healthcare professionals. One of the delights of being a leader is the ability to invite collegiality with a broad range of professional friends. It is amazing how people respond when you simply introduce yourself and ask them to help. In this age of technology, when you admire the work of an expert, do not be afraid to send off a note or make a call. Be prepared, respectful, gracious, and specific in your need.

Think about including experts in business, politics, anthropology, geography, languages, and even the arts as you build your personal style and repertoire to lead the next generation. Read the works of other disciplines, including those of current great minds. Think about how their thoughts might contribute to your work. Imagine how your world might expand and how others will benefit from your renaissance approach to healthcare leadership. Among the

most inspiring mentors in my own experiences (Marshall) in healthcare leadership have been a lawyer, a development officer, a musician, and a professor of Italian studies.

When you draw from a broad range of disciplines and communities, you create generative relationships that release energy and creativity to support change (Pesut, 2013). When there is productive sharing of ideas, problems, responsibility for decisions, and a variety of viewpoints, your work becomes more fulfilling and productive. It generates goodwill, positive change, worker satisfaction, and a generative foundation for the next generation of leaders. Soon, you will be surprised how others will be drawn to your leadership and your organization. They will want to be part of your team.

STRATEGIC PLANNING IN THE MIDST OF CONTINUAL CHANGE

Strategic planning refers to long-range visioning and planning for the entire organization. In today's healthcare systems, it is a critical exercise for the organization not just to survive but to thrive. Strategic planning is expansive and conceptual, whereas tactical or operational planning involves goal setting or objective development for shorter-term, more targeted, or local plans that are part of the larger strategic plan. Both kinds of planning are necessary and critically important to ensure that all stakeholders are included in the organization. Some kind of strategic planning is helpful at the team, group, unit, or system level. Strategic planning from a transformational perspective involves visioning, planning, and executing in the best possible manner to fulfill the purpose or principles for which the organization stands. Deliberate and careful planning helps the transformational leader to define and crystallize goals for the organization and the people involved. It allows the opportunity to affirm values, define principles, and break the path toward a more effective organization with high personal satisfaction for all involved in the enterprise. It requires precision of expression and innovative thinking.

A strategic plan is a road map to the desired future, so it may address the next 1, 3, 5, or even more years, but it must project into the future. There are several important purposes of a strategic plan. Some of these include the following (Baker et al., 2000; Uzarski & Broome, 2019):

- To represent a long-range vision for improving organizational performance
- To provide a model for planning and implementing structures and processes for the management of outcomes
- To reflect and shape the organizational culture and customer focus
- To provide decision support for difficult operational choices day by day
- To integrate and align the work of the organization

Effective strategy is built on the organization's vision, mission, and values. Vision, mission, and values have become the well-worn currency of

strategic planning. First, remember that mission, vision, and values *represent* what you do. They are important symbols and expressions. They are the voice of your organization—but are likely not what you actually do on a day-to-day operational basis. Regardless of their overuse in today's corporate world, mission, vision, and values retain their position as the foundation for the strategic direction of organizations. They are the currency of the day. So, they are reviewed here to help you avoid cynicism within your own organization. It is in your best interest as a leader to make them yours and make them live.

The vision should clearly identify *why* you do what you do. Vision provides people with a passion for what they do—it is the touchstone for every employee in the organization. It is the "why" we get up and go to work every day. Sinek (2010) spoke about "How great leaders inspire action," underscoring how critical it is that every leader examines the "why" of what he or she does before trying to work with others to develop a vision. Vision statements should be short and clearly inspire others. Some examples of vision statements for nonprofit organizations include the following:

- A world without Alzheimer's (Alzheimer's Association)
- A world where everyone has a decent place to live (Habitat for Humanity)
- To become a world leader at connecting people to wildlife and conservation (San Diego Zoo)
- That the United States is a humane community in which all animals are treated with respect and kindness (ASPCA)
- A world free of breast cancer (Alamo Breast Cancer Foundation)

A vision is the picture of your ideal future. It is idealistic, elegant, and ambitious but reflects the work and mission of the organization. It sets a standard of excellence; reflects the purpose, direction, and uniqueness of the organization; and inspires.

The mission clearly identifies your purpose and *what* you do as an organization. It is the vision put to work. Keep it simple and to the basics of the essential activities of the organization. Following is a homemade example: "Shawfeld Community Care is a community-based agency of professional nurses and volunteers who provide compassionate home health and support services to Smith county adults and children suffering chronic or life-threatening illness." Another example is the mission statement of the Alamo Breast Cancer Foundation (2016): "To end breast cancer by assisting patients, informing health professionals and policymakers, and expanding knowledge through education and community outreach."

Values are the guides for conduct and principles of behavior in performing the mission and following the vision. Examples are compassion, caring, quality, respect. Values are easy for people to list, but less easy for them to reflect and enact in their behavior on a daily basis.

Strategic Planning Process

Strategic planning in the midst of continual change in an industry such as healthcare is somewhat akin to driving a car while the road is still under construction. Some of the uncertainties of the future can make it difficult to dream and create a meaningful vision statement. Strategic planning is a useful process to guide the organization into a *preferred future*, but it is just an exercise if you and others are not committed to it. It can only be effective if you are a strategic leader and engage others in planning.

The strategic leader continually thinks of the organization with a perspective from higher levels, taking a larger perspective of analysis, and looking into the future. You must think conceptually and creatively, always examining internal applications in a context of the larger community. Strategic thinking looks forward. Thus, it always carries some challenges and risks. It is a challenge to think large and into the future while concurrently attending to the local immediate issues.

Strategic planning is a process that involves the following steps:

1. Collecting relevant data, perspectives, benchmark information, and scans of the external environment
2. Engaging a representative group of individuals to develop draft vision, mission, and values statements
3. Gaining input from the larger community in the organization
4. Developing of strategies, metrics, and an implementation plan (Uzarski & Broome, 2019)

As organizations have become more complex, so has the process of strategic planning. But the basic steps are simple. Thoughtful planning, effective execution, and ongoing evaluation are critical for the strategic plan to be more than just a symbolic exercise.

Schaffner (2009) outlined 10 steps for success in strategic planning for nursing, which we shall draw from and adapt to the larger healthcare perspective.

1. Appoint a strategic planning steering committee. This team should include the appropriate number of key personnel and stakeholders of the organization. Think about who should be included. You need some visionary thinkers, some realists, and some representatives from all corners of your influence as an organization, and you must have the support of higher administration. Orient members of the committee to their roles and the process of strategic planning itself.
2. Use strategic analysis to guide the planning, using key indicators. Schaffner proposed that this step may be done "behind the scenes" (p. 153). This is often done by external consultant teams who know the organization and have the time to collect data both internally and externally to present to the steering

committee. The data may include information related to finances, personnel, satisfaction, and quality metrics, community demographics, healthcare trends, competitors' scope of delivery and business, and whatever else is deemed important in planning.

3. Conduct interviews with key stakeholders to assess perceptions of the enterprise. This step is often overlooked in strategic planning activities and must be done carefully to ensure that those interviewed know that their responses will be only reported in the aggregate. Schaffner suggested the use of a standard set of questions, but you should spread the net wide for the interviews. Include all who have any vested interests in your enterprise. Remember that clients and/or patients may be an important part of this step. Include computer-based surveys of the broader population. Most important is to develop a data-based picture of the perceptions of the current situation and visions of the future.
4. Share key stakeholder interview and analytical data. Everyone involved in planning needs the benefit of all baseline information.
5. Conduct a SWOT analysis. This is a critical step in any strategic planning process: examination of **S**trengths, **W**eaknesses, **O**pportunities, and **T**hreats related to effective performance or to the fulfillment of the vision of the organization. The SWOT analysis can be valid only to the degree that all players are involved at some point in the process. Using data from the interviews, the steering committee can create a SWOT analysis and then vet it widely for feedback at town halls with a broad representation of employees. Evaluation of strengths and weaknesses must be honest, performed within an environment where all discussion is safe. This helps the leader and members of the organization to identify internal capabilities and challenges. Evaluation of opportunities and threats includes consideration of possibilities and challenges outside the organization. It requires analysis of issues within the community and the entire industry and identification of signs of future or emerging issues outside the realm of the organization. Use of the term *threats* is not always accurate in this context because this component of the analysis often does not refer to actual threats to the mission or success of the organization. Threats may include challenges in the community, changes in the external environment, or technological innovations that the organization should consider.
6. Brainstorm potential strategies. The first part of this step needs to be wide open and free. Allow time and space for dreaming. Record all possibilities; let no idea be withheld or precluded. The next step is to narrow the list of dreams to less than half a dozen strategic actions or goals that are aligned with the mission and goals of the organization and speak to its vision. This can be done by a smaller group and then presented back to the larger group for consensus and prioritizing. Strategies are stated within a framework of a road map or goals for the future. The strategies need to imply that their accomplishment will change the organization toward its desired future.

7. Complete a gap analysis around the strategies. Analyze the difference between the newly designed strategies and the current state of the organization. This helps the group to develop tactical goals or objectives.
8. Develop a tactical plan. Usually, a handful of specific tactical objectives are identified under each strategy. A timeline and responsible champion or leader for such should be included as well.
9. Develop metrics for the strategic plan. Metrics are the measures that reflect success or failure on each objective and strategy. They need to produce outcome data. In addition to specific measures, an evaluation plan needs to outline what the data sources are, when and how often measurements are taken, who is responsible, and to whom the results will be reported.
10. Communicate, communicate, and communicate. The plan should be broadly communicated at all stages. It can become a vehicle for sharing the organization's vision, mission, values, and direction as well as eliciting internal and external support for change.

The strategic plan is launched from the vision, which is the inspiring banner that reflects the loftiest identity and dream of the organization. As a nurse leader you will be working with other healthcare leaders to develop the plan, which begins with broad but achievable and measurable goals. They may relate to strategic leadership, systems, and specific aspects of the work of the organization. Under each of the strategic goals are listed more local, specific, and measurable objectives. In addition, the responsible team or person who is accountable for the achievement of the objectives is identified. The process to achieve the objectives is usually mapped out by some sort of timeline or logic model.

Implementation of the Strategic Plan

Once the strategic planning process is in place, obviously, it will do no good if it is put on the shelf until the next committee meeting, annual retreat, or accreditation visit. It really is possible for a well-developed strategic plan to guide the direction of the organization. But it is up to you as the leader to make it work. This will require that you, as a leader, make regular evaluations of the progress of the plan. This may be by verbal quarterly reports and/or annual written reports, using the framework of the strategic plan.

To implement the strategic plan, begin by communicating it broadly. It is helpful to outline the plan in a specific format or template (Uzarski & Broome, 2019). Templates are likely available within your organization and certainly can be found by examining strategic plans of other organizations. It is also a good idea to assign a champion for each section of the plan who can monitor implementation and achievement of goals. In addition, it is critical that the plan be evaluated annually so that if new initiatives surface, they can be integrated into the existing plan and not ignored. Evaluating people or groups of people

responsible for a part of the plan is a special case. Invite workers to articulate their performance goals alongside your expectations for their performance. Document and measure achievement of expectations. Track progress with data. Provide opportunities for improvement and follow-up. Use personnel evaluations not only as performance reviews for retention or advancement, but also for teaching and growth.

Another important component of the implementation will be communication progress on the plan. Depending on the degree of change in the organization, this should be done every 6 to 12 months. Town halls, newsletters, and small unit meetings all are viable options for communication.

Effective Evaluation of the Strategic Plan

Achievement of goals of the strategic plan is documented by an evaluation plan. Most evaluation plans follow some sort of logic model that includes inputs, activities, outputs, intermediate outcomes, and end outcomes. End outcomes must reflect tangible results that represent the success or failure of the organization. In other words, evaluation requires data, and the results of data analyses should reflect the mission and purpose of the work. Intermediate outcomes reflect the success of strategies to achieve the end outcomes. In addition to the strategic plan, evaluation plans may map performance plans, accountability tracking, or other data collection and data-tracking plans. All major aspects of the organization should be included somewhere in the overall organizational evaluation plan.

Each objective should be measurable, and the evaluation plan should include specific tools or measures with accountability and designated time intervals for taking measurements on each objective. Avoid too many tools or a plan that measures process instead of outcomes. If there is general resistance to an outcomes orientation or an evaluation plan, this component will be meaningless. Therefore, your evaluation activities should include motivation, clarification, and invitations to engagement. The organization must invest in evaluation and use the results to improve its work.

In today's culture of outcomes, evaluation encompasses much more than measures related to the strategic plan. Evaluation is a part of every activity of healthcare. Entire volumes, courses, and experts are available and should be consulted as you set out to develop and sustain an evaluation plan. We evaluate resources, personnel, patient outcomes, satisfaction, processes, and everything else we care about. As a leader, always think about how you will evaluate what you are doing, who is responsible for doing it, or both. Have an overall plan for data collection to provide evidence for the evaluation decisions you make. Evaluation should be done as systematically as research, with a plan, specific questions, data, analysis, and use of the data to make informed decisions. This pertains to processes, outcomes, and people. It is only when the loop of

BOX 2.3 LEADERSHIP IN ACTION: STRATEGIC PLAN IMPLEMENTATION: ENGAGEMENT THROUGH COMMUNICATION

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- Identify why it is important to communicate to and engage the people of the organization in a strategic plan and its potential challenges.
- Demonstrate how a cogent communication strategy will result in plan engagement and implementation success.
- Describe challenges to communicating strategic plan implementation and possible solutions.

INTRODUCTION

There it was, sitting in front of me on my desk: our new strategic plan. This colorful printed document was the product of 8 months of stakeholder interviews, focus groups, and involvement of over 100 members of our school's community. We had developed the focus areas, vision and mission, goals, and strategies that would guide our organization for the next 4 years. I had just joined the school and assumed the role of leading the implementation of the strategic plan. This seemed like a daunting task.

I realized that an important next step for our leadership team was to develop a sound process and structure for implementing our plan, one that was supported by all. This structure would serve as a foundation on which to build success. I also recognized that my project management experiences would serve me well, moving into this next phase. However, several of my cited publications noted that communication and engagement were two critical factors to ensure a successfully implemented strategic plan. The task of effectively communicating our plan and engaging our community for implementation seemed overwhelming.

I scratched my head, thinking, "How do we communicate our strategic plan in a way to foster a connection between the printed document and our people? How do we make the strategic plan something that our members would understand, relate to, and want to become involved with? How do we ignite our vision and goals among our teams? How would this plan become the vehicle for the future work of our organization?"

I did not have answers to these questions, but I intuitively realized that we would experience success only if our community members understood the plan, its relevance to our school's success, and desire to engage. The heart of an organization (and its plan) is its people. We would need to help our members connect the plan's goals and strategies to their own work and keep our plan (and vision) alive through our engagement during the next 4 years.

Discussion: What are the foundational principles in your own work unit or organization to implementing a strategic plan? That is, what would facilitate and what might be barriers to the implementation?

(*continued*)

BOX 2.3 LEADERSHIP IN ACTION: STRATEGIC PLAN IMPLEMENTATION: ENGAGEMENT THROUGH COMMUNICATION (*continued*)

USING COMMUNICATION STRATEGIES TO IMPROVE ENGAGEMENT

The challenges to any successful implementation of a strategic plan are communication and engagement. Even though our community members participated in the plan development, to require them to engage in continued work could be a challenge given their workload and demands of their many roles. It is difficult for people to commit to meetings and differing assignments over a long period of time. Also, since strategic plans are often viewed as lofty, members may not see their immediate importance or feel empowered to work on teams. It would be an error to assume that our community would readily embrace our work ahead.

Our leadership team committed to build a foundation of awareness and understanding of the plan, along with a commitment to inclusion and transparency. We asked ourselves, "As a member of our organization, what would I need to understand about the strategic plan to feel empowered and willing to engage?" After discussion with the team, I developed a set of aims and key principles needed to facilitate engagement, a graphic of our implementation structure, core values, recommendations for successful implementation, and expectations around engagement. For example, we took measures to stagger our members' involvement on task forces to prove a break in the work during the summer, and we were specific in the time demands of 8 to 10 hours of teamwork per quarter.

We realized that "branding" of our plan would help to connect it to our community and unique culture. Together, members of our communications team proceeded to carefully craft and disseminate messages by several means, including social media, digital monitor signage, electronic newsletters, our website, and presentations at community meetings. Embedding our strategic plan and associated images "front and center" at the school helped us to reach our members. Our vision and core values were placed on easels, banners, and digital monitors. A video helped our community to understand how our plan was relevant to the future of our organization. As a community, we celebrated the launch of the strategic plan implementation with a presentation and coffee mug event. In the back of my mind, I thought, "Are we clearly communicating a consistent message to appeal to different members within our organization?" I often elicited feedback from our members to help me tweak our message as needed.

We identified another aspect of communication that was critical to our success. We developed the strategic plan as a blueprint to articulate the school's vision to stakeholder groups outside the organization to garner support, promote engagement, and develop partnerships. I took advantage of every opportunity to share with external stakeholders and to give them opportunity for feedback.

(*continued*)

BOX 2.3 LEADERSHIP IN ACTION: STRATEGIC PLAN IMPLEMENTATION: ENGAGEMENT THROUGH COMMUNICATION (*continued*)

This included members of our academic-practice partnership team, our board of advisers, our alumni council, and others. I also encouraged our members to use the strategic plan when speaking to their constituents. This approach demonstrated the value of nursing and allowed our nursing presence, influence, and ability to collaborate to promote change.

We have been deliberate to thank our members for their hard work and continued support of the plan, and we celebrate milestones each year. Our community members and external stakeholders receive an annual published report that gives details on our collective success.

Discussion: As a nurse leader, how could you utilize resources available to communicate and engage your people in the work of a strategic plan?

EVALUATION OF THE IMPACT OF THE IMPLEMENTATION OF A STRATEGIC PLAN

We are now midway through our 5-year strategic plan implementation, and we are reflecting on our successes and the work that remains ahead. So far, more than 200 of our community members have voluntarily contributed thousands of hours to advance our initiatives identified 3 years ago. We have celebrated these successes as a community, and our work continues. Recently, over 60% of our members participated in focus groups and responded to a midpoint survey. We have received excellent feedback about how to reach our community, how to continue engagement, and how to edit our strategies to be more responsive to current challenges. We have edited goals, strategies, and metrics based on this input, and we have shared our findings with the organization.

REFLECTION

The first 3 years of our strategic plan implementation has been a learning experience for me as well as for our entire leadership team. I quickly realized the value of drawing on the knowledge of my team, experts, and relevant literature. Vigilance to the plan is important, but challenging, given the organization's multiple priorities. I learned how essential it is to build relationships and trust with people, the value of being mindful and intentional, the importance of keeping a finger on the pulse of the community, watching for cures about what is and what is not working, and reflecting on feedback. My work of shepherding our organization through strategic plan implementation has been gratifying, and it has helped me to challenge myself to develop flexibility and creativity.

visioning, planning, implementing, and evaluating is closed that true progress can be made. See Box 2.3 for leadership in action.

An understanding of contexts of complexity, effectiveness in the change process, and application of principles of strategic planning are critical to the leader in today's healthcare environments. The challenges can be daunting, but rewards are great for you as a leader and for your organization. Few things are more fulfilling than thriving in a complex environment, helping people through change to enjoy positive outcomes, and planning and implementing a new future.

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CHAPTER 3

Current Challenges in Complex Healthcare Organizations and the Quadruple Aim

Katherine C. Pereira and Margaret T. Bowers

Culture does not change because we desire to change it. Culture changes when the organization is transformed—the culture reflects the realities of people working together every day.

—Frances Hesselbein

OBJECTIVES

- *To understand current challenges driving healthcare delivery in the United States*
- *To describe the Quadruple Aim*
- *To understand healthcare teams and models*
- *To identify challenges related to health literacy*
- *To distinguish a variety of environments and settings for healthcare leadership*
- *To examine productivity, effectiveness, and safety and their impact on quality care*
- *To describe the unique role of the APRN in leading initiatives in primary care to improve outcomes across settings*
- *To articulate the importance of social determinants of health*

INTRODUCTION

Healthcare in the United States in the 21st century is influenced and challenged by a multitude of factors, including legislation, public policy, and consumer mandates. Many of these factors coalesced in the implementation of the Patient Protection and Affordable Care Act (ACA) in 2010 and initial introduction of the Triple Aim (McClellan, McKethan, Lewis, Roski, & Fisher, 2010; Whittington, Nolan, Lewis, & Torres, 2015). These reforms were intended to provide consumers and patients with more control over their healthcare by making it more accessible, affordable, and of higher quality. By mandating health insurance coverage

for all, the ACA cast a broad net to capture people in the low- and middle-income categories. The most significant impact of the ACA was seen in two distinct areas: (a) state adoption of Medicaid expansion and (b) increased coverage of adults 18 to 30 years old (Long et al., 2015). On the downside, Medicaid expansion has had variable impact based on whether or not states adopted the option to expand coverage for those previously uninsured (Long et al., 2015). The 29 states that adopted Medicaid expansion have seen a 38.3% reduction in the number of uninsured individuals (Miller & Wherry, 2017). It has been assumed that providing insurance coverage to those who do not have it will improve health outcomes and reduce disparities. Thus far, it appears that ACA implementation has resulted in improved rates of diagnosis and treatment of chronic diseases, improved access to preventive and health screening services, and access and adherence to prescription services. However, it has not resulted in improved desired outcomes in some specific areas, such as hypertension, measures of A1C or cholesterol maintenance, or improved utilization of ED services (Sommers, Gawande, & Baicker, 2017). Recent changes in the ACA, including the removal of the individual mandate that all citizens have health insurance, may result in these short-term gains being further destabilized. See Box 3.1 for related new media resources.

BOX 3.1 NEW MEDIA: THE CURRENT STATE OF HEALTHCARE IN THE UNITED STATES

TED Talk

Jan Denecker, Director of Healthcare Logistics for United Parcel Service. "How to Do More With Less in Healthcare." https://www.ted.com/talks/jan_denecker_how_to_do_more_with_less_in_healthcare

Podcasts

Aim Rishi Manchanda, MD, MPH, Chief Medical Officer, Institute for Healthcare Improvement. December 15, 2016. "WIHI: Moving Upstream to Address the Quadruple Aim." http://www.ihi.org/resources/pages/audioandvideo/wihi-moving-upstream-to-address-the-quadruple-aim.aspx

Hal Wolf, Healthcare Information and Management Systems Society (HIMSS) President and CEO. December 27, 2017. "Tackling Healthcare Challenges With Information and Technology, Differently." https://www.himss.org/valuesuite/tackling-healthcare-challenges-information-and-technology-differently

Website

Agency for Healthcare Research and Quality. "Transforming Hospitals: Designing for Safety and Quality." https://www.ahrq.gov/professionals/systems/hospital/transform/index.html

THE QUADRUPLE AIM

The ACA included implications for the delivery of healthcare in the United States through a focus on "value over volume" and maximizing performance of health systems (Shirey & White-Williams, 2015). The Triple Aim, as defined by the Institute of Medicine (IOM), includes principles of (a) population health, (b) management of healthcare costs, and (c) enhancement of the patient care experience, including quality and satisfaction (Whittington et al., 2015). The pursuit of the Triple Aim, including the widespread implementation of the electronic health record (EHR) resulted in identification of some provider concerns, including burnout and the need for resources to sustain provider resiliency to keep the focus on patient-centered care. Thus, the Quadruple Aim, as described by Bodenheimer and Sinsky (2014), was proposed to include the fourth aim of strategies to improve work life with a focus on the provider experience (Morrow, Call, Marcus, & Locke, 2018).

In an effort to address these aims, healthcare leaders must identify new priorities not only for healthcare delivery but to improve the work life of the members of the healthcare team. Transformational leadership is one strategy that focuses on motivating followers to achieve more than expected by looking beyond their own interests and challenging assumptions (Mitchell, 2014; Tepper et al., 2018).

The successful implementation of the Quadruple Aim depends on several important factors influencing the context of healthcare. Among these are the following:

- Success of emerging healthcare teams
- Improved health literacy of patient populations
- Effective use of the EHR
- Issues related to productivity, effectiveness, and safety
- Nursing workforce development
- Social determinants of health
- Provider resiliency

Resilience of workers impacts both recruitment and retention of the healthcare workforce and is a key component of the Quadruple Aim. Though this list is not exhaustive, it offers some important examples of issues addressed here.

CURRENT FORCES INFLUENCING HEALTHCARE

In 2014, the Institute for Healthcare Improvement (IHI) introduced the concept of the Quadruple Aim in an effort to expand the healthcare framework and link goals of healthcare as well as address impact on providers (Bodenheimer & Sinsky, 2014; IHI, 2016; Whittington et al., 2015).

Kaplan (2015) provided a comprehensive overview principle related to the cost of care and the influence of the Triple and Quadruple Aims on healthcare delivery. Efforts at measuring value should focus on the patient as the "unit of analysis." Kaplan proposed that measuring value includes a focus on health outcomes in relation to cost. This model can be applied from wellness to illness and across a cycle of care. This process must be transparent, and health sectors must be accountable for outcomes. Determining appropriate outcome measures must be done in a methodical manner and is not a swift process. Porter and Kaplan (2016) proposed value-based bundled payments as a strategy to address the Quadruple Aim by providing a single payment for a specific medical condition over a cycle of care. Joint replacements are some of the most commonly bundled payments and have been examined for cost savings. Navathe et al. (2017) noted substantial cost savings of $5,577 (20.8%) in total costs for 3,942 patients undergoing joint replacement, with savings noted from two key areas: choice of implant device, supplies, and postacute care.

Accountable care organizations (ACOs) were created as groundbreaking models for healthcare delivery in this new paradigm. About 1,000 organizations of various sizes and complexities now operate as ACOs. Some are part of large health systems, while others have resulted from partnerships between hospitals and private practices. To date, less than 50% of the organizations are receiving bonuses for reaching benchmarks for care, a key component of the program. Explanations include lack of substantial financial incentives, too few patients falling under the area of value-based care, lack of organizational knowledge on how to best implement care models, and the age old challenge of implementing change within organizations (Lewis, Fisher, & Colla, 2017). Overcoming the organizational challenges for ACOs will require teams that include APRNs with skills in change theory, finance, and entrepreneurship. Signs that the Quadruple Aim has been realized will include a healthier population with a focus on prevention rather than treatment of illness, reduced disparities in access to and quality of care, patient satisfaction and engagement with the healthcare community, reduced cost, less burdensome technology for clinicians, and improved perceptions of job fulfillment among providers.

HEALTHCARE TEAMS AND MODELS

Multidisciplinary healthcare teams are part of a model that has demonstrated clinical effectiveness in a variety of settings (Okun et al., 2014). Core competencies for interprofessional collaborative practice have been developed and endorsed by key health professional organizations. These competencies focus on values and ethics, roles and responsibilities, interprofessional communication, and teams and teamwork (Mackintosh et al., 2014). Interprofessional teams function in dynamic ways across clinical situations as well as environments of care. For example, a social worker may be the team leader when facilitating a

transition from an acute care setting to long-term care, or a pharmacist may emerge as the team leader in a critical care environment in the care of a medically complex patient. Successful teams balance individual strengths of their members with the needs of the entire team.

It has been postulated that integrated care models, defined as seamless care delivery for individuals transitioning from one care venue to another, improve care outcomes, reduce redundancy, and lower healthcare costs. One example is integration of mental health services with primary care. This model noted a significant reduction in ED visits, improvement of rates of normal blood pressure maintenance, and improved adherence to diabetes care metrics (Reiss-Brennan et al., 2016). Another model that has been proposed more recently includes the patient and family caregivers as key members of the team to create effective healthcare partnerships (Okun et al., 2014). The addition of these key team members supports the tenets of the Quadruple Aim by focusing on partnering with patients to achieve a key value in healthcare: a satisfying experience with positive outcomes in a cost-effective manner.

Challenges arise when the composition of healthcare teams is affected by organizational downsizing of personnel. Organizational restructuring may lead to gaps in needed numbers of skilled personnel to provide direct care. In an era of dynamic healthcare systems, there are leadership opportunities to address these gaps. Kilpatrick, Lavoie-Tremblay, Ritchie, and Lamothe (2014) proposed that APRNs take advantage of these leadership opportunities. As expert clinicians, educators, researchers, and leaders, APRNs can positively influence healthcare teams in the context of both primary and acute care settings (Kilpatrick et al., 2014). In addition to the challenges posed by reduction in staff, APRNs in acute care settings face barriers to integrating themselves into healthcare teams. Using effective leadership strategies, APRNs can bridge communication across diverse members of the healthcare team as they focus on providing quality patient-centered care. Effective utilization of resources is one example of how APRNs have demonstrated their leadership in clinical care (Kapu, Kleinpell, & Pilon, 2014). In a retrospective secondary analysis, Kapu et al. determined that the addition of nurse practitioners (NPs) to an inpatient care team at a single site demonstrated enhanced revenue through gross collections and cost efficiency, reduced overall lengths of stay, and standardized practices to improve quality care.

One example of a model focused on population health and cost reduction was described by Tetuan et al. (2014). The setting was a nurse-run clinic for annual wellness visits to promote adherence to mammogram and colonoscopy screening in a targeted Medicare population. The premise was that during an extended nurse visit, patients had the opportunity to express their personal health beliefs and discuss concerns about health screenings (Tetuan et al., 2014). The results of implementing this model of care demonstrated an increase in adherence to mammogram screening recommendations and a trend toward improvement in colonoscopy screenings. Through early detection and

prevention of breast or colon cancer, and more effective management of chronic disease, mortality and the total cost of care can be reduced and cure rates can increase.

APRNs as transformational leaders have the potential to play a pivotal role in care redesign by addressing patient-specific needs that look beyond the domain of a traditional clinical practice site. APRNs should be the leaders in coordinating care and identifying alternative methods of providing access to care. Amy Compton-Phillips, president and chief clinical officer of Providence Health & Services, has described opportunities to focus on caring, curing, and coordinating in future healthcare redesign in a specific setting (see Compton-Phillips, 2015).

Introducing new models of care has implications for improving efficiency, reducing cost, and ultimately enhancing productivity. APRNs do not consistently receive the same level of clinical support in primary care settings as their physician colleagues. For example, although medical assistants (MAs) can complete basic clinical tasks, they are often assigned to support only physicians and not APRNs. Liu, Finkelstein, and Poghosyan (2014) created queuing models to analyze APRN utilization in an effort to determine the provider service rate. By focusing on the provider service rate, they allowed for variability among providers across practice settings. Liu et al. (2014) compared APRN practice with and without MA support to determine which model was cost-effective and what ratio of MA to APRN yielded the most cost-effective care while improving access to care. They found that APRN productivity and cost-efficiency improved significantly when the nurses had assistance from MAs. As the workforce embraces a significant increase in APRN providers, healthcare systems need to evaluate the workforce mix to determine which models maximize the scope of practice for all levels of providers. An increase in the number of APRN providers should improve access to care. If supported by MAs, APRNs can maximize productivity in a cost-effective manner.

There is also growing emphasis on an expanded role for registered nurses in primary care. However, traditional prelicensure nursing education has traditionally emphasized competencies needed for the acute care setting rather than for primary care. The 2016 Macy Foundation Conference, Registered Nurses: Partners in Transforming Primary Care, recommended that skills in chronic disease management, care coordination, and population health need to be incorporated into undergraduate nursing curricula along with clinical experiences to include primary care settings. For this to happen, system redesign is needed, including incorporation of primary care content into the NCLEX-RN® licensure examination, creation of interprofessional outpatient clinical experiences, and student exposure to RN-led models of care (Bodenheimer & Mason, 2016).

As a discipline, nursing is grounded in advancing knowledge focused on promoting health and addressing human responses in health and illness. Doctorally prepared APRNs are poised to step into the role of change agent to examine systems of care and needed leadership for new models of care. APRNs

bring a unique perspective as nurses, and need to rise to the challenge to lead practice change initiatives, asserting themselves to be significant members of healthcare teams. The contributions of nursing to the implementation and study of care delivery models is crucial to the success of these models. Therefore, APRNs need to have an active voice in the process.

REFLECTION QUESTIONS

1. How can APRNs influence care redesign as transformational leaders?
2. How can the skill set of the DNP-prepared nurse be best utilized to create effective models of healthcare?
3. What strategies or skills are needed for APRNs to be successful in promoting the Quadruple Aim?

IMPROVING HEALTH LITERACY TO INCREASE SAFETY AND PATIENT ENGAGEMENT IN HEALTHCARE

One important factor in achieving the Quadruple Aim is to improve the health literacy of the general community. When increasing patient involvement in care, it is important to consider such factors as health literacy. Health literacy, along with health numeracy skills, can influence the quality of care delivery across the spectrum of settings and is vital to maintaining patients' engagement in their own health. Health literacy is defined as "the degree to which individuals have the capacity to obtain, process and understand basic health information needed to make appropriate health decisions and services needed to prevent or treat illness" (Health Resources and Services Administration [HRSA], 2015) and can promote understanding and safety in care delivery. Health numeracy is "the individual-level skills needed to understand and use quantitative health information, including basic computation skills, ability to use information in documents and non-text formats such as graphs, and ability to communicate orally" (Berkman, Sheridan, Donahue, Halpern, & Crotty, 2011, p. 99). Both skills are critical to improve quality and safety in healthcare delivery. See Box 3.2 for related new media resources.

It is estimated that only 12% of adults in the United States have adequate health literacy skills (Berkman et al., 2011), meaning the ability to read and understand medication label instructions. People with low health literacy skills are more likely to have poor health and associated risk for increased mortality (Bostock & Steptoe, 2012). Those with low health literacy are also less likely to seek out digital health information on their own (Manganello et al., 2017). Many individuals with functional literacy skills do not necessarily have functional numeracy skills. Low numeracy skills are associated with poorer health outcomes, higher rates of hospitalization or rehospitalization,

BOX 3.2 NEW MEDIA: HEALTH LITERACY

TED Talks

Dr. Lisa Fitzpatrick, MD, MPH, MPA, on Health Literacy. "Are You Confused About Health Information? You Are Not Alone." https://www.youtube.com/watch?reload=9&v=-x6DLqtaK2g

Steven Duggan, Director of Worldwide Education Strategy at Microsoft Corporation. "Sickness: Illiteracy as a Fatal Illness?" https://www.youtube.com/watch?v=ETAslvke4Uo

and the inability to self-manage chronic disease (Sheridan et al., 2011). Poor numeracy skills can affect how patients are able to interpret risk for disease, read graphs and tables in their own EHRs, and perform practical calculations such as determining portion sizes, counting carbohydrates, and interpreting peak-flow readings. As patients are required to develop stronger self-management of chronic illness skills, numeracy skills must receive as much attention as literacy skills.

Low health literacy is more common in under-erved and under-resourced populations, elders, lower socioeconomic groups, and minority populations (HRSA, 2015). Thus, low health literacy is one cause of the health disparities seen in these populations. Another layer of literacy challenges for patients includes the EHR and the complexity of data. Federal mandates related to the EHR include incentives for patient registration and interaction with patient electronic portals, such as viewing health information and communicating with healthcare providers through such portals. However, it has been recognized that racial and ethnic minorities and those with low health literacy are less likely to use the EHR health portals (Sarkar et al., 2010). Additionally, researchers are just starting to explore how the global implementation of EHR is the preferred form of provider/patient communication. Those with low literacy and cognitive, language, or memory challenges may find logging into portals and authentication processes to be insurmountable problems (Hemsley, Rollo, Georgiou, Balandin, & Hill, 2017). As EHR adaptation becomes more widespread and oral communication is increasingly replaced with written communication, EHR design will need to employ novel strategies that ensure widespread usability of this technology across literacy levels. Inclusion of various ethnic groups during usability testing, availability of EHR data in many languages, and the use of enhanced visual and video instructions would all increase patient comprehension of EHR data (Lyles, Schillinger, & Sarkar, 2015).

Removing barriers to understanding would allow more individuals to actively engage in health promotion activities. Providers also need to obtain

skills to facilitate accurate communication of healthcare information to patients. The Plain Language Act, passed in 2000, mandated the use of easily understood language in government documents and materials as a move to enhance comprehension for those reading them. The Agency for Healthcare Research and Quality developed the "Health Literacy Universal Precautions Toolkit" to help organizations to systematically assess the usefulness of patient education materials and then use appropriate strategies to improve materials within clinics and other healthcare organizations (Brega et al., 2015). Since lower health literacy is more common among minority populations, health information and communication methods must also be constructed using concepts consistent with cultural competency.

Roter (2011) employed a successful model to increase patient comprehension of complex orally communicated information by three simple constructs. The first of these, "strip it down," involves restricting the use of medical jargon terms and intricate explanations. The second, "bring it home," means providing the patient with contextual relevance and personalization of the provided information. "Mix it up," the final construct, refers to avoiding monologues and long-winded explanations with patients, with a shift toward conversational exchanges of information (Roter, 2011). Interventions to improve numeracy skills have been studied most frequently among patients with diabetes, an illness that requires multiple numeracy skills to successfully participate in self-care. Skills such as insulin titration, reading food labels, calculating serving sizes, and insulin pump therapy are particularly challenging for those with low numeracy skills. The PRIDE (Partnership to Improve Diabetes Education) Toolkit provides 30 learning units that can be customized to individual patient skill level and is available in English and Spanish, with an emphasis on shared goal setting between patient and provider. Color-coded instructions, visual aids, and alternative methods for portion estimation and insulin titration are provided that meet the needs of those with low literacy and numeracy skills (Wolff et al., 2016).

Healthcare providers may underestimate the health literacy challenges of their patients. Thus, increasing awareness of the problem may be the first step toward increasing competence in many organizations. In health professional training, strategies that enhance student knowledge related to health literacy include use of standardized patients in the simulated learning environment, practicing communication skills that avoid jargon, and use of the "teach-back" method (Coleman, 2011; Coleman, Hudson, & Maine, 2013). Incorporation of health literacy status into patient assessment and plan of care teaches practitioners to consider this as an important part of every interaction. Continued challenges include barriers to health literacy that occur during emergency and crisis situations (Diviani, van den Putte, Giani, & van Weert, 2015).

Several national organizations promote and provide resources to healthcare leaders to improve health literacy, including the Agency for Healthcare Research

and Quality (2018) and the Centers for Disease Control and Prevention (2016). The IOM identified 10 attributes of a health-literate healthcare organization (Brach et al., 2012) that can truly support patients as they navigate their engagement with the healthcare system (Box 3.3).

BOX 3.3 TEN TRAITS OF A HEALTH-LITERATE HEALTHCARE ORGANIZATION

1. Rewards leadership that makes health literacy integral to its mission, structure, and operations
2. Integrates health literacy into planning, evaluation measures, patient safety, and quality improvement
3. Prepares the workforce to be health literate and monitors progress
4. Includes populations served in the design, implementation, and evaluation of health information services
5. Meets the needs of populations with a range of health literacy skills while avoiding stigmatization
6. Uses health literacy strategies in interpersonal communications and confirms understanding at all points of contact
7. Provides easy access to health information and services and navigation assistance
8. Designs and distributes print, audiovisual, and social media content that is easy to understand and act on
9. Addresses health literacy in high-risk situations, including care transitions and communications about medicines
10. Communicates clearly what health plans cover and what individuals will have to pay for services

Source: Brach, C., Keller, D., Hernandez, L. M., Baur, C., Dreyer, B., Parker, R., … Schillinger, D. (2012). *Ten attributes of health literate health care organizations*. Washington, DC: Institute of Medicine. Retrieved from http://www .a healthy understanding .org/Portals/0/Documents1/IOM_Ten_Attributes_HL_Paper.pdf

REFLECTION QUESTION

You are leading the opening of a new oncology infusion center at a newly opened hospital. The community demographic includes a large percentage of older adults and Spanish-speaking individuals. Patient education materials for postchemotherapy care need to be chosen and implemented. The EHR contains standardized patient education materials. What other processes or assessments might need to be implemented to ensure adequate understanding of important patient care instructions for both of these populations?

SETTINGS FOR CURRENT AND FUTURE HEALTHCARE

The reality is that the future point of service in healthcare continues to extend beyond the hospital setting. This challenges our traditional thinking that persists in viewing hospitals as the center of the healthcare system infrastructure. Given this, it is valuable to consider the growing diversity of practice settings. Reviewing the breadth of purpose of care settings from prevention to curative, and their unique challenges moving forward, helps us think about the potential adaptations needed in leadership. Different settings present specific purposes and complexities and multiple ways for leaders to support and shape culture and environment. See Table 3.1 for this analysis.

Primary Care Environments

Primary care is commonly viewed as the first level of contact for people entering the healthcare system. It is best conceptualized as an approach to providing healthcare rather than a list of specific services (Shi & Singh, 2015). Within the U.S. healthcare system, primary care environments are of growing focus and concern. Issues affecting the success of primary care include a shortage of primary care physicians (Mann, 2017), current national initiatives for all Americans to possess health insurance and access to care, and an increasingly entrepreneurial approach among large health systems to acquire small, independent primary care practices (Sealover, 2015). Adequate primary care continues to be one among today's greatest healthcare challenges (see Marshall, 2011, p. 189; Winkler & Marshall, 2017, pp. 248–249).

The role of nursing in U.S. primary care remains one of both opportunity and relative adversity. One hundred and seventy-two thousand NPs are actively

TABLE 3.1 Practice Settings: Opportunities and Challenges

SETTING	LEADERSHIP OPPORTUNITIES	TECHNOLOGY CHALLENGES	QUALITY AND SAFETY
Primary care	Shortage of primary care providers: APRNs poised to meet this need	Provider satisfaction and workflow	Collaborative care Care transitions
Community and rural settings	Provide care in remote locations and become a leader in the community	Facilitation of telemedicine services	Reimbursement models and coordination of care
Home as place for care	Coordination of care between providers	Development of novel documentation systems for encounter	Reimbursement models and coordination of care

practicing in the United States. Of these, approximately 130,000 are providing primary care services (AANP, 2019). Yet, in as many as 28 states, serious limitations on scope of practice and regulation parity with medicine continue (Buerhaus, 2018). It is projected that NPs will comprise 29% of the primary care workforce by 2025 (Bodenheimer & Bauer, 2016). NPs consistently demonstrate similar or better outcomes than their physician colleagues across a range of health indicators (Buerhaus, DesRoches, Dittus, & Donelan, 2015; Hing, Hooker, & Ashman, 2011; Newhouse et al., 2011; Stanik-Hutt et al., 2013). Yet, "increasing the number of NPs alone will not address the deficiencies in primary care delivery because many policy and practice setting barriers affect NPs' ability to offer services at the full range of their educational preparation and competencies" (Poghosyan, Boyd, & Clarke, 2016, p. 146). Moreover, disagreement proliferates between physicians and APRNs regarding their respective roles in primary care (Donelan, DesRoches, Dittus, & Buerhaus, 2013) and how patients and the public perceive and view these roles (American Academy of Family Physicians, 2012; Budzi, Lurie, Singh, & Hooker, 2010; Maul et al., 2015). These and other unique challenges, such as roles and responsibilities of RNs in primary care, ways to facilitate collaboration with physicians (McInnes, Peters, Bonney, & Halcomb, 2015), and the role of nurses in patient-centered medical homes (American Academy of Nurse Practitioners, 2016; American Nurses Association, 2010; Carver & Jessie, 2011; Robezneiks, 2012), are critical for leaders to address as they strive to provide the best preventive, acute, and chronic care to patients and families (see Marshall, 2011, p. 189; Winkler & Marshall, 2017, pp. 248–249).

Community and Rural Settings

Community nursing leadership claims an inspiring history from the moment Lillian Wald set out to establish the Henry Street Settlement and officially launch public health nursing. Today's community-based nursing centers, from school-based clinics and academic outreach centers to faith-based organizations, reflect this legacy. Such centers serve the poor, underserved, and marginalized in both urban and rural settings and are led by practitioners who understand how these circumstances are produced from the social determinants of health. As it is expected that the need for such centers will only increase, the need for leadership to identify the best way to care for people and populations who live in these diverse settings is critical (see Marshall, 2011, pp. 189–190; Winkler & Marshall, 2017, pp. 249–250).

It is important to remember that the population of much of our nation, and the world, resides in rural environments, and each setting presents its own unique challenges for leadership. Such challenges include a decreasing ability of rural hospitals to survive financially, unique patient populations and aging communities, limited specialty services, patient acuity and volume

issues, workforce shortages, substance abuse, nurse staffing problems, and communication challenges—to name a few (Hall & Owings, 2014; MacDowell, Glasser, Fitts, Nielsen, & Hunsaker, 2010; Wakefield, 2018). In these communities, rural residents generally have poorer health status and less access to professional care than do urban families (Wakefield, 2018; Weaver, Geiger, Lu, & Case, 2013). Moreover, practitioners and leaders in rural settings are often isolated by distance among areas of service from colleagues, thus limiting mutual leadership support (see Marshall, 2011, pp. 189–190; Winkler & Marshall, 2017, pp. 248–249). Yet, despite these challenges, there are opportunities for rural healthcare leaders to optimize resources to improve health in their communities. Personal, cultural, and family attachments to rural communities are often strong, demonstrated by some as an exceptional attachment to community and a sense of home (Douthit, Kiv, Dwolatzky, & Biswas, 2015). Tapping into this loyalty and attachment to place may be an important clue as leaders seek to address some of the previously listed staffing and infrastructure challenges. Leaders and practitioners will also require a generalist approach to care, along with creativity, flexibility, and a broad knowledge base, to meet the distinct and varied needs of these communities. Furthermore, leaders need their own support systems and should strive to overcome their geographical distance by collaborating with leaders from other settings. Reaching out and connecting to other leaders can help facilitate (a) moving away from traditional care delivery models that exist within brick and mortar buildings to mobile and home-delivered care (Wakefield, 2018); (b) partnerships for additional services, as larger care systems move to provide specialized care to patients via telehealth (Marcin, Rimsza, & Moskowitz, 2015); and (c) assistance in implementing some of the core leadership competencies in rural health settings, such as understanding designated reimbursement mechanisms and developing leadership skills for dealing with multidisciplinary management teams (see Marshall, 2011, pp. 189–190; Winkler & Marshall, 2017, pp. 248–249).

Home as Place for Care

The patient or family home is another environment of care where leadership seeks definition. Home has special meaning for each person, group, and population, and it is not necessarily confined to a domicile but may be perceived as a family, neighborhood, community, cultural or ethnic group, or nation. The meaning of home is diverse, ranging from a discrete place of personal power, security and safety, togetherness, or self-reconciliation to a transitional process of nesting to achieve integration of person with place (Molony, 2010; see also Marshall, 2011, pp. 191–194; Winkler & Marshall, 2017, pp. 250–251).

Traditionally, home is where healthcare began—it was the place where babies were born, where the sick received care, and where the dying and bereaved were

comforted. Physicians and nurses aided as guests in homes, and family members were the primary caregivers. Eventually, science and technology formalized healthcare, and moved it from homes to institutions. Hospitals have been the center of care through most of the 20th century. However, care is again beginning to shift back to the home in response to increasing costs and efficiency of medical treatments; shortened hospital stays; increasing informal treatment of chronic illness and disabilities; decreased institutionalization for mental illness, physical disabilities, and the aging population; and growing palliative care and hospice movements (Landers et al., 2016). This shift demonstrates important improvements in patient outcomes, such as in pain and wound care (Data.Medicare.gov, 2015), but is simultaneously met with cuts in payment rates for home healthcare services from policy makers and a continued fragmented approach to home health payment from Medicare that emphasizes volume over value (Lee & Schiller, 2015). In addition, care is once again assigned to family members. As portions of care, time, and financial responsibility are reallocated in some capacity to these caregivers (Dybwik, Tollali, Nielsen, & Brinchmann, 2011), a number of consequences may result for family caregivers' own well-being and financial security (AARP Public Policy Institute, 2009; Dybwik et al., 2011; see also Marshall, 2011, pp. 191–194; Winkler & Marshall, 2017, pp. 250–251).

Therefore, the implications of the home environment for care are greater than one might imagine for healthcare leaders across all settings. The patient or family home is part of the entire spectrum of patient care and healing. Attention to the complex implications of the home environment for care is imperative to promote clinical practice interventions, policy, and leadership that recognizes all aspects of the family and health environment; accepts all aspects of the patient and family experience; supports patient and family strength and resilience; reduces informal caregiver burden; reduces financial hardship on the family and household; preserves the privacy and sanctity of home; and promotes the general health of all members of the community. How leaders address the patient's home is an indicator of their vision and sensitivity to all environments and settings for care (see Marshall, 2011, pp. 191–194; Winkler & Marshall, 2017, pp. 250–251).

Healthcare Practice Settings and Beyond

Despite the increasing shift in care to the home and community, a large majority of nurses (63.2%) continue to provide care in hospital settings (HRSA, 2013), and federal projections predict that the demand for RNs in hospitals will climb by 36% by 2020 (American Association of Colleges of Nursing [AACN], 2019b). As a result, many of you may find yourselves leading in these inpatient and outpatient hospital-based settings. Leadership at the executive level in these settings requires multiple skills and knowledge of the healthcare environment to implement strategic operations and to guide and execute cultural changes. For those who find themselves in the highest ranked administrative positions—such as

vice president, chief nursing officer, or chief executive officer—leadership is critical, as these individuals are responsible not only for developing strategies to promote practice excellence in clinical care, education, and research but also for simultaneously ensuring that strategies and practices are consistent with the organization's mission, vision, and values (Hader, 2009; see also Marshall, 2011, p. 195; Winkler & Marshall, 2017, pp. 251–252).

Beyond the settings of healthcare are other places where expert clinicians may find themselves taking leadership roles—for example, at insurance firms, to create more affordable and accessible insurance for their customers (Campaign for Action, 2015); or in academic institutions, to help educate the next generation of nurses, APRNs, and healthcare leaders. Further, with increased knowledge of legal and political issues, expert clinicians are ideally poised to shape national and even international health policy (Hanks, Starnes-Ott, & Stafford, 2018). Indeed, it is the leaders who are informed by clinical practice who are the ones to continue to make a significant difference in healthcare reform to meet the needs of American and global citizens. Innovative opportunities abound in areas and settings not yet imagined. Whole new industries, models, and environments wait to be invented to prevent illness, relieve suffering, and promote healing—and it may be your clinical expertise and leadership that helps to create or sustain these groundbreaking approaches to healthcare (see Marshall, 2011, p. 195; Winkler & Marshall, 2017, pp. 251–252).

PRODUCTIVITY, EFFECTIVENESS, AND SAFETY: IMPACT ON QUALITY CARE

The scope of measuring productivity and effectiveness in the current healthcare climate has created new challenges for the entire healthcare industry. Insurers, providers, policy makers, and consumers all influence how productivity and effectiveness are measured and evaluated.

The American Heart Association and the American College of Cardiology published a statement on the cost and value of implementing clinical practice guidelines and performance measures in cardiology. The statement focuses on the introduction of cost-effectiveness and value assessments as integral components to be included in clinical practice guidelines (Anderson et al., 2014). This statement is consistent with the premise of the Quadruple Aim that focuses on measuring the value of healthcare in the context of patient and provider satisfaction. Resource utilization and value are proposed as the nomenclature to ensure that the focus on cost is not the primary measure of performance. The inclusion of value in the context of medical decision-making is an emerging concept and is only one aspect of implementing clinical guidelines (Anderson et al., 2014). Healthcare providers face clinical and ethical issues that may arise while balancing the value of a medical decision with resource utilization. Historically, these issues arise when resources are scarce, such as in the case of organ transplantation. As value is considered, the implementation of clinical practice guidelines requires considerations of resource allocation.

Practice implications for implementing the Quadruple Aim affect both productivity and clinical effectiveness. For example, EHR implementation has had a significant impact on clinical implementation projects aimed at reducing costs and patient complications. The aforementioned initiatives have focused on reducing hospital-acquired infections, including catheter-acquired urinary tract infections (CAUTI), catheter-acquired bloodstream infections, and ventilator-associated pneumonia.

Another example of a case showing the challenge of new approaches for patient safety is seen in a study by Shepard et al. (2014). An EHR was used in surveillance of CAUTIs in an adult population over a 5-month period. An electronic algorithm was developed to streamline the process for CAUTI surveillance. This single-site intervention included an analysis of over 6,000 positive urine cultures in a 6-month period. Through use of this electronic algorithm, the study site was able to reduce CAUTI surveillance requirements by 97% (Shepard et al., 2014). This type of intervention was low cost with a high yield in productivity and effectiveness and could be integrated in diverse EHR systems.

It is well known that U.S. healthcare expenditure has increased exponentially over the past three decades, yet morbidity and mortality rates exceed those of countries that spend less on healthcare (Kaplan & Witkowski, 2014). As models of healthcare delivery continue to evolve, so, too, do financial structures and payment models. Relative value units, which assign cost to patients based on procedures and diagnoses, do not provide a true accounting of how cost relates to patient outcomes.

Kaplan and Witkowski (2014) reiterated the changes in value-based healthcare and urged us to prepare this new model of care, which includes bundled payments over a cycle of care while promoting provider and system accountability for measured outcomes. Care redesign is a significant component of this paradigm and relies on improving efficiency, developing standards of care, and consistently measuring outcomes across the cycle of care. Of increasing importance in such measurement of outcomes is the assurance of patient safety. See Box 3.4 on leadership in action and Box 3.5 on related new media resources.

BOX 3.4 LEADERSHIP IN ACTION: ANTIBIOTIC STEWARDSHIP IN THE OUTPATIENT SETTING

It is well recognized that 30% of all antibiotics prescribed annually in the outpatient setting are unnecessary (Fleming-Dutra et al., 2016). In a high-volume urgent care clinic, Kayla Fisk, DNP, implemented newly approved point of care (POC) testing for sexually transmitted infections (*Chlamydia trachomatis* and *Neisseria gonorrhea*) to reduce inappropriate antibiotic prescribing. The POC testing reduced the time to results from 90 minutes, as compared with traditional testing

(*continued*)

BOX 3.4 LEADERSHIP IN ACTION: ANTIBIOTIC STEWARDSHIP IN THE OUTPATIENT SETTING (*continued*)

that resulted in 3 to 5 days. Rapid results for STD testing resulted in appropriate antibiotic treatment occurring in 100% of the POC group versus 53% of the preimplementation group that required 3 to 5 days for results ($p = .000$). Empiric overtreatment with antibiotics occurred in 40% of the preimplementation group as compared with 0% in the POC group. Financial analysis revealed that POC testing would also generate revenue for the clinic through appropriate billing and coding of encounters.

Reducing unnecessary and empiric antibiotic prescriptions successfully requires the implementation of practice guidelines, the latest in accurate testing modalities, an understanding of change theories, financial modeling competencies, and strong leadership skills, and exemplifies the capabilities of the DNP-prepared nurse to change practice and improve healthcare systems of practice (Fisk, Holm, Hicks, & Derouin, in press).

BOX 3.5 NEW MEDIA: LEADERSHIP BLOGS

Healthcare Leadership Blog: Joe Babaian brings in guest bloggers and provides mini tutorials on relevant topics in healthcare. https://hcldr.wordpress.com/

HealthPopuli: Jane Sarahohn-Kahn, health economist, covers the healthcare ecosystem. https://www.healthpopuli.com/

Jeanne Pinder. "What if All Healthcare Costs Were Transparent." TED Talks. February 20, 2019. www.Ted.com

NURSING WORKFORCE ISSUES

Direct Care Nurses

Various factors may affect the appropriate number of nurses needed. The total U.S. nursing workforce increased substantially between 2003 and 2013, with a doubling of nursing graduates from 76,727 to 155,098. As a result, the nursing supply between 2014 and 2030 is expected to exceed demand, with a projected surplus of 293,800 RNs by 2030 (HRSA, 2017). Variations in the supply of RNs could occur from state to state, with some states and regions experiencing significant surpluses or higher demand. Additionally, the settings where nurses practice will also change, with a continued shift in emphasis to the outpatient and community settings and alternative models of care delivery. While the

overall nursing workforce may sustain itself, turnover of nurses within healthcare organizations is common, with 20% of nurses leaving their job within the first year of employment. In addition, implementation of the ACA has resulted in an increased number of individuals with health insurance (USDHHS, 2017), which has translated into an increased need for nurses.

APRNs

The national supply of APRNs has steadily increased in the past few years, yet the projected need for primary care providers will continue to grow in the next decade due to an aging population, population growth, and an increase in insured patients with access to healthcare under the ACA. Current projections include a deficit of 33,000 primary care physicians by 2035 (Petterson, Liaw, Tran, & Bazemore, 2015). It is projected that the NP workforce will grow significantly between 2013 and 2025, increasing by 93% (U.S. Department of Health and Human services [DHHS], 2016). NPs are poised to meet this need, yet many barriers exist to sustain the supply of APRNs. The range of practice authority varies from state to state, hindering job mobility for many APRNs, along with federal restrictions on APRN practice. For instance, NPs deliver home care services more frequently than other providers, yet orders for home care are still federally mandated to be signed only by physicians. There is also a growing consensus among APRN professional organizations and educators to require the DNP degree as entry to practice for all APRNs by 2025 (National Organization of Nurse Practitioner Faculty, 2018). Supporters of this mandate cite the growing complexity of the U.S. healthcare system as the driver for this recommendation. Opponents argue that the additional cost and time required for a DNP degree may make it more difficult to maintain workforce needs, and that healthcare organizations need to better understand the value of the DNP-prepared APRN (Broome, 2017). Limited availability of clinical learning sites and preceptors for APRN students (and other health professions students) is a chronic challenge for many training programs that limit enrollment capacity (Broome, 2015; Forsberg, Swartwout, Murphy, Danko, & Delaney, 2015).

New solutions to the preceptor shortage focus on the use of simulation in graduate nursing education to foster critical thinking skills and verify competency. Research on the use of simulation has been focused on prelicensure students and has led to the approved use of simulation that can replace clinical hours. This is not yet permitted in advanced practice education, and research is needed to demonstrate simulation's efficacy in improving APRN competency and as an alternative to traditional clinical experiences (Nye, Campbell, Hebert, Short, & Thomas, 2019).

During this time of rapidly changing healthcare delivery, leaders must mobilize, as appropriate, the nursing workforce while fostering innovative interprofessional partnerships and partnerships with other healthcare organizations. Nursing leaders are a crucial part of the teams testing innovative and

cost-saving models of care. Building strong teams with a strong likelihood of success, while facilitating nursing vision in shaping these innovations, will become an important role for the nurse leader. Many of these models include nurses as key players to facilitate success, and leaders must act as both change agents and advocates for those they lead.

Faculty Shortages

For the profession to remain strong, nurses need to be prepared by expert faculty members who are leaders in shaping health policy, generating new knowledge, promoting knowledge translation, and advancing innovative curriculum design. One of the biggest threats to the nursing workforce is the declining number of nursing faculty to prepare students. In 2014–2015, nursing schools turned away 68,936 qualified applicants for baccalaureate and graduate programs due to faculty shortages and other resource shortfalls, including lack of clinical learning sites, poor budget support, and inadequate teaching facilities. Over the last decade, there has been a steady trend of increases in faculty vacancies in nursing schools across the country. It is projected that one third of all 2015 nursing faculty will retire between 2016 and 2025, and faculty aged 50 to 59 will replace those retiring from faculty roles (Fang & Kesten, 2017). Seventy-two percent of nursing faculty members are over the age of 50, while 14% are 65 or older, working past the usual retirement age. In contrast, only 4% of nurses under the age of 40 work in academia (Budden, Zhong, Moulton, & Cimiotti, 2013). Maintaining faculty diversity is also a challenge, with minorities comprising only about 11% of nursing faculty.

Most nursing faculty members (about two thirds) report being of a junior rank, with the majority holding the title of assistant professor, which reflects a deficit in faculty prepared to take on more complex leadership roles in schools of nursing. While many nursing faculty members find their work fulfilling, they report symptoms of emotional exhaustion from long working hours (averaging 48 hours a week). About half of currently employed faculty members aged less than 50 are considering leaving teaching in the next 5 years (Yedidia, Chou, Brownlee, Flynn, & Tanner, 2014). The faculty shortage also creates a vicious cycle of faculty overwork and lack of teaching support, which may prompt decisions to leave teaching after only a few years.

One major cause of faculty shortages has been a lack of doctorally prepared faculty, although there are increasing numbers of nurses enrolling in doctoral programs. In 2014 to 2015, there were 18,352 students enrolled in DNP programs, a 26.2% increase from the previous year. Likewise, enrollment in research-focused doctoral programs in 2014 increased by 3.2% from the previous year to 5,290 students. However, DNP graduates are outpacing PhD graduates, and in 2016 only 733 of 4,855 nursing doctoral graduates were PhDs. Nurse scientists educated at the PhD level are needed to create new knowledge in

the profession, and the imbalance between PhD and DNP-prepared nurses may become even more pronounced.

It is clear that the rapid growth of DNP graduates has resulted in a significant number of nursing faculty prepared at the DNP level (Smeltzer et al., 2014) along with PhD-prepared faculty. This new faculty mix should be viewed as an opportunity for collaborative activities around scholarship, teaching, shared funded activities, and shared faculty appointments. Likewise, PhD and DNP students should have structured opportunities during schooling to reduce degree "silos" and to appreciate how each degree differs and yet complements one another. A recent student doctoral organization implemented at a research-intensive academic school of nursing provided for a larger shared network of contacts, fostered collaboration, and identified common clinical and research interests among students (Travers, Weis, & Merrill, 2018).

Many DNP graduates are interested in incorporating teaching into their clinical role after graduation (Smeltzer et al., 2015). The salaries in academia may be a hindrance to doctorally prepared APRNs pursuing faculty opportunities. The average annual salary of an APRN is $93,310, whereas the average salary of a doctorally prepared nursing faculty member is $73,333 for a 12-month appointment (AACN, 2014). Another barrier is that many universities preclude DNP-prepared faculty from participating in the tenure tracks, and only 11% of DNP programs offer formal training in curriculum design and educational concepts (Udlis & Mancuso, 2012). Also, the length of time required for doctorate completion, along with expenses, continue to create barriers for many nurses interested in pursuing higher degrees. Finally, some schools do not provide formal practice opportunities for APRNs to maintain professional certification, so these faculty often find themselves working at sites disconnected from the university on evenings and weekends, increasing role stress workload.

What would be effective strategies to address the nursing faculty shortage? With many faculty holding junior roles, there is a need for intentional efforts toward faculty development and succession planning in nursing schools. Succession planning has been overlooked by many institutions, with only 38% of nursing schools reporting strategies in place (Wyte-Lake, Tran, Bowman, Needleman, & Dobalian, 2013). There is also growing recognition of the need for formal professional leadership development of faculty members. National organizations are now placing more emphasis on leadership development within both the profession itself and academia. Examples include the Robert Wood Johnson Foundation's (RWJF) *Future of Nurse Scholars* program, which aims to develop nurses pursuing a PhD through scholarships, mentoring, development of leadership skills, and postdoctoral research funding. Other organizations, including the National League for Nursing, AACN, Sigma Theta Tau International, American Academy of Nursing, and Johnson and Johnson Nurse Leadership Program, have developed nurse leadership programs for nurses at all levels. Academic-practice partnerships along with increased pay, other

incentives, and increased faculty support have also been used to attract more nurses to pursue higher degrees within university health systems (Wyte-Lake et al., 2013). The federal Nurse Faculty Loan Program provides loans to nurses pursuing doctoral programs with 85% loan forgiveness if the graduate works in nursing education for 4 years after graduation as another effort to increase the pipeline for nursing faculty.

SOCIAL DETERMINANTS OF HEALTH

"The social determinants of health are mostly responsible for health inequities—the unfair and avoidable differences in health status seen between countries" (World Health Organization, 2011). Access to healthcare has been seen as an answer to improving population health in the United States, but access cannot be untangled from the issue of social determinants of health. Health is determined by an intricate interaction among individual lifestyle choices and the physical, social, and economic environments. Behaviors that are known to increase risk of disease, such as smoking, inactivity, poor diet, and alcohol use, differ across various social and ethnic groups. The chronic stressors of financial insecurity and poor social support systems also create physiological changes that have been proven to increase the likelihood of developing illnesses such as cardiovascular disease, mental health problems, and a hastened aging process. This chronic stress also reduces resiliency in the face of health problems (Adler & Stewart, 2010). See Box 3.6 for related new media resources.

Preventive services are vital for improving the health of the nation, reducing healthcare costs, and sustaining individual productivity. Healthy behaviors and risk prevention are more likely to occur at higher incomes and education levels. Smoking rates are higher in individuals aged 18 and above who have not completed high school (Garrett, Dube, Winder, & Caraballo, 2013). Non-Hispanic Blacks have a 50% higher chance of cardiovascular mortality before age 75 as compared with non-Hispanic Whites. Infant mortality rates for non-Hispanic Blacks are more than twice those for non-Hispanic Whites (Meyer et al., 2013). And poor education (particularly lack of high school completion)

BOX 3.6 NEW MEDIA: HEALTH INEQUITY

TED TALK

Health Inequity: America's Chronic Condition?

Esteban López, MD, MBA, Chief Medical Officer and Southwest Texas Market President for Blue Cross and Blue Shield of Texas

https://www.youtube.com/watch?v=56ZKfSNkcJc

and low income are associated with populations and ethnic groups that have more chronic health problems, such as diabetes. Twenty-seven percent of Americans lack convenient access to healthy food retailers, and the likelihood of living in geographical areas referred to as "food deserts" is increased for seniors and neighborhoods comprising mostly non-Hispanic Blacks (Grimm, Moore, & Scanlon, 2013).

Focus is shifting toward creative approaches and health equity. The RWJF established the Commission to Build a Healthier America to identify why some Americans are healthier than others, and why health outcomes in the United States are worse than those in many other countries. The commission recommended government funding to emphasize efforts to create healthier communities, enrich childhood development services, and establish safer communities. Priorities include enhancing early childhood development services, nutrition programs for food-insecure families, and public–private partnerships that would provide for grocery stores with healthy choices in food deserts. Childhood education that requires physical activity from grades K through 12 and healthy food choices in schools promote the idea that healthy children are more likely to be healthy adults. Other priorities, such as community health partnerships, initiatives that provide safe and healthy local housing, and employment opportunities, increase the likelihood of healthy behaviors. Figure 3.1 illustrates how medical care is dependent on other direct and indirect influences on health (Braveman, Egerter, & Williams, 2011).

To adequately deliver and coordinate care, providers must understand each individual's unique social determinants and incorporate this information into care decisions. Large health systems are now moving to integration of EHR screening tools that assess these determinants to include factors such as social isolation, education, race/ethnic group, stress, and financial resource strain (LaForge et al., 2018).

FIGURE 3.1 Social determinants of health.

Source: Braveman, P., Egerter, S., & Williams, D. R. (2011). The social determinants of health: Coming of age. *Annual Review of Public Health*, *32*, 381–398. Reproduced with permission of Annual Review, © by Annual Reviews, http://www.annualreviews.org

The city of Philadelphia offers an exciting illustration of the impact of widespread community–government–business partnerships. Crime, inadequate housing, poverty, low employment, suboptimal schools, and limited access to healthy foods were making parts of the city some of the unhealthiest places to live in the country. Get Healthy Philly is a citywide initiative and partnership with the Food Trust. Project leaders worked with over 900 retailers to increase healthy food choices in restaurants, farmers' markets, and grocery stores. "Certified Healthy Food Stores" were designated for increasing their health food choices and advertising them. Other incentives included bonus food coupons for purchasing fresh fruits and vegetables, safer areas for exercise, cooking competitions, educational campaigns about sugary drinks, and healthier choices at all city-supported activities. This multipronged approach has led to a 4.7% reduction in childhood obesity over 3 years (RWJF, 2015). Barriers to continued demonstration projects such as this include needed political and economic support.

Some observers believe that better healthcare to underserved areas couldbe influenced by educating a more diverse nursing and healthcare workforce. Recent estimates note that minorities make up 19% of the nursing workforce, whereas ethnic and minority groups make up 37% of the U.S. population (AACN, 2019a). An important trend is that ethnic minorities are now more likely to obtain a bachelor's or graduate degree in nursing than their White counterparts, although minorities are underrepresented in nursing school faculties. Individuals from areas that are racially, socioeconomically, and ethnically diverse can provide more culturally competent care. A nursing workforce that has the language skills needed to serve ethnically diverse populations can also enhance health teaching and understanding of health conditions while enhancing trust. Patients from various ethnic backgrounds may be more likely to trust a healthcare system that is not staffed by one exclusive ethnic or racial group. No one would argue that challenges for APRNs and other nursing leaders are abundant. As the past decade has evidenced the development and growth of leaders by DNP education, nurses are now armed with additional skills in leadership, scholarship, and change implementation that will make them pivotal team leaders able to bring solutions to these problems in healthcare. Solving these problems cannot be done in isolation and require active engagement of nurses, APRNs, and all healthcare leaders at all levels of healthcare delivery and policy creation.

Every nurse, particularly every APRN, must practice under the highest standards for providing patient-centered quality care while considering costs, access, and population health. APRNs are more likely to practice in rural and underserved areas and focus on the needs of the community. They are poised as leaders of the next generation to solve important problems and improve healthcare.

REFLECTION QUESTIONS

1. Assume that the nation has decided that all Americans should have access to care. As a leader, what do you think the care delivery system should look like, and what will your role in that care delivery system be?
2. How would you use your leadership skills as the nurse or APRN member of an interprofessional healthcare team?
3. As the United States approaches the goal of health insurance coverage for all citizens, how do you think this will change how nurse leaders function within organizations? How will social determinants of health challenge the ability to achieve the Quadruple Aim?
4. How do literacy skill challenges affect the successful implementation of the Quadruple Aim? How do organizations create and operationalize systems that consider health literacy?
5. Have you experienced workplace bullying or incivility? If so, how has this affected the morale and productivity of the work environment?
6. Does successful implementation of interprofessional teams and educational activities have the potential to contribute to reduced workplace incivility?
7. How do fluctuations in nursing workforce affect care delivery? What is one solution to attract and retain more nurses into faculty roles?

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CHAPTER 4

Practice Models: Design, Implementation, and Evaluation

Mary Cathryn Sitterding, Christy Miller, and Elaine Sorensen Marshall

Were there none who were discontented with what they have,
the world would never reach anything better.
—Florence Nightingale

OBJECTIVES

- *To define and differentiate professional practice and care delivery practice improvement models*
- *To describe care delivery influencers*
- *To describe factors influencing practice model designs, implementation, and evaluation*
- *To discuss the role of cultural competence in leadership and care models*
- *To articulate the importance and components of evidence-informed practice and big data*
- *To explain measures for quality of care and leadership excellence in models*
- *To describe systems thinking competencies*
- *To discuss factors related to patient safety and practice excellence*
- *To discuss implications for nurse and care delivery models integrating technology and artificial intelligence (AI)*

UNDERSTANDING PROFESSIONAL PRACTICE MODELS

Language matters. Understanding how professional practice models are defined, expressed, and applied provides a framework for the design/redesign, implementation, and evaluation of professional practice models. Professional

BOX 4.1 FIVE SUBSYSTEMS OF PROFESSIONAL PRACTICE

1. Values (nurse autonomy, nurse accountability, professional development, high-quality care)
2. Professional relationships (teamwork, collaboration, consultation)
3. A patient care delivery model (primary care and case management)
4. A management approach (decentralized decision-making, expanding the scope of nurse manager responsibilities, structural changes to support professional practice)
5. Compensation, rewards (recognized professional achievement and organizational contribution)

practice models are described as "the driving force of nursing care; a schematic description of a theory, phenomenon, or system that depicts how nurses practice, collaborate, communicate, and develop professionally to provide the highest quality of care for those served by the organization (e.g., patients, families, communities). Professional practice models illustrate the alignment and integration of nursing practice with the mission, vision, and values that nursing has adopted" (American Nurses Credentialing Center [ANCC], 2014, p. 74). The terms *professional practice model* and *care delivery model* are often used interchangeably. However, care delivery models or systems, in contrast to professional practice models, have been described as "integrated within the professional practice model and promote continuous, consistent, efficient, and accountable delivery of nursing care. The care delivery system is adapted to meet evidence-based practice (EBP) standards, national patient safety goals, affordable and value-based outcomes, and regulatory requirements" (ANCC, 2019, p. 145).

Foundational elements of professional practice are nursing autonomy, control over practice, and collaborative relationships. Early in the evolution of nurse-led practice models, Hoffart and Woods (1996) described a professional practice model as a system (structure, process, and values) that supports RN control over the delivery of nursing care and the environment in which care is delivered. They asserted that a professional practice model has five subsystems that remain relevant today (see Box 4.1).

BASIC ELEMENTS OF A PROFESSIONAL PRACTICE MODEL

Cordo and Hill-Rodriguez (2017) theorized that the basic elements of a professional practice model include nursing's values, leadership, collaboration, professional development, and a care delivery system. Among the most important elements of a professional practice model are autonomy and effective professional relationships.

Autonomy

Autonomy and trust are precursors of nurses' work engagement (Bargagliotti, 2012). Conley (2017), in a mixed methods study of nurse managers with more than 6 month's experience, identified the themes of power and influence as factors affecting their engagement. Power was described as the autonomy to make a difference. Influence was defined as the ability to influence and make a difference in staff and unit outcomes (Conley, 2017). (Influence and the significance of nurses as influencers is addressed later in the chapter.) Nurse managers further identified that organizational support regarding education and a trusting relationship with their direct supervisor as valuable to their role. In a longitudinal study of RNs from public, private, nonprofit, sociomedical institutions, and home care services, it was found that there were no statistical differences between healthcare services organizations as work settings and measures of autonomy (Aeschbacher & Addor, 2018). The study also reported that there was an association between working in a nonprofit organization and the highest degree of perceived autonomy (Aeschbacher & Addor, 2018).

Organizational strategies that appear to produce a positive impact on nurse autonomy include the following:

- Nurse training in adaptive individual action strategies (Muller, Heiden, Herbig, Poppe, & Angerer, 2016)
- Self-scheduling (Wright, McCartt, Raines, & Oermann, 2017)
- Collaboration with multidisciplinary teams (Bailey & Cardin, 2018)
- Interdisciplinary rounds (Bailey & Cardin, 2018)
- New nurse mentoring by charge nurses or clinical nurse specialists (Bailey & Cardin, 2018)
- Direct-care nurse participation in skin and wound initiatives (Bailey & Cardin, 2018)
- Monthly stipend for certifications (Bailey & Cardin, 2018)
- Internal and external poster and podium presentations (Bailey & Cardin, 2018)

Three additional studies reported either no effect (Im, Cho, Kim, & Heo, 2016; Labrague, McEnroe Petitte, Leocadio, Van Bogaert, & Tsaras, 2018) or a decrease in nurse perceptions of autonomy with organizational strategies (Catania & Tippett, 2015). A randomized controlled trial of a "huddling" program in Korea, that included measures to promote networking among nurse coworkers, was initiated for nurses with less than 5 years of experience failed to show a significant difference on measures of empowerment (Im et al., 2016). Labrague et al. (2018) studied RNs from nine hospitals in the Philippines and found no correlation between perceived organizational support and job satisfaction or autonomy. A quality improvement initiative of transitioning APRNs who were clinical specialists from a unit-based structure to a population-focused team showed significant improvement in perceptions of participation

BOX 4.2 LEADERSHIP IN ACTION: AUTONOMY AND THE DIFFERENCE IT MAKES

Where do you see autonomy and control over practice in this practice model? In what manner did the leader(s) influence the outcome in this exemplar?

Pressure injury (PI) among the critically ill was of concern within one academic medical center shown to be underperforming when compared with peers regionally and nationally. Two nurse executives (including the chief nursing officer [CNO]) sponsored the team and appointed an interprofessional triad leadership team including a clinical nurse director, clinical nurse, and respiratory therapist to lead the PI Steering Committee. The leadership team partnered with key stakeholders to form a representative steering committee including 50% direct-care clinical nurses, respiratory therapist, quality improvement experts, and operations leaders. Following steering team formation, a comprehensive needs assessment revealed the following: high variation in nursing and therapist knowledge and practice associated with PI risk factors and treatment, absence of standardized processes informing risk assessment and prevention, and variation in role (scope of practice) clarity associated with the autonomy, authority, and accountability to advocate for PI prevention. With an aim to build knowledge, skill, and ability among clinical nurses, the leaders advocated for clinical nurse participation in the Wound Treatment Associate (WTA) program provided by the Wound, Ostomy, and Continence Nurses Society. Informed by a return on investment (ROI) defense, the executive sponsor nurse dyad allocated funds for clinical nurses to become WTA associates. What followed was the development of a differentiated nursing practice model describing top of license performance for all levels of nursing with an effect on pressure injury risk assessment and reduction. Unit-based WTA associates were allocated time provided by nursing leadership to lead unit-based pressure injury rounds twice weekly. During these WTA clinical nurse–led rounds, WTA associates partnered with peer clinical nurses to observe and coach, informed by the clinical nurse–led, evidence-based PI prevention protocol. The collaboration between the clinical nurse providing care and the clinical nurse WTA associate was observed to positively influence the top of the license performance at the point of care (POC) delivery. The PI Steering Committee (including direct-care clinical nurses and WTA associates) facilitates a WTA champions' monthly meeting, where actual and near-miss event reviews are facilitated by direct-care clinical nurses with lessons, mitigation plans, and recognitions. Outcomes associated with this particular practice model include the following: benchmark performance PI regional and national attention with requests for visits, recognition for direct-care clinical nurse, and leadership approach to serious harm reduction.

in decision-making (autonomy), support of leadership, and a positive effect on patients and staff (Catania & Tippett, 2015). Let us reflect further on autonomy and the role of the leader in autonomy (Box 4.2).

Professional Relationships

Professional relationships and teams influencing the idea of community remain significant 20 years following Hoffart and Woods's (1996) seminal work. Implementation of team-building activities in single units (Christiansen, Wallace, Newton, Caldwell, & Mann-Salinas, 2016; Obenrader, Broome, Yap, & Jamison, 2019) increased communication, moral engagement, and relationships across all team members. Creation of a three-tiered peer support group (Wahl, Hultquist, Struwe, & Moore, 2018) can support nurses experiencing compassion fatigue, and provide emotional support and referrals to trained professionals as needed to prevent nurse burnout. Implementation of mentors (Kostrey-Horner, 2017) for new nurse practitioners increased retention, a "sense of belonging," and greater work satisfaction. Gerard, Owens, and Oliver (2016) suggested that the use of a decisional involvement tool across various units creates an opportunity to measure engagement satisfaction rates of staff and implement individual unit-based improvement plans based on results. Bugajski et al. (2017) and Havens, Gittell, and Vasey (2018) surveyed nurses about engagement, and results from both studies suggested that leader engagement and trust of the unit nurses were high indicators of nurses' intent to stay. Additionally, they discovered that interdisciplinary education improved nurse engagement. Garcia-Sierra, Fernandez-Castro, and Martinez-Zaragoza (2016) revealed that although workload was the highest predictor of nurse intention to leave, engagement ranked high, and suggested that support groups should be implemented. In one concept analysis, Camicia et al. (2013) described attributes of a practice model. Common themes among practice models include change, empowerment, improving nursing practice, improving outcomes, strengthening practice, and enhancing collegiality.

BUILDING THE CASE FOR INNOVATIVE PRACTICE MODELS

To describe and understand factors that influence practice model design, implementation, and evaluation, we can look at healthcare from a different perspective. We must examine care delivery practice model influencers such as economic drivers, regulatory standards, patient requirements, workforce factors, and cultural competency. What if banking, home building, automobile manufacturing, shopping, or airline travel were like healthcare? What have we learned about the cost of healthcare in the United States? How will that knowledge inform new models of care? A report from the Institute of Medicine (IOM,

2013, p. 5) included the following creative reminders to promote rethinking of how healthcare is funded:

- If banking were like healthcare, automated teller machines (ATM) transactions would not take seconds but perhaps days or longer as a result of unavailable or misplaced records.
- If home building were like healthcare, carpenters, electricians, and plumbers each would work with different blueprints, with very little coordination.
- If automobile manufacturing were like healthcare, warranties for cars that require manufacturers to pay for defects would not exist. As a result, few factories would seek to monitor and improve production line performance and product quality.
- If shopping were like healthcare, product prices would not be posted, and the price charged would vary widely within the same store, depending on the source of payment.
- If airline travel were like healthcare, each pilot would be free to design his or her own preflight safety check, or not perform it at all.

Hospital costs total more than $850 billion per year, almost 33% of all U.S. healthcare spending, with charges averaging $4,300 a day for hospitals in the United States (Costs of Care, 2016). The United States spends at least twice as much per capita per year, approximately $8,500, as any other developed nation. The IOM (2013) report titled *Best Care at Lower Cost* addressed the phenomenal waste of our nearly $3 trillion annual healthcare expenditures. Some factors that contribute to such costs include heavily promoted medications despite limited evidence regarding their efficacy, unnecessary procedures and surgeries, variation in the cost of instrumentation during surgery, and complications associated with surgery (Topol, 2015). New care design is imperative given the issues of patient experience, quality and safety, workforce, technology, and cost. Incremental innovation is insufficient to achieve radical change. Disruptive innovation is required. We must accelerate our efforts to meet the needs of those we serve and with whom we serve. An understanding of implications for professional practice models and the practice environment is important to advance such needed innovation.

CARE DELIVERY PRACTICE MODEL INFLUENCERS

Care delivery practice model influencers include economic drivers, regulatory standards, patient care requirements, workforce factors, and cultural competencies. During a period marked by unprecedented change, factors influencing healthcare delivery within the United States are becoming increasingly complex and interdependent. Organizations are challenged with forecasting anticipated payment reform changes during an uncertain political environment in efforts to remain financially sustainable. Increased access to healthcare services as a

result of health policy changes has increased the diversity of populations being served. The change in patient demographics creates challenges for healthcare professionals to effectively meet the needs of their customers. The ability to meet the needs of customers has become increasingly important as healthcare consumerism begins to reach new heights. As with other industries, consumerism has put patient (customer) requirements at the forefront of care delivery. Individuals most affected by all these transformations in healthcare are those who deliver the care. Understanding workforce factors that influence care delivery efforts is critical for healthcare executives. The following describes an exploratory review of literature about economic trends, regulatory standards, customer preferences, workforce distribution, and healthcare professional cultural competency and their influence on care delivery. Findings should be used with caution as healthcare continues to evolve in unprecedented ways that can limit generalizability of research results of the past. However, understanding what researchers have learned assists healthcare leaders in strategically planning for the future.

Economic Drivers

Health policy legislation, mainly the Affordable Care Act (ACA), has been a significant driver of economic factors impacting healthcare delivery over the past decade. With healthcare spending accounting for more than 20% of the United States' gross domestic product in the next 5 years, the continuation of healthcare cost opacity cannot continue (Robert Wood Johnson Foundation, 2016). Transparency of cost and quality for healthcare products and services is believed to be a key tool in lowering costs and improving outcomes for patients (IOM U.S. Roundtable on Evidence-Based Medicine, 2010). Calls for increased price transparency by consumers and leaders are spurring a new movement known as healthcare consumerism. With more consumers spending money out of pocket due to rising insurance premiums and high deductible plans, the need for informed decision-making has never been greater for patients. More than half of consumers are now seeking the cost of care prior to receipt (Ellison, 2015). In fact, as many as 67% of those consumers with deductibles ranging from $500 to $3,000 have done so, and 74% of those with deductibles greater than $3,000 sought this information. However, even with the call for price transparency many states are still not doing it well. The Catalyst for Payment Reform gave 45 states an F when it came to price transparency (Robert Wood Johnson Foundation, 2016). Increased openness regarding cost of care can become complicated as many physicians have relationships with pharmaceutical companies, hospitals, and financial stakeholders that may influence consumers and provider decisions (IOM U.S. Roundtable on Evidence-Based Medicine, 2010). Transparency also highlights that the cost range for similar services within the same geographical proximity can be astoundingly different without cause.

Since a majority of healthcare consumers do not believe that higher costs generally equate to better care (Robert Wood Johnson Foundation, 2016), transparency about quality is also needed.

Another significant economic influencer on healthcare delivery is related to the renewed emphasis on The Center for Medicaid & Medicare Services' (CMS) Accountable Care Organization (ACO) Program. This program is rooted in cost, quality, coordination, and satisfaction. As organizations achieve benchmarked quality indicators, they participate in a shared savings program. Being able to deliver high-quality care that meets the designated benchmarks lets organization share in the profits. Thus, organizations are focused on containing costs so that net margins are maximized.

Regulatory Standards

Regulatory bodies have a significant influence on care delivery, especially in terms of quality and safety. The CMS provides insurance coverage for a large proportion of the healthcare consumer population. Adult patients covered by Medicaid have been shown to have a higher rate of readmission than those who are privately insured. The rate of readmission nearly matches that of Medicare patients where one out of every five patients is readmitted (Jiang et al., 2016). Readmissions are seen as an indicator of poor quality of care during a recent hospitalization, a lack of coordination during an earlier hospital stay, or inadequate follow-up care for the patient (Jiang et al., 2016). Since readmissions are often viewed as preventable and contribute to increased costs for insurers, the CMS has implemented reimbursement changes (Jiang et al., 2016). Readmissions within 30 days of discharge for the same diagnosis are no longer reimbursed. This trend has been seen in varying capacities in the private insurance companies. The focus on value is a paradigm shift in an industry previously incentivized to maximize readmissions rather than reduce them (Jiang et al., 2016). Some warn that readmission reduction needs to be approached carefully. If organizations work too hard to reduce lengths of stay or admissions, it could potentially create unrealistic expectations and make operating the healthcare organization a challenge and reduce quality of care.

A second factor that influences healthcare delivery is the requirement to report serious safety events. In 1996, the Joint Commission on Accreditation of Healthcare Organizations (TJC) implemented a formalized policy that directs hospital practices around sentinel event reporting so that organizations could learn how to improve safety (Blanchfield, Acharya, & Mort, 2018). The National Quality Forum (NQF) also requires the reporting of 29 adverse safety-related events. Events meeting the criteria of being "largely, if not entirely, preventable, serious, and any of the following: adverse, indicative of a problem in a healthcare setting's safety systems or important for public credibility or public accountability" now need to be reported. More than half the states require

this reporting. It is estimated that $4.4 billion is spent annually on healthcare delivery costs related to investigating, processing, and reporting of events. In a resource-strained environment, the efforts involved in the investigation, processing, and reporting of events place considerable financial and human resource strain on organizations. In one study, it was estimated that 65% of the total costs for reporting serious safety events were for investigation, while public and internal reporting account for approximately 27%. The average cost per event can range anywhere from $6,600 to $21,000. While surgical and device-related events were the most expensive, the average cost of a serious event related to care management generally costs around $7,000 (Topol, 2019). Reduction in events and streamlined reporting efforts may be a way to control costs for organizations.

Patient Requirements

Patient care requirements during a period of growing healthcare consumerism require organizations to explore patient needs, preferences, and values. Chronic disease rates are increasing across the nation and account for 78% of healthcare spending (Bodenheimer, Chen, & Bennett, 2009). In 2005, more than 133 million Americans had at least one chronic condition, while 63 million had two or more (Bodenheimer et al., 2009). Chronic conditions are expected to continue to climb over the next few years and will require multidisciplinary support for optimal patient outcomes. These are complicated by other factors leading to repeated hospital admissions. These factors include financial stress, mental health and substance abuse disorders, medication nonadherence, and housing instability (Jiang et al., 2016). As the complexity of factors influencing patient wellness mount, attention must also be given to the preferences and values of patients.

Hundreds of studies have been conducted on patient and family satisfaction. Response and integration of findings has never been more critical. Across systematic reviews, the quality of care or the quality of healthcare professional performance has been a determinant of patient satisfaction. In one study, 66% of the variance in patient satisfaction was explained by facility quality and staff performance (Naidu, 2009). As with other industries, satisfaction drives loyalty. In the mid-1990s, negative word of mouth about care quality or experience could cost organizations anywhere from $6,000 to $400,000 over the course of a single patient's lifetime (Naidu, 2009). Satisfaction is critical in a time where consumers are driving care delivery, and in some cases, considered for reimbursement. Similarly, satisfaction with the healthcare professionals' competence was the second leading factor of satisfaction in another study (Batbaatar, Dordagva, Luvsannyam, Savino, & Amenta, 2017).

Access and convenience are becoming increasingly important and have significant implications for healthcare delivery teams. As patients of lower

socioeconomic status struggle to make appointments at times outside of their working hours, teams are considering extended clinic hours and walk-in appointments (Jiang et al., 2016). Also, the demand for access to personal health data is also increasing (Lusignan et al., 2014). A systematic review of patients utilizing electronic healthcare records such as *MyChart* has been shown to significantly increase satisfaction, reduce errors on medication lists, reduce incorrect drug reactions, improve participation in preventive care activities, and has had a small impact on adherence (Lusignan et al., 2014). Through such platforms, patients are empowered to communicate with their team. However, patients desire to communicate directly with their provider, while providers generally prefer to filter messages through their support team (Lusignan et al., 2014). Although the utilization of technology increases convenience and access to care teams, healthcare reimbursement practices are highly dependent on face-to-face interaction (Bodenheimer et al., 2009). Without widespread reform, such use of technology may compete with revenue-generating activities of seeing patients in clinics.

While cost is becoming a more significant factor for healthcare users, quality of care is also important to consumers (IOM U.S. Roundtable on Evidence-Based Medicine, 2010). Quality correlates with patient satisfaction (Batbaatar et al., 2017; Naidu, 2009).

Workforce Factors

The healthcare workforce (personnel) is the highest expense for institutions. Although this has led to some policies that work to replace nurses with less-expensive personnel, it has led others to invest in nursing so that patient outcomes are improved (Lankshear, Sheldon, & Maynard, 2005). Much of the recent research on nursing has been centered on workforce distribution. In general, across two systematic reviews and two descriptive studies, a higher proportion of nurses to other care providers was associated with improved patient outcomes such as mortality, failure to rescue, complications, adverse events, falls, pressure ulcers, and satisfaction (Dunton, Gajewski, Klaus, & Pierman, 2007; Hockenberry & Becker, 2016; Lankshear et al., 2005; West, Mays, Rafferty, Rowan, & Sanderson, 2009). Also, in limited instances, increases in nursing hours per patient day were shown not to have a significant effect on patient outcomes. For example, Whitman et al. also found no relationship between staffing and rates of pressure ulcers or central line infections (Lankshear et al., 2005). However, units having a higher utilization of contract nurses or licensed practical nurses (LPNs) was associated with a lower rate of overall satisfaction and likelihood that the hospital would be recommended (Hockenberry & Becker, 2016).

Other factors that affect care delivery are the distribution of nurses across care settings. As chronic care increases the need for additional nurses in ambulatory or outpatient settings, most nurses still work in inpatient units. Many healthcare professionals are unaware of the workforce factors that affect

patients' outcomes. One example is the lack of awareness of Medicaid patients' high risk for readmission. There is also a lack of understanding about cost to patients (Jiang et al., 2016).

There is also a lack of effectiveness in managing certain patient populations. One example is related to the ongoing mental health crisis. It is expected that chronic mental health disorders will increase from 30 million to 47 million (Bodenheimer et al., 2009). Healthcare professionals feel unprepared to access and mobilize resources needed to meet the psychosocial and behavioral needs of patients. More specifically, healthcare professionals are generally unprepared to manage the opioid dependency that the country is facing (Jiang et al., 2016).

CULTURAL COMPETENCY OF HEALTHCARE PROFESSIONALS: LEADING THROUGH DIVERSITY

The combination of increased access to healthcare services coupled with a changing population contribute to an increased need for cultural competency among healthcare professionals (Shingles, 2018). Numerous studies have documented that racial and ethnic minorities are exposed to higher rates of disease, disability, and death (McCalman, Jongen, & Bainbridge, 2017).

Research has identified key barriers related to cultural competency. One systematic review identified that language, limited resources, and cultural differences between the healthcare professional and patient can impact the quality of care provided. Language barriers impact care providers' ability to provide education or build trusting relationships (Grandpierre et al., 2018). Misunderstanding can also lead to missed or delayed diagnoses (Anderson et al., 2003). A lack of resources to meet the patient's needs may also be seen as being culturally unaware (Grandpierre et al., 2018).

Facilitators of cultural competency include awareness of cultural differences (Grandpierre et al., 2018). This can involve asking questions about everyday routines to help tailor care and understanding of the role that culture plays in relation to illness and healing (Grandpierre et al., 2018). When patients are from a different culture from care providers, it affects their comfort in asking questions about things they do not understand (Tavallali, Jirwe, & Kabir, 2017). This may affect trust, adherence, and outcomes.

In general, training has been shown to be effective in increasing knowledge, attitudes, and skills in relation to cultural competency (Beach et al., 2005; Govere & Govere, 2016). Some strategies employed to improve competency include foreign language classes, traveling to another country, classroom teaching, or engaging patients to design cultural competence training (McCalman et al., 2017). However, some evidence has shown that training alone cannot improve cultural competence. A systematic review revealed that when learners have negative constructions about culturally and linguistically diverse people, they exhibit higher levels of resistance and are more likely to rate such training as low (Dune, Caputi, & Walker, 2018).

Improved cultural competency among providers improves patient satisfaction and therapeutic relationships. Systematic reviews show that culturally competent care improves satisfaction, adherence, and perceptions of trust with healthcare provider, along with respect and listening (Beach et al., 2005; Govere & Govere, 2016). In a small qualitative study of Swedish parents, the longer the parents had lived in the country or had been in the hospital with their child the less important it was that the nurse understood all aspects of their culture. They felt that the nurses had respect for the family and that through time with one another learned about each other's culture. The exception to this was when patients had chronic and serious illnesses; it was then necessary for nurses to be familiar with religious practices (Tavallali et al., 2017).

The lack of cultural competency can have devastating effects on the therapeutic relationship between the patient and the provider. If the provider is not seen as culturally competent or understanding of how diversity may affect patients' health and practices, it can put patients at risk (Dune et al., 2018). This is evidenced by studies that have shown differences in referral practices, prescribing patterns, treatment plans, and procedures. When care providers have ethnocentric attitudes related to society, health, economics, and politics, it can reinforce racism, discrimination, prejudice, and exclusion (Dune et al., 2018). See Box 4.3 for a related new media resource.

Leaders must ensure that care delivery and practice models of the future reflect autonomy and control over practice, and interprofessional teams must address aging populations and the increased burden of chronic disease, new roles, and multigenerational workforces.

BOX 4.3 NEW MEDIA: CULTURAL COMPETENCY

Video

"Becoming a Culturally Competent Nurse." Johnson & Johnson Nursing. https://www.youtube.com/watch?v=r62Zp99U67Y

REFLECTION QUESTIONS

1. Reflect on a professional practice or place you have worked as a nursing professional. Were the processes and patient outcomes patients' ideal? If not what do you think influenced those outcomes?
2. Reflect on a professional practice or place you have experienced as a patient or family member. Do you think the healthcare professionals met your goals for care? If not what influenced that?
3. What regulations and regulatory standards that you think have negatively influenced patient care. Provide one concrete example.

PRACTICE MODEL REDESIGN: IT IS TIME

The time has come for a new generation of practice models. Given the unprecedented levels and speed of research output and technological advances, the forecast includes transformative breakthroughs and innovative care with exponential effect. Transformational leadership is required to positively influence professional practice models. Excellence in practice model redesign, implementation, and evaluation depends on you and the next generation of transformational leaders.

There is, perhaps, not a single person in the United States who will argue that our healthcare system does not need change or redesigning at some level. In evaluating redesign, we must assess the environment and communication as it relates to relational coordination, teaming, and psychological safety inherent to a healthy work environment. The U.S. healthcare system is ranked among the highest in cost and lowest in outcomes on almost any scale among those of developed countries. Our healthcare system has been the brunt of criticism from popular media to the federal government. Selected metrics of healthcare in the United States have changed in the past 40-plus years arguably demonstrating the need for change (Topol, 2019; Table 4.1).

Assessing the Workplace Environment

How might you assess the environment for professional practice, including care delivery? Nearly as important as environment for patient care is the concept of the work environment for the clinician. For the past 30 years, leaders in nursing

TABLE 4.1 Changes in Metrics and Indicators of Healthcare Industry

METRIC	1975	2019
Number of healthcare jobs	4 million	↑ 16 million
Healthcare spending per person	$550/year	↑ $11,000/year
Time allotted for office visits	60 min new 30 min return	12 min new 7 min return
Percent of GDP healthcare	<8	18
Hospital daily room charge (average)	~ $100	$4,600
Miscellaneous	None of these	Relative value units, electronic health records, health systems

GDP, gross domestic product.
Source: Topol, E. J. (2019). High-performance medicine: The convergence of human and artificial intelligence. *National Medicine, 25*(1), 44–56. doi:10.1038/s41591-018-0300-7.

have been investigating work environments that support nursing practice, recruitment, and retention, and are beginning to identify how such factors are important to patient outcomes. The nursing work environment demands attention to promote healthcare quality, safety, and patient and clinical well-being (Lake et al., 2019). The American Association of Critical-Care Nurses posited six standards that cumulatively reflect healthy nursing work environments. These are the following: (a) skilled communication, (b) true collaboration, (c) effective decision-making, (d) appropriate staffing, (e) meaningful recognition, and (f) authentic leadership. Lake's work underscores the imperative that nursing education includes content describing the association between healthy nursing work environments and the following outcomes: nurse job outcomes, patient health record–based outcomes, patient satisfaction, and nurse assessment of quality and safety (Lake et al., 2019).

Early health system work environmental studies include Magnet® hospitals, which have been officially recognized to provide positive environments for professional nursing practice. During the process of both self-assessment and external assessments various components of the nursing care delivery processes are examined. Two examples of nursing work environment and practice model assessments frameworks include the Magnet Recognition Program (discussed later) and Transitions to Practice Programs. An example of parameters or criteria used in such assessment programs are shown in Box 4.4.

BOX 4.4 PRACTICE MODEL EVALUATION PARAMETERS

PRACTICE MODEL EVALUATION PARAMETERS

(Each Evaluated From 1 to 10 According to Evidence Provided)

- Transitions to practice programs
- Differentiated nursing practice
- Interdisciplinary collaboration
- Clinical care emphasizing quality, safety, interdisciplinary collaboration, continuity of care, and professional accountability philosophy
- Contributions of nurses' knowledge and expertise recognized
- Nursing representation at decision-making tables at all levels of the organization
- Clinical advancement programs based on education, certification, and advanced preparations
- Professional development structures and processes for nurses
- Collaborative relationships among members of the healthcare provider team
- Utilization of and technological advances in clinical care and information systems

Skilled Communication: Relational Coordination, Teaming, and Psychological Safety

Inherent within healthy work environments are skilled communication, relational coordination (Gittell, Godfrey, & Thistlethwaite, 2013), and teaming (Edmondson, 2019). Relational coordination (Gittell, 2009) describes the interdependence among tasks, but more importantly the interdependence among people who perform those tasks. The theory of relational coordination describes three attributes of relationships that support the highest levels of coordination and performance among members of a team and include shared goals (transcend team members' specific functional goals), shared knowledge (enables team members to see how their particular tasks interrelate), and mutual respect (enables team members to breakthrough status barriers influencing their ability to see the work of others). Gittell (2009) found that shared goals, shared knowledge, and mutual respect reinforce, and are reinforced by, specific dimensions of communication that support coordination and high performance, specifically, frequency, communication that supports coordination and high performance, timeliness, accuracy and, a focus on problem-solving rather than blaming. See Box 4.5 for related new media resources.

Situational humility, curiosity, and a willingness to fail and learn quickly together are factors that positively influence teaming and psychological safety within a fearless team. Edmondson asserted that psychological safety is what it takes to thrive in a volatile, uncertain, and chaotic world. Psychological safety is the "belief that the work environment is safe for interpersonal risk

BOX 4.5 NEW MEDIA: RELATIONAL COORDINATION, TEAMING, AND PSYCHOLOGICAL SAFETY

TED Talks

Amy Edmondson, PhD. "How to Turn a Group of Strangers Into a Team." https://www.youtube.com/watch?v=3boKz0Exros

Jody Hoffer Gittell, PhD. "The Power of Simple Ideas." https://www.youtube.com/watch?v=X7nL5RC5kdE\

Websites

- Published papers on relational coordination including, but not limited to relational coordination measurement: https://heller.brandeis.edu/relational-coordination/resources/recent-papers.html.
- Resources including workshops, assessment tools, and so on, to improve team-based communication and coordination: www.rchcweb.com\

taking" (Edmondson, 2019, p. 8). As described, psychological safety allows members of a team to focus on shared goals rather than self-protection. Fear negatively influences psychological safety, inhibits learning, and consumes physiological resources diverting them from parts of the brain that manage working memory and our ability to process new information. Fear inhibits analytical thinking, creative insights, and problem solving (Edmondson, 2019, p. 14). Framing the work, emphasizing the purpose, inviting participation, proactive inquiry, systems and structures, expressing appreciation, destigmatizing failure, and sanctioning clear violations are necessary attributes of leaders creating psychologically safe work environments. Edmondson (2019, pp. 181–182) offered leaders some guiding questions to self-assess the psychological safety of their followers and teams related to their own leadership behaviors (see Exhibit 4.1).

EXHIBIT 4.1 PSYCHOLOGICAL SAFETY: LEADER SELF-ASSESSMENT

1. Have I clarified the nature of the work? To what extent is the work complex and interdependent? How much uncertainty do we face? How often do I refer to those aspects of the work?
2. Have I spoken of failures in the right way, given the nature of the work? Do I point out that small failures are the currency of subsequent improvement?
3. Have I articulated clearly why our work matters, why it makes a difference, and for whom?
4. Have I made sure that people know that I do not think I have all the answers?
5. Have I emphasized that we can always learn more? Have I been clear that the situation we are in requires everyone to be humble and curious about what is going to happen next?
6. How often do I ask good questions rather than rhetorical ones?
7. Do I demonstrate an appropriate mix of questions that go broad and deep?
8. Have I created structures that elicit ideas and concerns?
9. Are those structures well designed to ensure a safe environment for open dialogue?
10. Have I listened thoughtfully, signaling that what I am hearing matters?
11. Do I acknowledge or thank the speaker for bringing the idea or question to me?
12. Have I done what I can to destigmatize failure? What more can I do to celebrate intelligent failures?
13. When someone comes to me with bad news, how can I make sure it is a positive experience?
14. Have I clarified the boundaries?
15. Do I respond to clear violations in an appropriately tough manner to influence future behavior?

REFLECTION QUESTIONS

1. Take a few minutes and think about a time when you experienced extraordinary team performance.
2. What do you believe were two or three factors influencing what made team or teaming in that particular experience extraordinary?
3. What did you experience or observe in the role of the leader in team and teaming?

Practice Model Redesign and Implementation

As mentioned earlier, practice model redesign begins with an assessment of the professional practice model, care delivery model, and healthcare environment. Collaborative assessment, including all key stakeholders, is imperative as involvement in the assessment of need dramatically influences adoption of the next generation practice model. Redesign should include all key stakeholders—those influenced by and operating within the redesigned model, including disciplines outside of nursing, consumers (patients and families), and payers. See Box 4.6 for practice model redesign in action.

BOX 4.6 LEADERSHIP IN ACTION: PRACTICE MODEL REDESIGN

Scenario: It is 2025. Fifty percent of your nursing workforce has reached the retirement age. New graduates have doubled over the past few years; however, the days are long gone when a new graduate selected one role within one setting and remained in that role and that setting for more than 2 years. Transformational nurse leaders are in high demand and are expected to positively influence acquisition or sustainability of Magnet designation, with prioritization monitoring the workforce and mitigating knowledge loss given the typical 1-year turnover rates experienced in U.S. hospitals. The volume and complexity of healthcare needs and expectations among baby boomers have crippled many organizations practicing traditional eminence-based medicine. A Magnet system of hospitals in the Midwest is recruiting transformational leaders. You are one of their top three candidates. Your final interview is with the system chief nurse executive (CNE), chief executive officer (CEO), chief financial officer (CFO), and patient–family advisory representative (PFAR). They present you with the following challenge:

> *We believe we need to disrupt our existing practice model. We and our board of trustees are particularly concerned about two seemingly*

(*continued*)

BOX 4.6 LEADERSHIP IN ACTION: PRACTICE MODEL REDESIGN (*continued*)

different practice settings: critical care and our 25-clinic ambulatory setting. We need to stabilize our critical care practice delivery as the first-year turnover is 20%, most of our clinical nurses have less than 2 years of experience, and we barely exceed the mean in preventing hospital-acquired conditions. Our nurse managers are exhausted. New nurses seem to want more development-expecting career conversations on hire and every quarter. We are also concerned about the ambulatory service challenged with access, efficiency, and effectiveness results. You can be as creative as necessary regarding human and material resources, given that you optimize the role of the RN and all assignments are within licensed scope of practice.

A few simple rules are as follows:

- You must remain budget neutral.
- Your plan must be patient-centric and reflect the ideas of those closest to the POC delivery.
- Target empirical outcomes must reflect the Quadruple Aim: patient–family experience, quality and safety, employee experience, and cost-effectiveness.

Take the challenge. Embrace the opportunity to redesign and transform. It is your turn to design.

CHANGING MODELS OF CARE THROUGH EVIDENCE-INFORMED PRACTICE

No organizational or system-wide change can be effective or enduring without the wise and appropriate use of evidence. As part of patient care delivery and outcomes in any current professional practice model, a key component should be continual use of evidence. By now, EBP should be a way of professional life. Its value has been well demonstrated in all aspects of healthcare and proven to be so critical to patient care outcomes that the leader who is not inspirational in its universal application is irresponsible. It is fundamental to clinical practice, and is an essential role for leaders to ensure its universal implementation. Nevertheless, Melnyk et al. (2018) found among 2,344 nurses representing 19 hospitals or healthcare systems that nurses reported they were not yet competent in meeting any of the 24 EBP competencies. The basic tenets of effective use of evidence must be part of the daily discourse of the transformational leader. The leader can facilitate the examination and use of evidence from all disciplines. No single profession, practice, or area of study owns all helpful information for healthcare.

Nurse Leaders: How to Engage Clinical Nurses in Evidence-Informed Problem-Solving

Models enabling nurse leaders to engage clinical nurses in problem-solving require (a) application of the psychology of change framework, (b) differentiating and optimizing quality improvement, (c) use of lean, POC evidence-based scholars programs, and (d) shared governance structures in the institution. Hilton and Anderson (2018) described many evidence-based, research-derived bio- and socio-medical models that, if reliably applied and scaled to meet demand, would save or improve many lives. However, most reach only a portion of benefit, given it is often difficult to disseminate and scale up (McCannon, 2007); difficult to translate from experimental setting to "real-world" (Ioannidis, 2005); and difficult to reproduce in settings with heterogeneous resources (Parry, Carson-Stevens, Luff, McPherson, & Goldman, 2013). Nursing leaders understanding and applying the Institute of Healthcare Improvement (IHI) Psychology of Change Framework (Hilton & Anderson, 2018) engage clinical nurses in evidence-informed problem-solving through three levels of agency: self (individual agency to make his or own choices), interpersonal (collective agency of people acting together), and system (structures, processes, and conditions that support the exercise of agency within and across institutions). Nurse leaders activate the clinical nurse self and interpersonal agency through the following:

1. Unleashing intrinsic motivation as intrinsic motivation galvanizes individual and collective commitments to act
2. Codesigning people-driven change because those most affected by change have the greatest interest in designing it in a manner that is meaningful and workable for them
3. Coproducing with others within an authentic relationship as change is coproduced when people inquire, listen, see, and commit to one another
4. Distributing power because people contribute their unique assets to bring about change when power is shared.
5. Adapting in action as acting can be a motivational experience for people to learn and iterate to be effective.

See Box 4.7 for leadership in action.

Shared Governance and the Role of the Nurse Leader in EBP Implementation

Unfortunately, despite universal recognition of the importance of EBP, it continues to require the vigilance of a bold leader to implement and ensure its practice throughout the entire organization. Practice leaders and managers can support specific evidence-based projects and decision-making, facilitate measurement of quality and safety, use outcome measures to evaluate quality,

REFLECTION QUESTIONS

1. How might you begin to lead an evidence-based improvement initiative through engaging the POC clinical nurse in either the acute or primary care setting? What "learning opportunities" could you provide those nurses about themselves, care delivery, and patient outcomes?
2. What strategies would you use to distribute power (autonomy) to others with less-informal positional authority in an effort to improve a quality or safety outcome of interest?
3. Who are your initial "go to" people that will positively influence change adoption? Why have you chosen these individuals? What qualities do they have that make them effective in influencing others?

BOX 4.7 LEADERSHIP IN ACTION: ENABLING PRACTICE EVIDENCE-INFORMED MODEL DESIGN

One example from an academic pediatric hospital in the Midwest, demonstrates how the nurse leader engages clinical nurses in evidence-informed problem-solving. Nurse leaders can engage clinical nurses in evidence-informed problem-solving through POC scholar programs. POC scholar programs support evidence-based, autonomous, evidence-informed clinical decision-making. Nurse leaders engage clinical nurses through protected time, access to professional literature, use of a laptop computer, and a mentor from an expert in evidence-based decision-making. POC scholars' protected time is spent in applying the evidence-based practice process described by Melnyk (2011), from creating a clinical question to making an evidence-based decision for nursing care.

For example, a clinical nurse led venous thromboembolism (VTE) risk-reduction team exploring current practice within the perioperative setting related to the use of sequential compression devices (SCD) for children at risk for VTE. Clinical nurse POC scholars noted the absence of standard guidelines for the application of these devices when they were ordered for children at risk for thromboembolism undergoing surgery. They observed that nurses were inconsistent in their practice of applying the SCD in the perioperative setting. The clinical question developed by the POC scholar clinical nurses was the following:

> Among children and adolescents at risk for deep vein thrombosis (DVT), does the application of sequential compression devices prior to anesthesia induction compared with application after anesthesia induction affect the development of DVT during the postoperative period?

Clinical nurses were allocated time and resources to build EBP competencies otherwise absent as described by Melnyk et.al. (2018). On completion of the POC

(*continued*)

BOX 4.7 LEADERSHIP IN ACTION: ENABLING PRACTICE EVIDENCE-INFORMED MODEL DESIGN (*continued*)

scholar program, clinical nurses presented their project to their colleagues in the operating room. As a result, clinical nurses were invited to join the organization-wide Venous Thromboembolism-Hospital Acquired Conditions (VTE-HAC) task force. The organization-wide task force created a bundle of interventions for venous thromboembolism prophylaxis. Among the interventions included in the bundle was the evidence-based recommendation for patients at risk of a VTE who are undergoing general anesthesia. As identified by the clinical nurse participating in the POC scholars program, it was recommended that SCD be applied prior to anesthesia induction and remain in use for the duration of the surgery or procedure.

and support exemplars at the point-of-service level of care (Newhouse & Johnson, 2009). Smooth and pervasive use of evidence in practice requires some degree of change or transformation of the entire system, culture, leadership characteristics, evaluation methods, and professional environment (Cummings, Estabrooks, Midodzi, Wallin, & Hayduk, 2007; Newhouse, 2007, 2009).

Nurse leaders in clinical practice can inspire and promote the use of evidence in practice by linking with academic settings that foster collaboration with students and faculty. APNs can model the use of evidence in daily patient care. Each setting has its unique characteristics that must be considered in the application of evidence. Implications of context and culture are especially important, since EBP is not a solitary act of practice but an initiative that requires an entire community of committed clinicians. For example, conditions in rural and community hospitals may require unique and inventive infrastructures to support EBP (Jukkala, Greenwood, Motes, & Block, 2013; Kram, DiBartolo, Hinderer, & Jones, 2015). Recruit everyone at all levels into the role of implementing EBP in a context of shared accountability and shared governance (Melnyk & Fineout-Overholt, 2014; Newhouse, 2009; Waddell, 2009). Pervasive use of evidence in practice certainly requires the support of leadership, but it must also be claimed, integrated, and practiced with a sense of autonomy and creativity at the POC (Strout, Lancaster, & Schultz, 2009) and throughout the system.

The IOM Roundtable on Evidence-Based Practice (IOM, 2009) called for 90% of healthcare to be evidence-based by 2020. To meet this imperative, nursing leaders must communicate and execute a clear vision for EBP within their organizations. The role of the nurse leader is to create the infrastructure, climate, resources, program-enabling sustainment, and report and reward successes (Cullen & Hanrahan, 2018). Implementation and dissemination of EBP is consistent with the Magnet Recognition Program requirements (ANCC, 2019, p. 64).

For example, to move from adoption of a practice change to expanding and sustaining EBP across the organization, internal reporting is essential.

Cullen and Hanrahan (2018) asserted that nurse leaders have a *responsibility* to articulate EBP work in a way that is heard and understood by decision-makers. The benefits are twofold: (1) Senior leaders are informed about great work that has been accomplished, and (2) the business case for evidence-based care is communicated to governing boards. Communicating with boards about EBP goals, initiatives, and achievements is an important part of any successful EBP journey (Bisognano & Schummers, 2015; Cullen & Hanrahan, 2018; Mason, Keepnews, Holmberg, & Murray, 2013). Factors influencing adoption of evidence at the POC delivery include characteristics of the evidence (newly developed or revised guideline or protocol); availability of practice; prompts that trigger the adoption of evidence; the perceived advantage of adopting the evidence from the perspective of the end user; and mindful communication with all key stakeholders, including opinion leaders, change champions, core groups of influence; and academic detailing (Pittman & Sitterding, 2012).

Supportive leadership behaviors required for organizational institutionalization of EBP reflect a complex set of interactive, multifaceted EBP-focused actions carried out by leaders from the chief nursing officer to staff nurses. Stetler, Ritchie, Rycroft-Malone, and Charns (2014) proposed a leadership framework that may provide concrete guidance needed to underpin the often-noted but abstract finding that leaders should "support" EBP. The findings of this study outline and reinforce the dynamic nature of EBP-supportive leader behaviors. They illustrate the need for leaders to strategically and routinely use a range of integrated and transparent behaviors to achieve and sustain EBP as the norm. Supportive leadership behavior for EBP is illustrated and acted on through the strategic plan and, as such, leading successful implementation and maintenance of EBP is enculturated within an organization reflecting observable and consistent leader behaviors that are strategic and functional, and often transformational (Stetler et al., 2014).

The advent of the doctor of pursing practice (DNP) degree launches the opportunity for the clinician prepared at the highest level to guide other healthcare providers in practice inquiry. DNPs are prepared to lead systematic inquiry regarding the realities and complexities of practice, the challenges of translating discovery research into practice, and effective integration of evidence into individual, community, and population-based healthcare. The DNP focuses on providing leadership for EBP. This requires competence in translating research, evaluating evidence, applying research in decision-making, and implementing viable clinical innovations to change practice. Considerable emphasis is placed on a patient population perspective, including how to obtain assessment data on populations or cohorts and how to use data to make decisions about and evaluate programs (AACN, 2015).

Practice-Based Evidence and Use of Big Data

Pioneers in practice-based evidence, Horn and Gassaway (2007, p. S50) described it as a "rigorous, comprehensive" research methodology "that fills gaps in information needed by clinical and health policy decision-makers." Horn et al. (Tunis, Stryer, & Clancy, 2003; Westfall, Mold, & Fagnan, 2007) have led the charge to point out weaknesses in traditional methods of EBP to answer all clinical, leadership, and policy questions. Rather than performing randomized controlled trials, practice-based evidence proposes the use of practical or pragmatic clinical trials (PCT).

Characteristics of PCT include comparing clinically based, existing alternative interventions actually in practice rather than introducing new interventions; large and diverse study populations rather than selected criterion-based samples; recruitment of samples from heterogeneous practice settings rather than from matched, controlled settings; and data collection from a broad and vast range of outcomes rather than selected, isolated variables. In other words, methods of practice-based evidence study what is practiced in a large number of situations, by collecting huge data sets of detailed information on as many variables as possible to compare the effectiveness of interventions and identify what actually works in practice. Furthermore, variables of study are drawn from the perspective of an inclusive multidisciplinary team of researchers, practitioners, and others who have direct experience with the issues to be studied, and the method depends on local knowledge. Rather than *efficacy* measured by evidence-based approaches, practice-based methods measure *effectiveness*. What might be considered as confounding and irrelevant variables in a randomized controlled study would be considered relevant, included, and controlled statistically in the practice-based method. The method resembles a kind of epidemiological method largely within institutional acute care environments.

From this method several measures of severity indices used in clinical practice have been developed (Horn et al., 2002). One of the first published incidents of using big data to influence decision-making by physicians was in 2011 at Lucile Packard Pediatric Hospital, Stanford, where Dr. Frankovich searched through her medical records of pediatric lupus patients to determine whether to prescribe anticoagulant medication. Because there were no published guidelines and scant literature on the subject, she resorted to analyzing the patterns revealed in her collection of medical charts. Practice-based or big data research in nursing enables the discipline to use large datasets to examine important healthcare quality questions, looking for hidden patterns in the data that inform hypothesis generation versus hypothesis testing. The term *big data* refers not only to the volume of data, but also to other characteristics, such as variety, velocity, veracity, and value. Brennan and Bakken (2015) asserted that nursing needs big data and big data needs

nursing. Schools of nursing are currently revising their graduate curricula to reflect the need for nurses to understand big data and how to use that information in their practice and research (Broome, 2016). Practice-based evidence reveals patterns shared by thousands and can inform hypotheses that in turn can be answered through the analytical evaluation of multiple data streams (big data).

Data science is defined as the systematic study of the organization and use of digital data to accelerate discovery, improve critical decision-making processes, and enable a data-driven economy (Schmitt, 2014). Practice-based steps or the process and structure for data science inquiry are as follows: (a) obtain (O), (b) scrub (S), (c) explore (E), (d) model (M), and (e) interpret (N) (see Table 4.2). Together, these steps form the acronym OSEMN, pronounced as "awesome" (Mason & Wiggins, 2010).

Data science inquiry is changing with advances in technology and the explosion of data volumes. Data sets are growing faster than ever before, resulting in a shift from digital data generation to data management and analysis (Chen et al., 2018). Data repositories (data storage for both new and existing data) with open data policies allow for retrieval of data ultimately improving statistical rigor and reproducibility (Callier, 2009). Retrieval of relevant datasets in these repositories for reuse in data science inquiry, albeit complex and challenging based on the volume of such data, is becoming more of the norm. Funded through the National Institutes of Health, Big Data to Knowledge Program, a biomedical and healthCAre Data Discovery Index Ecosystem (bioCADDIE) has been developed to improve discoverability (Chen et al., 2018). An open-source biomedical data discovery system prototype called DataMed can search diverse types of biomedical data sets across many repositories, taking full advantage of existing data, facilitating knowledge discovery, and making scientific discoveries more productive and reproducible. DataMed is one of the first data discovery indices to harvest metadata from a broad range of data providers and make it available through a single integrated search system (Chen et al., 2018).

Data that need to be identified, described, discovered, and reused must adhere to guiding principles such as those endorsed by making data Findable, Accessible, Interoperable, and Reusable (FAIR) Data Principles (Wilkinson et al., 2016). FAIR Guiding Principles describe distinct considerations for current data publishing environments with respect to supporting both manual and automated deposition, exploration, sharing, and reuse (Wilkinson et al., 2016).

The roles of nurses at various levels in data science have been proposed as follows: (a) baccalaureate-prepared nurses would be expected to implement data policies, contribute to knowledge development from the bedside, and contribute to devising pathways of informed practice; (b) masters-prepared and doctoral-prepared APRNs would be expected to oversee and implement data policies, initiate knowledge development from the bedside,

TABLE 4.2 Practice-Based Evidence: OSEMN Model Steps

DATA SCIENCE STEP	STEP DESCRIPTION
Obtain: Pointing and clicking does not scale	Without data, there is little data science you can do. So, the first step is to obtain data. Unless you are fortunate enough to already possess data, you may need to do one or more of the following: • Download data from another location (e.g., a web page or server) • Query data from a database or application program interface (API; e.g., MySQL or Twitter) • Extract data from another file (e.g., an HTML file or spreadsheet) • Generate data yourself (e.g., reading sensors or taking surveys)
Scrub: The world is a messy place	It is common that the obtained data have missing values, inconsistencies, errors, weird characters, or uninteresting columns. In that case, you must *scrub*, or clean, the data before you can do anything interesting with them. Common scrubbing operations include: • Filtering lines • Extracting certain columns • Replacing values • Extracting words • Handling missing values • Converting data from one format to another
Explore: You can see a lot by looking	Once you have scrubbed the data, you are ready to explore them. This is where it gets interesting, because you will really get into the data. The command line can be used to do the following: • Examine the data • Derive statistics from the data • Create interesting visualizations
Models: Always bad, sometimes ugly	If you want to explain the data or predict what will happen, you probably want to create a statistical model of your data. Techniques to create a model include clustering, classification, regression, and dimensionality reduction
Interpret: The purpose of computing is insight, not numbers	The final and perhaps most important step in the OSEMN model is interpreting data. This step involves the following: • Drawing conclusions from the data • Evaluating what the results mean • Communicating the results

Source: Mason, H., & Wiggins, C. (2010). A taxonomy of data science. *Dataists*. Retrieved from http://www.dataists.com/2010/09/a-taxonomy-of-data-science/

and devise pathways of informed practice; (c) data-intensive PhD-prepared nurses would be expected to conduct inquiry into basic nursing phenomena supported by data science methods; and (d) doctoral-prepared nurse data scientists would be expected to generate new methods informed by the discipline's phenomena of concern and knowledge-building traditions (Brennan & Bakken, 2015).

The characteristic of variety refers to the type of data, such as images or data that come in a continuous flow (e.g., electronic medical records). Veracity of the data is determined by whether the data can be validated and traced to a source. Velocity of the data refers to the speed at which data are generated and received, while value is the potential of the data for contributing to important scientific discoveries (Brennan & Bakken, 2015).

Practice-based evidence shows promise in public health and is certainly helpful to policy leaders, yet this method needs to be further developed in those areas. All nurses are responsible for providing EBP. Not every nurse will be or should be a data nurse scientist, but all nursing practice should be informed by evidence and data science. The role of the nurse leader is to facilitate all nurses learning their role in the use of data and evidence in driving excellence in care delivery.

EBP and practice-based evidence recommendations are generally insufficient to translate evidence to the POC delivery. Process improvement models are necessary to translate the evidence or new knowledge. Steps in process improvement include the following: (a) interdisciplinary team formation (representing expertise on the topic, those expected to implement the evidence, and the voice of those influenced by the evidence—patients and families); (b) development of a key driver diagram (identification of factors influencing adoption of the evidence); (c) development and implementation of interventions matching the key driver diagram; and (d) measurement representing the rate and effectiveness of adoption.

Evidence-Informed Practice: Role of Nurse Leaders

Just as research indicates the need to integrate EBP throughout healthcare practice, conventional wisdom suggests that evidence can drive leadership. But that is not always the case. Likely in no other area of clinical practice are individual characteristics, preferences, and situations more complex and unique than in the context of leadership. Nevertheless, evidence informs leadership.

Indeed, a growing number of healthcare leaders prefer the term evidence-*informed*, rather than evidence-*based*, practice in leadership and policy (Best et al., 2009; Fretheim, Oxman, Lavis, & Lewin, 2009). Certainly, appropriate evidence and use of data are critical to most aspects of leadership practice (Brandt et al., 2009), but caution is warranted in wholesale development or use of formal or standardized protocols for leadership.

First, empirical evidence based on controlled trials is simply not available or sufficient to mandate a particular formula for a specific leader's decision-making in a situation or setting. Second, leadership is objective and artful, intellectual and emotional, evidence-based and creative risk-taking, often all at the same time. There are helpful guidelines, studies, experts, cases, competencies, and anecdotes, but effective leadership does not follow neatly from a database of clinical trials and outcomes (Arndt & Bigelow, 2009). Leadership is empirical and metaphysical, positivistic, and interpretive. It happens always in the natural setting rather than a controlled environment. Data are important to successful leadership, but leading is often about meaning more than measurement. People function in a place of context, meaning, and stories. Thus, the wise leader balances use of data from evidence, appropriate technologies, and educated talents of instinct.

Productivity and Effectiveness Models

We use technology to seek, store, and measure results. But measurement of productivity in healthcare is a special challenge. Although we are in the business of healing, healthcare is an industry, a business that measures outcomes and expects accountability and productivity. Increases in cost, wide variations in quality, more diverse and better-informed patients and consumers, and public and business concerns regarding value for investment have provoked a greater interest in productivity and effectiveness in healthcare in general across the United States. Value is what the customer receives for the price paid. Promotion of efficiency and productivity requires integrated and streamlined processes and attention to meeting the needs of the customer, client, or patient.

Traditionally, productivity refers to the amount or quality of output per unit of input, a return on investment, or worker efficiency. It is easy to measure the productivity of a machine or even that of labor to produce a product. Healthcare outputs are more vexing. To a large healthcare system in today's market-oriented culture, productivity may mean its margin of the market. To a hospital worker, productivity may be the timely accomplishment of the day's duties. Ultimately, the productivity of a national healthcare system must be measured by the health of all its citizens.

From a management and human resources perspective, productivity usually refers to productive hours of human labor, most often referred to as full-time equivalents (FTEs), or staff workload used in some formula of output. In acute care systems, outputs are usually measured in some measure related to patient census, acuity levels, patient throughputs, or procedures performed. Other measures include staff turnover related to manager effectiveness.

There are several formal quality and productivity programs. Among the most popular are Six Sigma and Lean. These programs are focused toward manufacturing production, but are growing in use in large healthcare systems

and hospitals (Shankar, 2009). Their goal is to improve quality and decrease cost, with a focus on work processes. Six Sigma is "a disciplined data-driven approach and methodology for eliminating defects" (Lean Enterprise Institute, 2016). The program uses jargon such as "champion" for leaders and awards "belts" (e.g., "green belt" and "master black belt" status). The management approach is driven by outcomes data, usually financial, and based on projects to improve processes by controlling variation and improving predictability. Lean is "a systematic approach to identifying and eliminating eight 'wastes' through continuous improvement by following the product at the 100 percent pull of the customer" (Lean Enterprise Institute, 2016; Pepper & Spedding, 2010). Systems measure productivity by reducing waste of time and human resources for a "lean" journey of the patient across care settings facilitated by efficient coordination of care (Kim, Spahlinger, Kin, Coffey, & Billi, 2009). Principles are that all work is process, process flow can be optimized, and employee flexibility increases productivity and reduces waste. The eight wastes of lean are waiting, defects, extra processing, inventory, excessive motion, transportation, overproduction, and underutilized employees. An increasing number of such outcomes-based measures are considered in a context of productivity.

The long-term value of such programs in human healing organizations is yet to be determined. Effectiveness is reflected by accomplishment of mission, goals, and outcomes and satisfaction by all concerned, including and especially the people we serve. The danger of a focus on efficiency, in its usual sense, in healthcare is its potential effects on quality and patient satisfaction, not to mention pushing out the goals of healing and well-being, which have some human subjective, reflective, and social characteristics that challenge productivity measurement. Productivity and effectiveness must ultimately refer to a focus on value.

The future will require increased knowledge, facility, and creativity by all leaders in healthcare regarding how to integrate important business and market principles into the enterprise of healing. We will need to move beyond safety and efficiency toward value and excellence. The leader who promotes productivity and fosters effectiveness continually sends a message of clear intention of what is expected and when it must be produced. He or she instills a sense of ownership of goals, processes, and outcomes. Even detractors must know the goals, the work, and the desired outcomes of the organization. In business, effectiveness is often associated with the concept of execution. Execution is the action of getting things done. It requires a careful match of people with processes and tasks that come together for highest performance and best results. All does not always go as planned, but the leader guides the team through continuous improvement and recovery. The leader is also the key person to clearly articulate desired outcomes in a manner that can be identified and measured. Why do some good organizations fall short of acceptable productivity and effectiveness? Leaders, be aware of some habits that can quash the spirit to produce. Over-planning and over-measuring can kill the spirit, especially in healthcare. We are in it because we want to help people. We need time to reflect, to cherish

our contact with those we serve, and to create. Over-planning, over-processing, and "over-proceduring" can be devastating. Good leaders hold people accountable, then guide them toward success, recognize that success, and celebrate it.

Effective practice design and management for the future will consider innovative models, embracing an entrepreneurial context. Such designs must include continual assessment at the local unit and entire systems level, decisions based on evidence, effective use of technology in all areas of patient care, and creative ways of measuring effectiveness that improve the efficiency of the system while promoting environments of healing.

MODELS OF CARE DELIVERY

Improving Patient and Healthcare Outcomes

Patient and healthcare outcomes generally refer to the results of our practices on structure, process, or products. The modern origin of the concept of outcomes management is attributed to Ellwood (1988), who referred to outcomes management as "a technology of the patient experience." His basic principles included an emphasis on established standards; measurement of patient functional status and well-being and disease-specific clinical outcomes; collecting outcome data from the broadest reach; and analysis and dissemination to healthcare decision-makers.

The first, most important factor in high-performing organizations committed to improving patient outcomes is commitment of the executive and senior leadership and leadership direction, alignment, and commitment to the vision and mission of the organization (Ulrich, Zenger, & Smallwood, 2013). Achievement of positive healthcare outcomes requires vision, passion, and example at the highest levels. Second is leadership evaluation and accountability. You cannot expect leaders and managers at all levels to function without development as leaders themselves. This is part of the stewardship of generativity of leaders. Managers benefit from development specifically focused to prepare them as leaders. The third factor important to achieving positive outcomes is open communication and formal opportunities for such communication throughout the organization. Finally, a fourth factor is that high-performing organizations nurture a culture where everyone knows that patient-centered care and positive patient outcomes are the "right thing to do," and that they "should" be doing what makes sense for patients. Such organizations report a more friendly and helpful atmosphere, collaboration teamwork, and regard for each other within the organization as well as for patients themselves.

Outcomes have become the language of education and healthcare, but that means whenever an idea or concept grows in organizations, it develops theories; coins its own language, jargon, and meanings; attracts structures; and soon becomes a world of its own. Soon, citizens of that world begin to use only the language of the new world, speak only to each other, and build systems and processes around themselves. Do not let this happen in the endeavor to pursue positive outcomes in healthcare. Allow some positive deviance to break open the

thinking occasionally. Positive deviance approach focuses on those who demonstrate exceptional performance, despite facing the same constraints as others. Positive deviants are identified and hypotheses about how they succeed are generated. These hypotheses are tested and then disseminated within the wider community. The positive deviance approach is being increasingly applied within healthcare organizations. The approach assumes that problems can be overcome using solutions that already exist within the environment. Despite facing the same constraints as others, positive deviants identify these solutions and succeed by demonstrating uncommon or different behaviors. Frontline or POC participation is integral to the approach; for example, the staff selects the problem to address, identifies the positive deviants, and explores how they succeed. Solutions are internally generated (from the bottom up) rather than externally imposed (from the top down), ensuring they are feasible within current resources, acceptable to others, and sustainable over time (Baxter, Taylor, Kellar, & Lawton, 2016).

Sometimes, solutions are in plain sight but just need a new way of looking at them. We need new practices outside the tradition. Look at old problems in new ways. To do that is a hallmark of transformational leadership. The unfortunate rhetorical assumption related to outcomes is that there *is* actually an outcome, or destination, to care. The reality is that healthcare is an ongoing, iterative process to promote health, relieve suffering, and encourage healing. The inspiring leader keeps that vision ahead of the work with a healthy perspective that outcomes are markers on a continuing road toward excellence and improved health.

Quality Improvement and Customized Care: Currency of Customers and Clients

Safety and quality may be the most common areas of discussion and action in healthcare today. They are critical to individual patient care and for the very survival of healthcare systems. Continuous quality improvement is the official jargon for creating an institutional culture that examines processes and systems of care to ensure quality of care. Note that chief nursing executives now spend most of their time on issues of quality, compliance, and patient safety requirements. Nursing leaders have begun to fill that leadership gap to make quality one of the most important current issues in all healthcare situations. Nurses at all levels require leadership skills to contribute to patient safety and quality of care (Agency for Healthcare Research and Quality [AHRQ], 2019; Spann, 2011).

There are several databases or standards directed specifically at quality for nursing practice. We suspect you are familiar in your own agency with at least one of these. Examples include the National Database for Nursing Quality Indicators and the Veterans Administration Functional Status and Outcomes Database. The National Quality Forum (2014) outlined 15 "nursing-sensitive" measures now generally used in acute care institutions as indicators of quality. The measures are divided into three areas: patient-centered outcome measures,

nursing-centered intervention measures, and system-centered measures. Patient-centered outcome measures include failure to rescue (or death among surgical inpatients with treatable serious complications), pressure ulcer prevalence, patient falls prevalence, falls with injury, restraint prevalence, urinary catheter-associated urinary tract infections, central line catheter-associated infections, and ventilator-associated pneumonias. Nursing-centered intervention measures include counseling patients with acute myocardial infarction, heart failure, or pneumonia regarding smoking cessation. System-centered measures include skill mix among RNs, practical nurses, and unlicensed personnel; nursing care hours per patient day; measures of nurse involvement in system governance and professional relationships; and voluntary turnover of nurse employees. Obviously, the list reflects important measures for patient survival, but if a stranger from another planet with superior healthcare visited our system, would that stranger find these measures as minimum for safety or as measures of excellence in healing? We are moving in the right direction with the focus toward improvement of care, and such efforts are making a difference in nursing performance and patient outcomes. But again, the challenge of leaders of the next level is to move performance to higher levels of excellence and healing.

BENCHMARKING

There are several mechanisms by which leaders may engage the organization in pursuit and evaluation of quality. One common way for leaders to confirm, measure, or monitor quality is benchmarking. Benchmarking is a method of comparing aspects of performance with similar organizations. It is usually done to provide information for strategic planning or to improve the processes, productivity, and quality of services. It allows you to make a professional comparison of the quality of your own setting with that of others anywhere in the world (Hollingsworth, 2012). Indeed, engagement in benchmarking activities in itself is a step toward improvement of quality. There is a difference between benchmarking and adopting industry standards or regulatory guidelines. Benchmarking is a voluntary, thoughtful, and selective activity of identifying peer organizations or organizations that you aspire to emulate on a specific process or outcome. You are then able to set specific goals related to the benchmark findings. Following are some of the steps outlined by Hollingsworth (2012, pp. 49–50) for successful benchmarking (sponsored by the American Society for Quality):

1. Identify benchmarking partners.
2. Determine what constitutes the benchmark calculation or data source.
3. Gather information from peer sources.
4. Compare actual data to benchmark data.
5. Identify variances and calculate gaps in performance.
6. Identify ideas for improvement, set goals, and develop and implement an action plan.

Benchmarking is most commonly done in hospitals and educational settings, but the principles apply to other settings such as primary care or public health.

MAGNET DESIGNATION

Magnet designation is another mark of quality. Magnet has been recognized since 1994 as a hallmark of excellence for quality and professional nursing in hospitals and healthcare organizations.

Basic criteria, or "forces of magnetism," include quality of nursing leadership, organizational structure, management style, personnel policies and programs, professional models of care, quality improvement, consultation and resources, autonomy, community supportive partnerships, nurses as teachers, image of nursing, collegial nurse–physician relationships, and professional development. Magnet hospitals have consistently scored high on support to nursing practice, nursing workload, and nurse satisfaction (Lacey et al., 2007). Application of Magnet principles has spread abroad (Chen & Johantgen, 2010) and has moved practice settings outside hospitals (ANCC, 2019). The fundamental shift between the 2008 and 2013 models is an emphasis on empirical outcomes. For organizations applying for Magnet designation, evidence of empirical outcomes as sources of evidence for transformational leadership, structural empowerment, exemplary professional practice, and new knowledge are required. Outcomes are defined as "quantitative and qualitative evidence related to the impact of structure and process (intervention) on the patient, the nursing workforce, the organization, and the consumer. These outcomes are dynamic and measureable and may be reported at the individual unit, department, population, or organizational level" (ANCC, 2019, p.17).

BALDRIGE NATIONAL QUALITY AWARD

Another example of a specific external measure of quality for hospitals is the Malcolm Baldrige National Quality Award (American Society for Quality [ASQ], 2019), a federal award to healthcare organizations. It evaluates how organizations meet particular standards on leadership; strategic planning; customer and market focus; measurement, analysis, and knowledge management; human resource focus; process management; and results (ASQ, 2019). The standards include strategic business principles, core values, and role modeling of leaders in principles that ultimately promote quality, such as "planning, communication, coaching, development of future leaders, review of organizational performance, and staff recognition" (National Institute of Standards & Technology, 2019).

NATIONAL QUALITY FORUM

The National Quality Forum (NQF) is a private, nonprofit organization that develops strategies for quality measurement and reporting in healthcare. Its

mission is to be the trusted voice driving measurable health improvements. Its strategic plan for 2016 through 2019 answered the unmet need for NQF to lead, prioritize, and ensure collaborative measurement, thereby resulting in better, safer, and more affordable healthcare for patients, providers, and payers (NQF, 2019). It has exerted considerable recent influence on performance, influencing initiatives of pay-for-performance, which is a paradigm that began with the CMS whereby third parties reimburse healthcare providers based on quality and efficiency rather than solely on services and procedures. Subsequently, third parties have begun to withhold payment for conditions related to poor care quality and paying for performance on safety and quality; with little evidence this approach has been effective (Roberts, Zaslavsky, & McWilliams, 2018). The movement has begun to change the culture of quality in patient care.

Such trends toward quality offer important opportunities for leadership, particularly in nursing. Similar initiatives need to be tested in settings beyond hospitals. Transformational nurse leaders must have a foundation in understanding the interdisciplinary aspects of care in continuous quality improvement processes and in patient-centered care. The next challenge is to create systems in which quality of care is integrated as second nature into all aspects of healthcare, including primary care and community healthcare. As the leader, remember that the tools for quality management are "the means, not the end."

Almost always, an initiative for quality improvement mandates change for leadership, whether it is a change of procedure or process, change of product, or change of culture. Grenny, Patterson, Maxfield, McMillan, and Switzler (2013) asserted that influence is the new science of leading change. The three keys to influence change include: (a) focus and measure; (b) find vital behaviors; and (c) engage all six sources of influence. Six sources of influence include: personal motivation, social motivation, structural motivation, personal ability, social ability, and structural ability. Motivation and ability make up the first two domains with subsequent subdivided domains including personal, social, and structural. Influencers on a personal level connect vital behaviors to intrinsic motivation as well as building personal ability to perform a vital behavior. At the social level, influencers build on the power of social influence to motivate and enable key behaviors. At the structural level, incentives and/or sanctions motivate and enable people to adopt the vital behaviors (Grenny et al., 2013, p. 217). See Box 4.8 for leadership in action and Box 4.9 for related new media.

Knowledge and processes of quality improvement in healthcare have expanded to become recognized as a science with its own emerging body of knowledge. Cronenwett (2010) outlined its characteristics. It "considers local context, or what outcomes are achieved in what settings with what roles and processes, and it requires knowledge of [the specific] discipline, local culture, quality improvement methods and measures, and how to manage change." Furthermore, specific methods for reporting and publishing work on quality improvement have been proposed (Howell, Schwartz, O'Leary, & McDonnell, 2015).

BOX 4.8 LEADERSHIP IN ACTION: INFLUENCE

Background: Increasing respiratory hospital-acquired infections were observed on the medical-surgical nursing unit. These were observed to occur in clusters of adjoining patients. Data were obtained from the unit's infection preventionist that confirmed these observations. Casual adherence to handwashing and isolation precautions were observed.

Evidence Review: Unit-based champions (direct-care clinical nurses) partnered with the division of APRNs to both understand the evidence and to build and review competencies among direct-care champions (influencers). Findings of the evidence review revealed a moderate grade of evidence to support the recommendation of strict handwashing and personal protective equipment adherence. Of the three systematic reviews, two were of high quality and one of lesser quality as determined by the champion clinical nurse/APRN team. There was one lesser quality randomized controlled trial (RCT) as well as one high-quality cohort study. The studies revealed positive results associated with education among staff.

Leader Discussion: This is your division and one of your nursing units. You are accountable for serious harm associated with patient safety including, but not limited to harm associated with vital behaviors such as handwashing and personal protective equipment.

1. How might you influence vital behaviors through the personal, social, and structural domains?
2. How would you enable and influence others by coaching them on the *six sources of influence?* Provide specific examples of what you would do and how they might respond in two specific areas.

BOX 4.9 NEW MEDIA: INFLUENCE

Video

"The Influencer Model: The Power to Change Anything." https://www.youtube.com/watch?v=lpvskOJZiVE

In all the efforts to accelerate quality initiatives, we must not forget the viewpoint of patients themselves. Aspects of care that are most meaningful to clinicians, patients, and family members may not be reflected in these measures. Consequently, while enormous measurement activity may be taking place, nurse executives must ask themselves, "What are we gaining from this activity and does it reflect the aspects of care that are most vital? How can we use the

findings from the measurement efforts to make improvements in the quality of patient care?"

Quality and customized service are the currency of consumers across society today. People have become accustomed to demanding quality and to having service for particular individual needs. Providers of a service such as healthcare cannot afford to overlook the personal meaning of that service to those who need it and receive it.

Although most of the published work on quality reflects practice in acute care, as a leader, you will devote considerable attention to quality. The public now demands it. There is an amazing array of resources for leaders in standards, structures, and processes to test, evaluate, and improve quality. The vigilance and hard work required to sustain formal activities in quality improvement are enormous. In the midst of all the work, remember that you are the transformational leader. Look beyond the work operations activities to the vision and meaning of improving lives and promoting healing. Quality work can be exhausting if it is not ultimately meaningful to patients and providers and born from passion and inspiration. That reflects the true challenge to leaders.

Assessing and Managing Risk When Implementing New Models of Care

Risk is the other side of safety and quality and a necessary element of practice model evaluation. There are two aspects to risk management. One is to reduce risk to patients' situations, such as taking measures to reduce infection transmission or to prevent pressure ulcers. The other part of risk management is to prevent incidents for which the institution may be held liable or to provide an environment for patients and workers that reduces loss to the organization (Pozgar, 2011). With the increased attention to patient safety, attention to risk to patients and to organizations has risen to the forefront of healthcare. Legal issues can become entangled with risk management. Risk managers have become invaluable in helping to assess issues, develop interventions, and evaluate outcomes to prevent and reduce risks to patient safety and to the organization, as well as to interpret legal implications. Risk management encompasses an entire body of knowledge and experts. The effective nurse leader recognizes and works effectively with others who have such expertise.

Depending on the size of the organization, either the risk manager or you as a leader are responsible for developing and enforcing systems to identify, report, and communicate incidents that expose individual or organizational risk. Risk managers develop policies and procedures that address issues related to risk, such as confidentiality, informed consent, product performance, and sentinel events. They work closely with clinicians, managers, and quality management experts. Major areas of stewardship in risk management include loss prevention and reduction, claims management, financial risk, and compliance with regulatory and accrediting organizations (Dearman, 2009).

It has become the responsibility of the leader to ensure the effectiveness of systems and to change the culture toward a systems perspective and transparency. Most important to reduce adversarial and litigious responses to risk is transparency, to be genuine with patients and families, and to meet their expectations. Patients and families expect reliable, competent care each and every time.

Ensuring High Reliability

The populations we serve as nurses expect highly reliable performance. High reliability encompasses several components illustrated within teams and organizations that anticipate and contain hazards (see Figure 4.1). Hazard anticipation is influenced by a preoccupation with failure, reluctance to simplify, and a sensitivity to operations. Hazard containment is influenced by an environment enabling deference to expertise and resilience (Weick & Sutcliff, 2011).

Hazard anticipation and hazard containment describe high reliability behaviors. Preoccupation with failure (things going wrong), sensitivity to operations (staffing patterns), and reluctance to simplify are components enabling hazard anticipation. In contrast, resilience and deference to expertise enable hazard containment. Each of these components is critically necessary for risk anticipation and management. (For a detailed discussion defining and describing each of the components of high reliability, see Weick & Sutcliff, 2011.)

Highly reliable performance requires high levels of mindfulness at POC delivery. Although highly reliable performance is difficult, it is not necessarily expensive and can be instilled through changes to existing structures (e.g., human resources practices that reward and support interpersonal competence and learning; consistent leader rounding and follow-up; selecting people who operate well under difficult conditions), as well as by changing conversations (e.g., infusing high levels of honesty, respect, and trust into interactions); and through the questions we ask (e.g., "What do we need to look out for? What is a different assumption we could make about this problem? Where does the

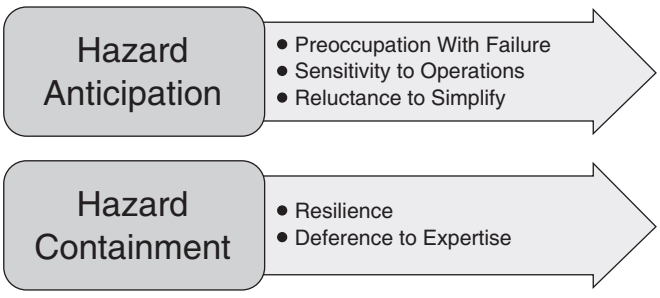

FIGURE 4.1 High-reliability framework.

BOX 4.10 LEADERSHIP IN ACTION: HIGH RELIABILITY

You are the nurse administrator on call this weekend. It is the holiday season. The units are a bit short and census is high. You are rounding on-charge nurses during bed huddle and hear the following:

1. Baby Boy Smith was to receive vancomycin IV 305 mg. Elizabeth, RN, administered the scheduled dose of vancomycin. Elizabeth did not check the label for patient's name and dose. She also did not scan the medication or Baby Boy Smith's ID band. Elizabeth, RN, realized she did not scan medication or patient as she left the room, but made the decision not return to the room to scan and verify medication because the patient was having behavioral issues throughout the day and was finally sleeping. Elizabeth, RN, did not want to wake the patient. Jessica, RN (oncoming shift), caring for this patient noticed when she went to hang her vancomycin that the last dose hanging was for a different patient and the dosage was wrong. Describe elements of high reliability in this scenario.
2. Does the scenario describe both hazard anticipation and hazard containment? What is missing? How might you discover?
3. How might you coach the nursing team toward high reliability behaviors in this scenario?

relevant expertise reside, and how can I draw on it when I need it? How do we know we need to stop and adjust?"). Operating in a highly reliable manner through processes of mindful organizing can also benefit employees through increasing commitment, lowering emotional exhaustion, and reducing turnover (Vogus, Cooil, Sitterding, & Everett, 2014). See Box 4.10 for leadership in action.

High reliability is a developmental process that needs to be kept alive. You are never done becoming highly reliable and sustaining high reliability. It needs to be continuously achieved. High reliability is best thought of as an ongoing process of organizing rather than a stable structure of an organization.

Also, important is the demand for the nurse leader to evaluate the effect of psychological safety on the practice model and clinical nurse capacity to engage, learn, and perform. Psychological safety is the "belief that the work environment is safe for interpersonal risk…that is, the fear of looking ignorant, incompetent, or disruptive" (Edmondson, 2019, p. 8). The role of the nurse leader evaluating and positively influencing practice models is generating thought-provoking questions, psychologically safe questions that trigger learning as opposed to self-protection. Edmondson (2019) describes the attributes of powerful questions as follows:

- Generate curiosity in the listener
- Stimulate reflective conversation

- Are thought-provoking
- Surface underlying assumptions
- Invite creativity and new possibilities
- Generate energy and forward movement
- Channel attention and focuses inquiry
- Stay with participants
- Touch a deep meaning
- Evoke more questions

Key components of effective risk management include effective policies and procedures, documentation of patient care and other clinical activities, and timely and transparent reporting of critical incidents. Effective risk management requires leadership at the highest level of ethical behavior. The transformational leader engages the expertise of risk managers and lawyers as appropriate to manage and contain risk for patients, employees, and the organization. Such a leader also has the values and principles that provide the foundation for effective assessment, management, and reduction of risk.

SYSTEMS THINKING COMPETENCIES

Organizations with high reliability that can ensure quality care, low-risk environments, and a patient-centered focus demand transformational leaders. These competencies are well described by Waxman and D'Alfonso (2017) and include communication and relationship building, knowledge of the healthcare environment, leadership, professionalism, and business skills. Moreover, Hughes, Beatty, and Dinwoodie (2014) described leadership competencies important in systems thinking. Such competencies include business acumen, strategic acting and thinking, organizational decision-making, managing conflict, impact and influence across the system, building collaborative relationships, promoting organizational transition, adaptability and agility, initiating organizational innovation, and demonstrating vision. Exhibit 4.2 contains questions to guide your own self-assessment of these competencies.

BEYOND PATIENT SAFETY TO PRACTICE EXCELLENCE

Safety is the most basic and essential expectation of effective healthcare (Cronenwett, 2010). Reason demands that it is the right of anyone receiving care. Cipriano (2008, p. 6) confirmed that attention to patient safety requires systems thinking. She asserted that, first, we must remove individual fear from the system, changing the question from "Who did this and what did the person do wrong?" to "What is the flaw in the system or process that provided the opportunity for error?" Thus, "eliminating fear and blame encourages people to report

EXHIBIT 4.2 SYSTEMS THINKING SURVEY

SYSTEMS THINKING COMPETENCY	SURVEY QUESTION
Business acumen	To what extent do I understand the perspectives of different areas in the business and have a firm grasp of external conditions affecting the organization?
Strategic planning	To what extent do I develop long-term objectives and strategies? Am I effective at translating vision into realistic business strategies?
Organizational decision-making	To what extent do I make timely decisions? Do I really understand complex issues? Do I develop solutions that effectively address problems?
Managing conflicting perspectives	To what extent do I recognize that every decision has conflicting interests and constituencies? Am I able to balance short-term payoffs with long-term improvement?
Act systematically	To what extent do I understand the political nature of the organization and work appropriately within it? How effective am I at establishing collaborative relationships and alliances throughout the organization?
Influence across the organization	To what extent am I good at inspiring and promoting a vision? Am I able to persuade and motivate others? Do I skillfully influence superiors? Am I able to delegate effectively?
Build collaborative relationships	To what extent do I know how to build and maintain working relationships with coworkers and external parties? Do I negotiate and handle work problems without alienating people? Do I understand others and get their cooperation in nonauthority relationships?
Promote organizational transition	To what extent do I support strategies that facilitate organizational change initiatives and position the business for the future?
Adapt to new conditions	To what extent can I adapt to changing business conditions and remain open to new ideas and new methods?

(*continued*)

EXHIBIT 4.2 SYSTEMS THINKING SURVEY (*continued*)

SYSTEMS THINKING COMPETENCY	SURVEY QUESTION
Initiate organizational innovation	To what extent am I visionary, able to seize new opportunities, and consistently generate new ideas? Do I introduce and create the needed change even in the face of opposition?
Demonstrate vision	To what extent do I understand, communicate, and stay focused on the organization's vision?

Source: Hughes, R. L., Beatty, K. C., & Dinwoodie, D. L. (2014). *Becoming a strategic leader: Your role in your organization's enduring success* (2nd ed.). San Francisco, CA: Jossey-Bass, p. 268.

mistakes and allows creativity to flourish" to reduce errors and improve safety. She explained this in the context of the complex adaptive system of healthcare.

Conditions are changing. Nurses are quickly taking the lead to launch initiatives that improve patient safety. For example, the Quality and Safety Education for Nurses (QSEN) consortium, sponsored by the Robert Wood Johnson Foundation (Cronenwett, 2010), began a major national effort to prepare health professionals, especially nurses, to lead in shaping professional identity among students and practitioners by committing to continuous improvement of quality care and patient safety. The project articulated specific knowledge, skills, and attitudes needed to promote patient care quality and safety. Specific goals, or competencies, of the project include patient-centered care; teamwork and collaboration; EBP; commitment to quality improvement, including use of data to monitor outcomes of care processes; safety; and informatics, or use of "technology to communicate, manage knowledge, mitigate error, and support decision-making" (Cronenwett, 2010).

Borrowing from other high-risk industries such as airlines, healthcare facilities are moving away from scrutinizing and condemning individual actions to emphasizing how to build safety into the entire complex system. This shift requires a change of assumptions, interprofessional collaboration, new views of policy, and universal transparency. Indeed, an expanded body of knowledge and a new realm of research on systems and patient safety are quickly emerging.

Another key aspect of safety that has recently come to the forefront for nurse leaders is that of employee and nurse safety. The American Nurses Association (ANA, 2016) has launched several initiatives to raise professional, social, and

policy consciousness about health, safety, and quality for nurses and healthcare leaders, including its Healthy Work Environment program, which maintains that the workplace should be safe, empowering, and satisfying (ANA, 2016). A healthy work environment is not merely the absence of real and perceived threats to health, but a place of physical, mental, and social well-being. Other safety initiatives at ANA include bullying and violence prevention; chemicals, drugs, and biohazard safety; safe patient handling and mobility; safe staffing; and sharps safety. Leaders in healthcare today, especially those who most closely oversee patient care, are diligently searching for ways to ensure the safety of patients. We are researching, creating plans, impaneling experts, and funding programs focused specifically on safety—but let us remember that safety is only the beginning. When will safety become the second nature, the rightful outcome of every patient, family, and provider experience? When will safety be the everyday stipulation and reality of our work, and when will the focus of our practice move beyond safety to excellence? Your charge as a leader is to help create the answers to these questions.

We must ask ourselves why major national panels must take official positions on patient safety, while we spend time and resources to design new models for safety. Think of it: *safety*—among the most basic needs. In other words, we are still trying to simply do no harm. Huge resources are now devoted to designing systems to prevent us from giving the wrong medication or the wrong dose to the wrong patient. We are developing programs with targets to avoid needless deaths in our system—a *healthcare* system, a system in which people enter unaware and with every right to expect that there is no possibility they will be harmed or killed by the system. When can we move from safety to excellence and healing? The answer must come from the next generation of leaders like you.

TECHNOLOGY: IMPLICATIONS FOR PRACTICE MODEL DESIGN, IMPLEMENTATION, AND EVALUATION

What are the benefits and barriers of technology to care delivery, and how might this information shape new models of care? The deployment of new technology is a driving force behind rising healthcare costs. Predictive models of health and societal care requirements for the next quarter century suggest a staggering shift in complexity of care requirements influenced by advanced population age and multi-morbidity. This will raise the cost of care. Cost-effectiveness analysis provides a means of measuring the value of new technology and considering value in relation to societal willingness to pay for new and expensive technology.

The telehealth platform and a highly monitored home environment can serve as an adjunct to traditional health services, enabling people to receive care in their homes instead of in a hospital, and offering a healing environment at a lower cost, within the comforts of their home. Studies show a reduction in

readmissions from this model, which gives patients and families the tools they need to participate in their own recovery and wellness, while giving care teams the oversight they need to care for their patients and connect in meaningful ways (DiSanzo, 2014).

Yet, health information technology (IT) usability and effectiveness is imperfect at best. Metzger, Welebob, Bates, Lipsitz, and Classen (2010) described in a simulation study, a computerized physician order entry system in which 62 hospitals failed to identify 52% percent of potentially fatal errors. Furthermore, Schiff et al. (2016) found that 79.5% percent of all erroneous orders were entered with 28% percent easily placed, and another 28.3% percent placed with only minor workarounds and no warnings. Health IT has also been shown to contribute to clinician burnout (Babbott et al., 2014). Health IT usability testing is not uniformly conducted (Ratwani, Fairbanks, Hettinger, & Benda, 2015), thus explaining clinician resistance, use of workarounds, and low satisfaction.

Technology: Informatics, Electronics, and Other Tools

Modern use of evidence always includes some aspect of technology. Sometimes, the very word *technology* feels like either some wolf in the wilderness waiting to ambush our comfort in the status quo or the next great gadget to make life easier. Indeed, in too many cases, technologies continue to be "underused, misused, or overused" (Fitzpatrick et al., 2010, p. 16). The truth is that technology has always been part of the work of leadership in healthcare. Although we all seem to have an image of what technology means, there is not a clear definition. It generally refers to the application of science and scientific invention to practice. It includes the tools and devices used to monitor, care for, and treat patients; clinical information systems; communication systems; databases for patient classification; education systems; clinical evidence; and even personnel management.

INFORMATICS AND HEALTHCARE

Informatics is the science and application of gathering, using, manipulating, storing, retrieving, and classifying information. Broadly, it may include AI, computer science, information science, cognitive science, social sciences, and healthcare sciences. It focuses on how data are structured and organized to support knowledge building and decision-making. The goal of informatics is to store and integrate data to provide accurate, accessible, and useful information. Just as it is hard to imagine professional leadership and practice without using informatics, it is nearly impossible to imagine future possibilities for applications of informatics to support leadership and healthcare.

Informatics and technology for consumers already provide information access, distance support groups, communication resources, and direct-care by telehealth. New areas of expertise continue to emerge among healthcare providers. One can only imagine what the future may hold for consumer healthcare using informatics. On the horizon are personal access to medical records and

databases, customized diagnoses, and personal prescriptions and treatments. Informatics is critical to define, represent, and apply nursing and healthcare knowledge across care settings, as well as to provide large data sets to promote the discovery of new knowledge.

Such data sets collect, identify, and provide information related to demographics, service, and healthcare data; environment and financial elements; and other provider-sensitive data to improve patient outcomes. Access and management of information have broken down barriers across countries, across distance, across disciplines, and across roles. But as a leader, never forget that human beings create knowledge, and *knowledge* is very different from *information*, and *wisdom* a step beyond knowledge.

TELEHEALTH AND TELEMEDICINE

Telehealth and *telemedicine* are terms that are also commonly used, often without specific definition. Telehealth has been defined as "the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration" (U.S. Health Resources and Services Administration, 2001). Telemedicine is now generally considered synonymous with telehealth. Telehealth continues to extend the benefits of excellent healthcare to populations without access and to extend educational opportunities to clinicians beyond restraints of distance and resources. In rural, underserved areas, telehealth can offer immediate feedback, decrease isolation, and extend health and lifesaving benefits not otherwise possible. As the promise of telehealth becomes a reality, it requires the most creative and effective leaders to maneuver through a variety of challenges, such as licensure and practice across state or national boundaries, access and insurance coverage to patients, fair reimbursement to providers, scrutiny of liability and other legal issues, patient privacy, fair distribution of resources and services, assurance of interprofessional collaboration, standard patient documentation systems, and a world of other issues yet unknown. Telehealth must be practiced outside traditional paradigms, so all of our thinking related to what we have always done is challenged. Over a decade ago, Rae-Dupree (2009) observed that the idea that technology decreases the provider–patient relationship is a myth. It enhances it. Overcoming perceptions of this mismatch between technology and relationships requires thoughtful and effective leadership.

Technologies on the Horizon: AI

Regardless of its form, it is clear that technology will continue to change the face of healthcare practice and leadership. It will provide entrepreneurial opportunities beyond current imagination. One example is the growth of genetic identification of disease propensity now, followed by technological advancement in the development of genetically informed individualized medications and treatments. Patient assessment, interventions, and communications will become

more technological than mechanical, and mass customization will become as prevalent in healthcare as it is currently in online shopping. As technology continues to advance and change communication modes, choice and access will shift control of healthcare decisions toward the patient and community, and finally, we will begin to see consumers as central members of our professional care teams. Topol (2019) described the current industrial age revolving around AI, robotics, and big data as so profound that it may not be enough to compare with the invention of steam power, the railroads, electricity, mass production, or even the computer age in terms of the magnitude effect. AI tools have expanded to deep network models such as deep learning. Deep medicine (Topol, 2019) requires three deep components:

1. Deep definitions of human: Digitizing the medical essence of humans using all relevant data that may include: medical, social, behavioral, family history, one's biology: anatomy, physiology, and environment; multiple layers of our biology: DNA genome, our RNA, proteins, metabolites, immunone, microbiome, epigenome, and more
2. Deep learning: involves pattern recognition, machine learning, and a wide range of applications including virtual medical coaches to guide consumers to manage their health conditions
3. Deep empathy: Deep empathy is the connection between the patient and the clinician as described by Topol (2019). As described, the greatest opportunity offered by AI is decreasing medical errors or increasing workflow efficiency, but restoring the time-honored connection between the patient and the clinicians.

AI: Implications for Leadership

AI implications for leadership consideration include healthcare workforce and workflow, space, and most importantly—patient centeredness, or deep empathy. In 2017, healthcare became the number one U.S. industry by total jobs for the first time (current employment statistics highlights, Fayer & Watson, 2017). More than 16 million people are employed by health services, with over 300,000 new jobs created during each calendar year in 2017 and 2018; one in every eight Americans is employed by the healthcare industry (Terhune, 2017). Projections from the U.S. Bureau of Labor Statistics for the next 10 years indicate that the majority of job growth will be in healthcare with the highest growth to include personal care assistants, home health aides, physician assistants, nurse practitioners, and physical therapy assistants (U.S. Department of Labor Bureau of Labor Statistics, 2019).

Twenty percent of healthcare spending is related to the cost of administration (Frakt, 2018). Current day operational and administrative inefficiencies are remarkable. For example, manual human scheduling for operating rooms or staffing all the inpatient and ambulatory clinics within a hospital system result

in inefficiencies overwhelmingly unacceptable and inconsistent with the experience economy (Pine & Gilmore, 2011; Topol, 2019). Some propose much of the work that requires patients calling to schedule appointments could be accomplished with natural language processing with human interface—as a backup.

Today, algorithms have been developed and are being used to predict no-shows for ambulatory appointments—a significant source of waste and inefficiencies given the idle workforce in the face of missed appointments (InoviaGroup, Artificial Intelligence Virtual Assistant, 2018). A better prediction of diagnosis in real time is another direction of AI efforts. Sepsis, for example, is responsible for 10% of intensive care unit admissions. Treating sepsis costs up to $10 billion annually and treatment often fails. Timely diagnosis is essential given patients can deteriorate rapidly, often before appropriate antibiotics are selected and administered. AI efforts are underway to determine whether the condition can be detected sooner (Henry, Hager, Pronovost, & Saria, 2015; Liu & Walkey, 2017). Preventing nosocomial infections is also a priority for hospitals as one in every 25 patients acquires a nosocomial infection from a caregiver or the healthcare environment. AI efforts underway at Stanford University demonstrated with the use of video footage and depth sensors just how clean caregiver hands were with 95% accuracy (Hague, 2017).

WORKFLOW

Healthcare workflow is another major challenge today that is becoming a priority for AI efforts. Approximately 350,000 advanced practice providers (APP) complement 700,000 practicing physicians today in the United States. The prediction is that APPs will assume an increasingly autonomous role given the number of AI algorithms in development to support clinicians—expected to dramatically influence provider workflow (Auerbach, Staiger, & Buerhaus, 2018).

Leader implications will also be influenced by space as some predict the planned "extinction" of the hospital room as we know hospital rooms and space today (Libberton, 2017). The first virtual hospital in the United States, Mercy Hospital's Virtual Care Center in St. Louis, opened in 2015. AI surveillance algorithms detect warnings and alert clinicians. As described, nurses at the Virtual Care Center have regular, individualized interactions with many patients and families over time. See Box 4.11 for related new media resources.

The role of the nurse as virtual health coach will also take on significance given the advent of AI. Smart watches collect more data than ever enabling

BOX 4.11 NEW MEDIA BOX: WORKFLOW

Video

"Artificial Intelligence and Virtual Care." Mercy. https://www.youtube.com/watch?v=jAQuEZUdB-A

continuous heart rate, sleep, and physical activity. However, the impact of the AI health coach is only as good as the quality of the data—high variation remains describing the accuracy of digital trackers for walking, for example, compared with biking or swimming. There are big data for an individual, making it both a challenge and perfectly suited for AI—likely requiring hundreds of hidden layers of neural network to get to our desired input of real-time, accurate, predictive, valuable information enabling health promotion through coaching. Nurse leaders will be required to see and align care model design and the implications for workforce, workflow, and patient and nurse experience optimizing AI in the future (Topol, 2019). Why should nurse leaders care? AI and predictive analytics can evolve nurses' thinking about care delivery and operational tasks in functionally disruptive ways to positively influence population outcomes, quality of care, patient and healthcare delivery team satisfaction and engagement. Beyond workforce, workflow, and space is the impact of AI on what Topol referred to as deep empathy. Some posit that AI can influence the gift of time with patients and families. In 2018, the Institute of Public Policy published a paper describing the effect of AI and technology titled "Better Health and Care for All," projecting the potential time freed up for care of patients and families to average greater than 25% across various types of clinicians (Darzi, 2018). Being present is essential to the well-being of patients, families, and caregivers—and fundamental in establishing trust.

Technological advancements, including AI, have drastically changed the structure and organization of the healthcare industry. Would routine nursing care dictated solely by prescribed procedures and accomplishment of nursing tasks be best performed by machines? How will nurse leaders be involved in deciding which aspects of their practice can be delegated and or improved by AI? How might nurse leaders oversee the introduction of automated technology and AI ensuring autonomy, authority, and accountability for professional nursing practice? Nurse leaders must ask these questions of themselves and each other. The future is here, and we must be ready for it!

The topics of this chapter offer only a glimpse at the many, varied, and important areas to be considered in designing, implementing, and evaluating practice models. The next generation of leaders will need to consider aspects as varied as economic and cultural drivers, cultural competency, EBP and leadership, measures of excellence for models and organizations, systems thinking, and new frontiers for technology.

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CHAPTER 5

Collaborative Leadership Contexts: It Is All About Working Together

Marion E. Broome and Elaine Sorensen Marshall

Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has

—Margaret Mead

OBJECTIVES

- *To describe how emerging leaders build networks with other leaders within and across the organization(s) to effect change that will support improved outcomes*
- *To describe the core values, skills, and competencies needed to enable effective intra- and interprofessional collaboration*
- *To identify key communication strategies to ensure successful organizational impact*
- *To describe various venues for dissemination of care improvement projects*
- *To describe how a leader utilizes evidence and other resources to make effective decisions*

INTRODUCTION

As you advance in your clinical expertise, formal education, and leadership development, you have a responsibility to expand your sphere of influence. You become a citizen of the larger discipline of healthcare leadership and a leader among leaders. The world awaits your ideas, skills, and the unique contributions you will make. If you have the courage to use your voice, experience, and expertise you will claim membership among thoughtful, committed people who can make a difference. Doors will open and opportunities will appear for you to make transformational change in ways you could not imagine before you entered this society of leaders. The challenges in healthcare of patients, their families, and those who seek to live healthier lives are too complex to be overcome by a sole creative person or even by a collection of representatives from a

single discipline. Transformational change happens only through the collaborative choreography of groups and teams of leaders.

Other emerging leaders struggle with similar issues in their work. They may share your concerns but have different perspectives, complementary skills, and new ideas that can amplify your abilities. Leaders in other disciplines offer so much that nurses can use to transform our vision of practice to improve lives. Just as this book and your program focus on the talents and skills for leadership among nurses, the need for effective leadership across healthcare is recognized and promoted among various professions, each of which offers ideas, advice, and rationales for why members of that discipline are best poised to be the leaders of the future. It will "take a village" of healthcare disciplines to address the complex problems we face (Dietz et al., 2015). Others claim that this is the time for nurses to take the helm as leaders to transform healthcare (Mason, Jones, Roy, Sullivan, & Wood, 2015), and studies have shown that nurses can and do in fact evolve their leadership to address new challenges (Pittman & Forrest, 2015). Box 5.1 describes one example.

BOX 5.1 EVOLVING ROLES FOR NURSES IN THE HEALTH SYSTEMS OF TODAY AND TOMORROW

The purpose of this study was to explore how leaders of pioneer accountable care organizations (ACOs) proposed that the roles of RNs must evolve to bring about decreased healthcare costs. The findings of this study, gleaned from interviews with nurse leaders in 18 of the original 32 pioneer ACOs, reported eight types of changes in roles of the RN:

- Enhancement of the role
- Substitution
- Delegation
- Relocation of services
- Transfer of nurses across settings
- Use of liaison nurses across settings
- Partnerships of nurses coordinating patients' care in acute care and primary care settings
- Increased number of nurses

These findings suggest the need for broad-based changes in healthcare that require the ongoing attention and focus of nursing leaders to support the growth of RNs who provide direct and indirect care within their evolving organizations.

Source: Pittman, P., & Forrest, E. (2015). The changing roles of registered nurses in Pioneer Accountable Care Organizations. *Nursing Outlook, 63*(5), 554–565. doi:10.1016/j.outlook.2015.05.008

Yet others propose that the best leadership can come only from a business model. The truth is that we are all in this together. Success in the next decades can come only from a community of leaders who understand each other's values, theories, and approaches to finally create true interprofessional leadership. You will be a leader among those leaders.

FORMAL AND INFORMAL NETWORKS

The commonly assumed context of leadership is the formal organization, with divisions, departments, positions, job descriptions, and tasks. Entry and advancement are usually validated by credentials, qualifications, merit, or seniority. Leaders and other workers are employees with designated titles, and the higher the position, the greater is the presumed authority to lead. Decisions that have organization-wide impact are usually made by those in authoritative positions, and it is presumed that each leader is representing his or her constituency when such decisions are made.

But every organization also has an informal network that provides the real context for how any decision has (or does not have) an impact. The informal structure is an extension of the social structures that develop within the formal context. It includes individuals with personal qualifications, goals, and motivations, as well as the spontaneous emergence of smaller groups and organized units with their own activities and goals. Leaders often emerge from the informal context by their charisma, personal qualities, and the ability to influence others. Formal leaders are wise to be sensitive and supportive of informal leadership contexts, to recognize and emulate influence and interest in others, and to care for individuals and their goals and means of communication. Informal leaders do what they do through strong communication channels with powerful relationships in which they help or challenge others.

In a context of complex adaptive systems, or simply within any community, most people are willing to notice, risk, help, and lead. Indeed, many great movements worldwide can be attributed to one person noticing a need, persistently working on the problem, enlisting the help of others, and not giving up. That is precisely how Lillian Wald founded public health nursing, how Loretta Ford "invented" the nurse practitioner's role, and how <u>you</u> will make a difference. It is not easy, but it does work: One person picks up the cause and wears his or her heart out; others take note and join. And thus, a movement is formed, and the world is changed. But it is not only the individual who makes the difference. The individual champion engages others to add their voices and shape the change needed and to develop initiatives to address the gaps. Any innovation in roles, such as the DNP, required collaboration among groups (i.e., academe, practice leaders) to scale the new degree and create positions (Ayob, Teasdale, & Fagan, 2016).

Academic–Practice Partnerships: Intraprofessional Networks

One specific and important collaboration model in healthcare is the academic–practice partnership (Beal et al., 2012; Broome, Everett, & Wocial, 2014). There is a broad range of types and degrees of success. Among such partnerships, the most common academic–practice partnership is between a school of nursing and a clinical agency. These partnerships may include innovative initiatives such as dedicated teaching units (Jeffries et al., 2013; Warner & Burton, 2009), expanding educational enrollment capacity (Clark & Allison-Jones, 2011), improving clinical education (Mulready-Shick, Kafel, Banister, & Mylott, 2009), or clinical staff recruitment (Clark & Allison-Jones, 2011). However, such successful partnerships seem to fall at one end of the continuum; many schools of nursing exist separately, lacking strong networks with clinical departments of nursing in health systems.

Effective nursing partnerships incorporate a variety of different models. They may include joint appointments (Broome et al., 2014), joint implementation science and evidence-based practice (EBP) projects (Stetler, Ritchie, Rycroft-Malone, Schultz, & Charns, 2009), or original research collaborations (Granger et al., 2012). Beal et al. (2012, p. 333) proposed the following guiding principles for academic–practice partnerships:

- Collaborative relationships between academia and practice are established and sustained.
- Mutual respect and trust are the cornerstones of the academic–practice partnership.
- Knowledge is shared among partners through a variety of mechanisms.
- A commitment is shared by the partners to maximize the potential for (nurses) to reach the highest level within their individual scope of practice.
- A commitment is shared by the partners to work together to determine an evidence-based transition program for students and new graduates that is both cost-effective and sustainable.

MacPhee (2009) proposed a logic model for such partnerships. The model outlined inputs that include partnership champions, compatible philosophies of partners, a shared vision, key stakeholder commitment, formalized agreements, shared goals and accountabilities, and dedicated time and resources. Activities include open, ongoing communications; shared decision-making; and shared professional development. Outputs include shared or compatible action and strategic planning, and outcomes include productive short-term action-plans or tactical goals and successful completion of long-term strategic goals.

Successful academic–clinical partnerships bring together key stakeholders, create a common vision to enhance the mission and culture of each organization, and commit to effective collaborative communication and shared

decision-making. This requires uncommon mutual leadership, exemplary collaboration, and shared vision among staff, students, and all other constituents. In addition, it requires sustained human and fiscal resources from each partner and commitment to track outcomes that support the work of both the clinical and academic endeavors.

In the long run, results and outcomes become secondary to effective personal relationships. That is, the individuals involved continue the important work and projects with their partners as a result of energizing and satisfying relationships (Broome et al., 2014). Some examples of specific outcomes reported by some successful partnerships have been described. These include increases in the number of evidence-based and research projects that involved direct care nurses, increases in the number of baccalaureate-prepared nurses, and increases in the number of clinicians involved in teaching students in areas of their expertise (Broome et al., 2014; Granger et al., 2012; Jeffries et al., 2013; Stetler et al., 2009).

The American Association of Colleges of Nursing (AACN) led an initiative in 2016 to inspire the many academic-practice partnerships to move to the next level. This initiative was called "Advancing Healthcare Transformation: A New Era for Academic Nursing," and was based on a yearlong assessment of the current state of academic nursing within the healthcare industry, including how leader colleagues in practice worked with deans and faculty to advance health. The report included recommendations for more fully integrating nursing education, research, and practice, and focused on how a paradigm shift needed to occur across both academic and practice settings to create change and ultimately transformation. The AACN leadership board reported the following achievements of the project (Sebastian et al., 2018):

- Identified ways academic nursing does and can contribute to healthcare innovation
- Explored leadership skills deans of nursing must demonstrate to collaborate with clinical nursing partners, other health professionals and clinical service leaders, academic administrators, and community members to advance their goals
- Recommended how changes in governance structures and policy initiatives could advance transformation

The aspirational work they proposed will take years to process and to build structures that will facilitate the shared vision and strategies necessary to accomplish what is needed (see Figure 5.1, ERA report). The collaborative efforts require both leaders at the top to set the vision, to "live collaboration" and shared credit for their initiatives and to inspire followers in their settings to join the partnership to further their own professional goals (Everett, 2016).

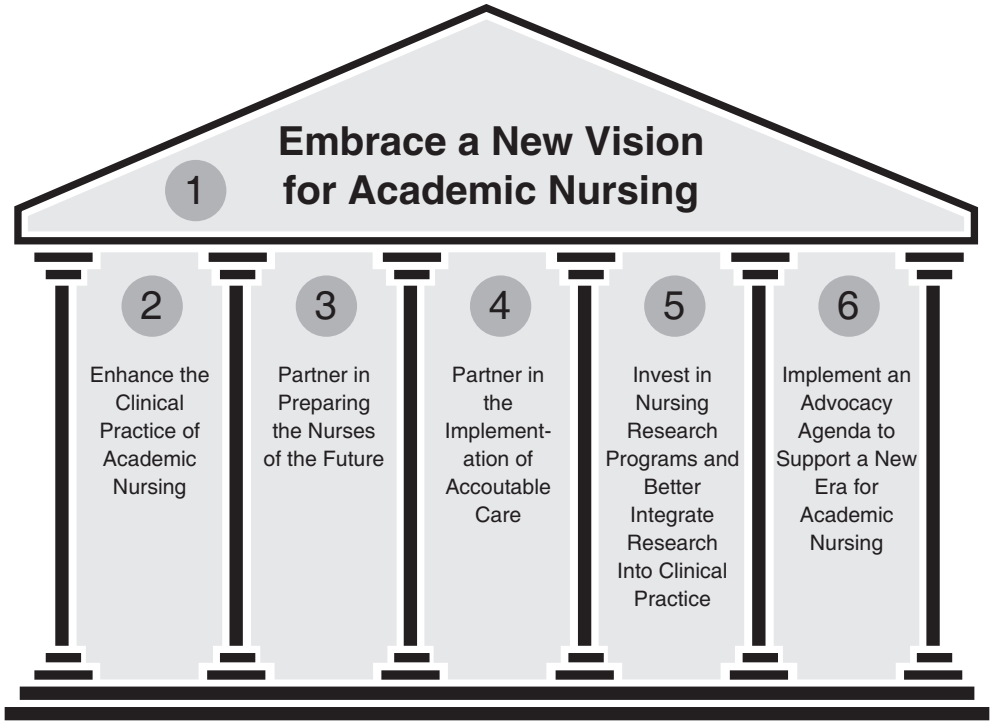

FIGURE 5.1 American Association of Colleges of Nursing (AACN) recommendations for building a strong partnership.

Source: American Association of Colleges of Nursing. (2016). *Advancing healthcare transformation: A new era for academic nursing.* Washington DC: Author, p. 19 (Figure 4).

Informal Networks

As a leader, you will have many opportunities for a variety of informal networks. Some will provide support and enrichment to your work, some will allow you to solve problems or develop new initiatives, and some will launch you to new heights of creative endeavors.

One effective and supportive informal network is the "community of practice" model. Such self-organized communities, often supported with technology by a larger organization, are networks of people who come together because of shared interest in a specific domain. Often, such communities are formed through distance media. They share stories, resources, skills, and information to solve a problem, enhance information, share experience, collaborate, and map knowledge in the domain. A community of practice may reflect interdisciplinary practitioners, government groups, educational groups, and members of social groups.

Seldom discussed in the context of networking is the cost to enter and sustain networks. Sometimes efforts at networking are random and haphazard,

REFLECTION QUESTIONS

If you are in a class or a work setting, team up with another individual. Review and discuss the guiding principles outlined by Beal et al. (2012), the conceptual model and outcomes in the Indiana University Nurse Learning Partnership (Broome et al., 2014), and the Academic–Practice Partnerships tool (American Association of Colleges of Nursing, 2015) found on the AACN website (http://www.aacn.nche.edu/leading-initiatives/academic-practice-partnerships/tool-kit).

1. If you created a partnership team, who would be members of that team from each setting? What critical logistical steps would you take to develop those commitments?
2. What barriers do you think you would face, and how would you begin to address those?
3. What are some common outcomes on which your partnership might focus?
4. What resources would you need to develop and sustain the partnership?
5. What criteria would you use to evaluate the effectiveness of the partnership?
6. How would such a partnership help you as a leader to develop a professional network? How could that work inform the formal leadership structures and networks in the two settings?

based on the assumption that the more participants, the merrier, and the more involvement per individual, the better. Engagement in networks requires time and energy of members—for communication, meetings, and other personal contributions—that can sometimes detract from performance or quality. Cross, Grey, Cunningham, Showers, and Thomas (2010) and Benton, Perez-Raya, Fernandez-Fernandez, and Gonzalez-Juardo (2014) described how one can use network analyses (e.g., determining what individuals connect with others and how many they influence) to take a strategic outlook and determine specific goals from networking, what patterns and levels of connectivity would best meet the goals, and how to develop initiatives that secure effective networks. More studies on how communication in nursing networks are needed (Benton et al., 2014).

The formal concept of networking probably emerged 30 to 40 years ago. New technologies and perspectives on emergent creation of communities will continue to change the traditional view of networking. Tomorrow's leader will have a new world of choices, relationships, and new means to sustain networking across disciplines, language and jargon, culture, and geography. It will require new ways of thinking and connecting and will change leadership as we know it.

Informal networking is also an important benefit of participating in professional and community organizations. As a leader, your role can be greater than simply paying dues and going to meetings. Opportunities to serve on committees, or simply taking the time to get to know and collaborate with colleagues, can add so much to your outlook and your accomplishments.

Informal networks are most commonly built through professional associations. Members can attend their national meetings and present their current research, practice projects, educational strategies, and so on. Another very important way to build one's networks with colleagues from different parts of the country, institutions, and backgrounds is to join some committees in the professional association. All associations need volunteer members to develop new guidelines for common practice problems, evaluate grants for which the group provides funding, a board of directors to lead the organization, and so on; many also have communities of practice such as the Public Health Nursing Section in the American Public Health Association in which like nurses "think together" about areas of concern related to those they care for. Another example is within the Association of Nurse Practitioners in which specialty groups (i.e., family nursing, gerontology/adult/pediatric) can join Specialty Practice Groups (communities) that support discussions, document sharing, and networking through online forums. Each member can also access resources that affect all specialties such as building a business, practice management, managing information technology demands, and so on.

Engaging in a variety of networks enriches your work and is important in leading others through the dynamics of change. As you collaborate and simply share among colleagues within networks, the entire professional community becomes better prepared to negotiate the challenges of change.

INTERPROFESSIONAL COLLABORATION

Most professionals, particularly those in healthcare, are educated and socialized into discipline-specific bodies of knowledge built on strong discipline-specific theories and frameworks. They are licensed and regulated into rigid professional practice jurisdictions. It is an impressive challenge for such highly trained professionals to move out of the comfort and habit of their specific occupations to work together. Such work requires sensitivity to other theoretical foundations and ways of knowing and thinking. It requires learning new languages and skills. Interprofessional collaboration requires applying a major change in professional logic, adopting new paradigms, and working in new social environments (D'Amour, Ferrada-Videla, Rodriguez, & Beaulieu, 2005).

D'Amour et al. (2005) reviewed concepts and theoretical frameworks among empirical reports of interprofessional collaboration. Such collaboration was described as a dynamic, interactive, and evolving process. Process steps might include negotiation and compromise in decision-making or shared planning

and intervention, transcending professional or disciplinary boundaries. They identified five major overarching concepts of (a) collaboration, (b) partnership, (c) interdependency, (d) power, and (e) team. They found the following concepts most often mentioned in definitions of collaboration: sharing, partnership, interdependency, and power. Furthermore, they identified several uses of the concept of sharing as a construct of collaboration, including shared responsibilities, decision-making, healthcare philosophy, values, data, and planning and intervention.

Partnership was characterized by a collegial relationship that is authentic and constructive, open, and honest, and noted by awareness of and value of the contributions and perspectives of others, common goals, and specific outcomes. Interdependency implies mutual dependence. The concept of power was conceived of as shared and symmetrical in power relationships and characterized by empowerment of all parties. D'Amour et al. (2005) also identified a variety of terms in the context of team environments. This model was examined for clinical utility with healthcare providers in practice related to shared decision-making in clinical care (Legare et al., 2011). Stakeholders suggested that the patient should be placed at the center of the model, and that it would be important to clarify expected outcomes and to recognize how environment and emotions of those on the team influence the utility of the model.

Barriers to successful interprofessional collaboration include poor communication; lack of knowledge of other professional roles, perspectives, and language; minimal understanding of when and to whom to refer specific patient problems; the need for training in successful team function; and the need for evidence of improved patient outcomes (Moaveni, Nasmith, & Oandasan, 2008). Additional challenges include differential power among team members, the time it takes to collaborate, and insufficient resources to support collaboration (Legare et al., 2011).

More recently, the concepts of interprofessional education (IPE), interprofessional practice, and interprofessional collaboration have been emphasized in documents, standards, and competencies and white papers in the health professions. In 2011, five professional associations in nursing, allopathic medicine, pharmacy, osteopathic medicine, public health, and dentistry published *Core Competencies for Interprofessional Collaborative Practice* (Interprofessional Education Collaborative Expert Panel, 2016) in which they described four domains of competency: values and ethics for interprofessional practice; roles and responsibilities; interprofessional communication; and teams and teamwork.

Each of these domains contains eight to 11 subcompetencies that illustrate critical core values of respect, accountability, communication, and teamwork to succeed in collaborations that shape quality care for patients and families (see Table 5.1).

Although calls for interprofessional approaches to solve the many crises of American healthcare are heard above the sound of nearly every other cry,

TABLE 5.1 Interprofessional Collaborative Practice Competency Domains

COMPETENCY	DOMAIN	SUB-COMPETENCIES
1	Values/ethics for interprofessional practice	**VE1:** Place the interests of patients and populations at the center of interprofessional healthcare delivery **VE3:** Embrace the cultural diversity and individual differences that characterize patients, populations, and the healthcare team **VE9:** Act with honesty and integrity in relationships with patients, families, and other team members
2	Roles/ responsibilities	**RR3:** Engage diverse healthcare professionals who complement one's own professional expertise, as well as associated resources, to develop strategies to meet specific patient care needs **RR6:** Communicate with team members to clarify each member's responsibility in executing components of a treatment plan or public health intervention **RR8:** Engage in continuous professional and interprofessional development to enhance team performance
3	Interprofessional communication	**IC2:** Organize and communicate information with patients, families, and healthcare team members in a form that is understandable, avoiding discipline-specific terminology when possible **IC4:** Listen actively and encourage ideas and opinions of other team members **IC6:** Use respectful language appropriate for a given difficult situation, crucial conversation, or interprofessional conflict
4	Teams and teamwork	**TT4:** Integrate the knowledge and experience of other professions—appropriate to the specific care situation—to inform care decisions, while respecting patient and community values and priorities/ preferences for care **TT7:** Share accountability with other professions, patients, and communities for outcomes relevant to prevention and healthcare **TT8:** Reflect on individual and team performance for individual, as well as team, performance improvement

Source: Interprofessional Education Collaborative Expert Panel. (2016). *Core competencies for interprofessional collaborative practice: Report of an expert panel*. Washington, DC: Interprofessional Education Collaborative.

reaction has been slow. Numerous national organizations and commissions have officially mandated interdisciplinary collaboration as one of the primary hopes for improved healthcare of the future. Healthcare has become far too complex for any single organization to rely on its own dedicated employees without collaboration either across the organization or across disciplines (Interprofessional Education Collaborative, 2016, 2018).

Although each discipline must be able to distinguish the specific scope of its contribution to patient care, each member of the group must understand his or her own unique contributions as well as respect the unique knowledge and skills of the other members. No single individual is viewed as the consistent leader; rather, depending on the context of the patient or organizational situation, team leaders change. Few can argue that interprofessional collaboration in healthcare would best be facilitated at the foundation of educational preparation of the various professions. This is where individual understandings are formed and the respect and value for all health professions are learned. Although valiant attempts are going on, actual formalized, integrated collaboration is not yet widespread. Thibault (2010) outlined the following barriers to generalized IPE:

- *Cultural:* Strongly held value systems of each profession
- *Structural:* Different schedules and locations (in educational preparation)
- *Faculty:* Not comfortable and not rewarded (for interprofessional collaborative endeavors)
- *Temporal:* Establishing the ideal developmental times for (interprofessional) interaction (e.g., are first-year medical students and first-year nursing students [at parallel developmental points] in their preparation?)
- *Non-core:* Elective experiences at off-hours. (Many groups who have tried interprofessional collaboration in education provided such opportunities only as elective experiences requiring additional time beyond the requisite program.)
- *Nonsustaining:* Series of "cameos." (Most programs have been short-term demonstration projects dependent on limited or temporary resources.)
- *Lack of leadership from the top:* Usually driven by passion of one or two faculty members
- *Asymmetry:* (Have not been) equally supported by all participating professions

Despite the barriers to interprofessional preparation, there are some hopeful initiatives to support such collaboration between medicine and nursing. Two examples of promising models of IPE are of those at the University of Colorado and Arizona State University. At the University of Colorado (Center for Interprofessional Planning and Education, 2019), all health professions students are oriented together and then share, across their education years, educational experiences related to bioethics, quality and patient safety, and simulated patient care scenarios. At Arizona State University (Center for Advancing

Interprofessional Practice, Education and Research, 2019), the Schools of Nursing and Social Work, along with the University of Arizona–Phoenix Schools of Medicine and Pharmacy, have developed a primary care curriculum and team-based care clinical practicum for students from those disciplines who work as teams in clinics across the city and surrounding areas.

Furthermore, many DNP programs promote interprofessional collaboration as a core component of preparation. Such programs offer promise for a brighter future of collaboration in the daily work of healthcare among a variety of professions. Effective collaboration is not only personally and professionally satisfying to those involved, but also contributes to a unified and holistic approach to patients and clients, facilitates faster internal decision-making, reduces cost through shared resources, and promotes innovation (National Center for Interprofessional Practice and Education, 2015).

Successful partnerships are particularly enriching to the leaders involved who are able to work with new friends, new perspectives, and new supporters outside the daily work environment. We are just beginning to understand the real-world value of interprofessional collaboration on actual patient outcomes (Reeves, Perrier, Goldman, Freeth, & Zwarenstein, 2013). It will be the responsibility of the leaders of the future to develop working models for collaboration and shared decision-making. One systematic review of IPE studies documented positive effects of interprofessional practice models for patient outcomes in diabetes, emergency department patient satisfaction, and documented reduction of clinical error rates in ER and operating rooms (Reeves et al., 2013).

As you enter a new leadership role, regardless of the setting, efforts to connect and secure collaborative projects with leaders outside your organization are likely to produce lasting professional friendships and collegial relationships, creative contributions, and renewed energy and insights. Such personal benefits spill into effective services to patients and the community.

COMMUNICATION

Effective networking cannot happen without effective communication and decision-making. Communication and making decisions are skills discussed in every leadership class and described in every leadership book. Theories on these issues abound across business management and healthcare leadership. But do not be fooled: No teacher, guru, or book has the answers. They will offer great advice, helpful insights from experts, and abundant evidence from research, but will not be able to tell you exactly what will work best for you, for your style, or in your situation. A commonly heard principle of organizational leadership is, “It’s all about the people”—and we would add, “It’s all about communicating, communicating, and communicating with those people.” Throughout your career, you will learn your own lessons about communication, how to handle conflict, and make better decisions, so you must share your own learning along the way. Here you learn what has worked for others.

Communication to Build Relationships and Facilitate Productivity

Human communication is among the few things essential to life. Human beings must connect physically, emotionally, intellectually, and spiritually. It is as necessary as breathing, but much more complex (Yoder-Wise, 2014). We all know that there is a message sender and a message receiver, but myriad factors affect actual communication. When two people interact, each brings filters that include attitude, assumptions, intentions, beliefs, emotional state, physical conditions, history, culture, and experience. All affect the nature or the quality of the communication.

Verbal and written communication are deal makers and breakers for the aspiring leader. Mastery of all forms of communication, including nonverbal, makes all the difference in how you present yourself. You are the package that people will notice before they take in your message. Keys to effective communication are self-knowledge and sensitivity to what others want and need to know.

Communication is about dissemination of your ideas, thoughts, feelings, and experiences (McBride, 2020). Leaders communicate in speech, writing, actions, body language, and even in silence. Effective communication begins with an awareness of your own style, of how others respond to you. For example, when considering speech communication, recognize that others respond to your tone, volume, word choices, and ethnic or regional accent—and that does not even consider your body language or facial expressions. As you aspire to leadership at the highest levels, it is most important to examine your own style of verbal communication (see Exhibit 5.1).

EXHIBIT 5.1 VERBAL COMMUNICATION SELF-ASSESSMENT

Don'ts

- Do you overuse jargon? Acronyms are often used as shortcuts for entities or practices; it is assumed everyone understands—but, in fact, may not—such as "interprofessional education (IPE)" or "Joint Commission on Accreditation of Healthcare Organizations (JCAHO)."
- Do you use colloquial phrases such as "my docs" or "the folks in housekeeping"?
- Is your style either too informal or too pedantic?
- Is your voice harsh, whiny, or intimidating?
- Do you speak too fast?
- Do you end most sentences with a question mark?
- Do you give advice often when not asked?

Do's

- Do you smile and greet others when you meet people in hallways?
- Do you make eye contact when speaking?
- Do you stop to listen to another's explanation?
- Do you nod your head to indicate understandings?
- Do you ask clarifying questions?

Among the most effective tools for successful communication is active listening. Indeed, listening is often more important and effective than speaking. Many problems are solved simply by listening. Successful listening simply requires that people feel heard. In today's world of handheld distractions, it is a treasured gift to focus your full attention and listen to another human being. Active listening is especially important. Yoder-Wise (2014) outlined the characteristics of active listening. They noted that the purpose is to assure the speaker that he or she has been heard, that the intensity of tone or emotion is heard and understood, and that it is safe to continue. As an active listener, paraphrase both the content and the tone of the message and reflect them back to the speaker in a genuine, empathetic manner. Sometimes, it is helpful to simply reflect the person's own words, but you must be truly interested. If you are just practicing a technique, it will not be helpful and will come off as near mockery.

MEETING MANAGEMENT: COMMUNICATING TO GET THE WORK DONE

After listening, speaking is the most important signature of your leadership style. One of the most common means of communication for leaders is the "meeting." When I (Marshall) moved from a faculty position to an administrative role, the first, biggest, and most distressing shock was the sheer number of meetings. Then I began to note the length of the meetings. I found that if you set a meeting for 2 hours, it will take 2 hours and 5 minutes. Furthermore, if you set a meeting for 1 hour, it will take 1 hour and 5 minutes. The tradition was for our meetings to be scheduled in 2-hour blocks. I found that every meeting of every group, committee, and task force required the full 2 hours and 5 minutes. I changed the meeting schedule to 1½ hours. Guess what? The work still got done, and we cut 2½ hours off each meeting day.

Now, that is not to say that the work might have been done in 1-hour or 15-minute meetings. But not knowing the threshold of time needed, we simply filled the time space allotted. It is important to hold face-to-face meetings in many situations, and it is often preferred. But think about the purpose of the meeting and what is to be accomplished. Communication must be clear, fair, and facilitate the views of all. The following strategies for meeting management help you accomplish your goals (and everyone else's) in the most efficient manner.

- Think about not only your agenda but also the agenda on the mind of every member of the group. Meetings should be for group process or for very important messages from the leader that can only be delivered personally.
- Place times next to each agenda item (e.g., 3:00–3:15). Initially, it will be difficult to gauge which items will take more time and which less, but after a few meetings of the group this will become easier.

- Meetings are also important to promote esprit de corps and a sense of belonging. It therefore is good to check in with each member, welcome new members, celebrate those leaving related to their accomplishments while a member, and so on. This will be an important investment of a few minutes of time at the beginning of the meeting.

After the meeting, other means of communication, such as email, should be used appropriately to facilitate sharing the meeting results. Using a streamlined three-column format to summarize the takeaway notes from each meeting (column 1 = topics discussed; column 2 = large areas of the discussion; column 3 = responsibility for follow-up) increases the likelihood of busy people reading them and provide items for the next agenda. If any item with a complex background is scheduled to come before the group for a decision, it is most helpful if the individual bringing the issue or challenge prepares in advance a one-page document that outlines (a) the scope and background of the issue; (b) two or three proposed solutions; (c) resources (i.e., suggested reallocations or new resources), including people, time, talent, funding, or a combination of these; (d) how the success of the strategy implementation will be evaluated, and (e) when the evaluation will be done. This approach allows group members to prepare to give their best advice, even if the document is received the day before the meeting. In my (Broome) experience, it is also common for those preparing the document to decide not to bring a challenge forward after completing a description of the issue in writing. Simply preparing to bring up the issue helps them realize they have the authority to implement one of the proposed strategies without involving everyone in the group.

Communication: Verbal Presentation as Persuasion

Presenting a talk to a large (and often powerful group) is often intimidating. Several experts provide helpful strategies to consider whenever you make a presentation to a group (Box 5.2):

- Know your subject and be prepared to help the audience understand it using terms they can identify with (McBride, 2020).
- Make sure your opening is powerful. Capture attention and create interest. You might begin with some startling attention-getting information specifically about your topic. Keep it grounded in the audience's experiences or potential experiences (Sue, 2001).
- State your case and support it with evidence, facts, and examples. The importance of data cannot be overstated, but their inclusion must make the case for the compelling premise you want the audience to leave with (e.g., "we must increase the number of advanced practice nurses in this subpopulation of patients to manage their care") (McBride, 2020).

BOX 5.2 PREPARE YOUR STORY

Ultimately as a leader, you must know the story of your organization so well that you are able and eager to tell it at any moment with passion. Purposely prepare a story moment.

- Prepare your "elevator moment," a 30-second version of your story. When someone asks what you do, you have already chosen the story and set each word as a jewel in a setting to share your clear and compelling message.
- Prepare your 5-minute moment for any opportunity when you are called to a podium or around a table to introduce yourself.

Take advantage of opportunities to be in the right meetings where you are invited to tell your story, and then stand up prepared to share. Do not confuse the 30-second moment with a longer one. Never overstay your welcome with your message. Above all, remember that your story is not about you; it is about the great organization that you have the opportunity to lead.

- Use visual information, but only if it is powerful. Do not rely on your PowerPoint to *be* your presentation. Remember, it is only a blue screen with a few words or bullet points. *You* must convey the message (Capes, 2015; Sue, 2001).
- Re-engage your audience every 6 to 8 minutes. Tell a relevant story, share a surprising statistic, have the group do something, but keep them with you.
- Use notes, but never memorize or read your presentation (Capes, 2015; Sue, 2001).
- Set the rules early for how questions and answers will be handled. Is this an open discussion? Is it an information session during which you expect to be peppered with questions? Will you take questions only at the end (Sue, 2001)?
- If this is not a formal presentation, rehearse what you are going to say at least four times without interruption, especially when the information is a surprise or bad news. Make an outline, keep it to only the number of points you can remember (for us, that is only three to five items), and know them (McBride, 2020; Sue, 2001).
- Check the environment before you present. Be sure you have set the stage by considering as many environmental factors as possible. Arrange the room, chairs, temperature, clutter, equipment, water, and food. Take away distractions and remove all barriers to your message (Sue, 2001).

Dissemination of the Findings of a Quality-Improvement Project

Dissemination of one's project, either done in the workplace or done as part of an educational program, is the final step in sharing information and evidence to improve clinical practice. One common vehicle for dissemination is the poster

presentation. Yet this is often one of the more daunting aspects of any project conducted by nurses.

There are a variety of resources available to help guide the novice who wants to present the findings of their project. Most include guidance about how much content to include, how to organize the content, and how to make the poster visually appealing to anyone reading it. Every poster should include the following components:

- Background: Why is the topic of the project (initiative) a problem? This slide should place the project in a larger context outside of the institution. It should then also include some information related to the local context.
- Evidence: What is the evidence that supported a need to address identified gaps and make a change in process to improve safety, quality of outcomes, efficiency, cost, and so forth?
- Innovation: What was developed to address the gaps or problem? How was this linked to the evidence?
- Procedure: What was done, to or with whom, what was the timeline, how was information collected to evaluate what was done?
- Evaluation: What evaluation plan was used to assess changes in identified outcomes? What data waere collected, by whom, and using what methods?
- Discussion: What was the conclusion of the project? How would the findings be applied to practice? In the future, what should others seeking to make a similar change think about doing?

Written Communication

After listening and speaking, written communication is your most important tool as a leader (McBride, 2020). Leaders are required to write every day. First, you must decide which form of written communication is most appropriate for the situation: email, formal memo, letter, or public announcement. Even before that decision, you must decide to be a good writer. That means you must practice. Get help. Nothing will defeat your leadership more quickly than poor writing. Consult models and collect "templates" to use as models for documents such as letters of recommendation, executive summaries, proposals, or other communications that you write regularly (see Box 5.3).

Decide the purpose of your writing. Do you need to persuade, get information, clarify, motivate, solve a problem, make a recommendation, or defuse a crisis? Regardless of what you write, *always* make an outline. It helps clarify your purpose and gives a structure for your message.

A note about texting as professional communication—do not do it. Occasionally, a text message may be helpful for a brief purely informational message, such as to confirm the time of an appointment. But, generally, texting is for personal, informal communication. There is too great a risk for misunderstanding if you try to use it for important formal conversations, however

BOX 5.3 NEW MEDIA: EFFECTIVE COMMUNICATION IN HEALTHCARE

Online Resources

Nurse, Author, & Editor. http://naepub.com (no cost for access). A resource for writing and short articles related to various topics in publishing your work.

McNamara, C. (2018). "Guidelines to Conducting Effective Meetings." Free Management Library. http://ManagementHelp.org

TED Talks

Dishman, E. "Health Care Should Be a Team Sport" (16 minutes). March 2013.

Stenge, Ilona. "The Role of Emotions in Science and Research" (11 minutes). December 2017.

Blog

"How to Use Social Media in Healthcare: A Guide for Health Professionals." February 2019. www.hootsuite.com

enticingly convenient it may seem. Save it for personal, family communication. In all communication as a leader, your goal is to set a professional standard.

Even after you have become an expert in all aspects of communication, some challenge is likely to erupt that tests all your best skills. It helps in those times to step aside from yourself and examine your communication skills. You may need to edit your style. Take care not to be drawn into a style that is unbecoming or ineffective.

Writing an Article for Publication

Most of us rely on reading journal articles that report on a variety of topics: practice guidelines, research, quality improvement initiatives. The experience and evidence produced by others helps us think through how what they did and evaluated could be used to support change in our own organizations. The circle of inquiry is not completed until others can hear and read about the findings, recommendations and "lessons learned."

Leaders are responsible for disseminating their own projects in a variety of forms, such as the poster presentation described earlier. Learning to write to communicate processes and outcomes are inherent to strong leadership. And in the case of the written word practice does make "near" perfect and much easier. Most professionals find it less intimidating to develop the poster or presentation of the project first and then use much of the same content as they prepare and shape the article. Another valuable resource as one is shaping a

manuscript is to review the appropriate publication guidelines found at The Equator Network (www.equator-network.org). This website contains guidelines for a variety of health-related research projects including randomized controlled trials (CONSORT) and quality improvement projects (SQUIRE). There are other sets of guidelines to help authors to decide what key information must be included in any report of their project.

So how do you get started? Just do it!

- Review guidelines for authorship before you start. Then find a coauthor who has experience and was involved in the project (unless you conceptualized, conducted, evaluated, it all by yourself).
- Select a professional journal or two that you think attract the audience that would be interested in your work. Review two to three papers already published on similar topics (e.g., quality improvement, how to case with a patient).
- Develop a detailed outline of the paper using accepted subheadings in the selected journal.
- Hold a meeting of the coauthors and discuss the outline and authorship order. Divide up the sections so everyone can have something to write about. Set a deadline for the sections to be sent to you (assuming you are the first author).
- When the sections are returned, order them according to the original outline and then sit down and read, and reread.
- Then write, revise, and rewrite. Then put it aside, see it again fresh, and revise. Writing and rewriting helps clarify your thinking.
- When you read the paper look for the following: Is the background sufficient to explain why the study was done? Is the procedure section clear in terms of what your team did, to whom, and for what reason? Do the ideas flow? What is not explained well? What has been overlooked? Are the points in the discussion clear and innovative?
- Make tracked changes with comments for the team to address for their sections. Meet again and go over the paper and see what others think and are willing to do.
- Once their revisions are in, it is up to the first author to polish the manuscript, send to someone to also critique, polish again, and then submit on behalf of the group. It often helps to have a personal critic outside the team to read and offer suggestions.

Expect that the decision to reject or revise will take a few months. Most journals are now produced via submissions to a website. Be careful about choosing a reputable journal (Oermann et al., 2018) and not one that promises fast publication without peer review (also called predatory journals). Ask others who have experience with publishing about selected journals where you would like to publish. Most professional associations publish their own journal. Also look at the articles you have referenced. If this seems like a lot of work, it does take

BOX 5.4 LEADERSHIP IN ACTION: INTERPROFESSIONAL COMMUNICATION AND DECISION-MAKING

Sarah W., RN, DNP, the leader of a team of health professionals in the cancer center follow-up clinic, implemented a new guideline for patients and their follow-up care after surgery for a GI solid tumor. These patients were discharged on a complicated diet, pharmacologic regimen, and dressing changes. The entire improvement team consisted of Sarah, the project team lead; Denaris W., MD, a third-year oncology resident; Jon M., PharmD; and Jayda K., RD. The guideline was implemented over 6 months requiring significant training for staff—both inpatient and home care—as well as phone calls for the first three weeks after discharge and a clinic visit. Denaris and Jon were involved in the guideline development, while Sarah and Jayda conducted all the staff training and supervised follow-up calls to the families. Sarah worked with the health system data analytics team to examine changes in readmissions, adverse events, and family satisfaction levels. Now the team is planning a meeting looking at the results and discussing dissemination plans.

1. Denaris emails Sarah to explain how he must be first on the poster presentation for the Safety Conference 3 months away as he had to complete a quality improvement project for his third year. Jayda also sends an email saying she should be the first author on the poster given all the time she spent training staff and overseeing follow-up calls. If you were Sarah how would you prepare for the meeting? What background information would you collect to share with the group prior to the meeting? Who would you get advice from? Construct an agenda for that meeting.
2. When the group meets and agrees on the order of the names for both the poster and the publication manuscript, they tell Sarah she understands the project best so should take the lead on drafting the poster and the paper, even though she will not be first author on it either. What communication skills would you use to bring the group to consensus about sharing the workload of preparation?

time and effort. But any author will tell you that it is worth the effort to see your work published and know you have contributed to the discipline. See Box 5.4 for leadership in action.

SHARING THE NEWS: YOUR STORY AND THE ORGANIZATION

Preparing to Share the Bad News

The skills discussed for use in both developing written communications and presenting information to members of the organization are essential competencies to develop. This is especially true when the organization is experiencing

stress as a result of financial concerns, community disasters, tragedy within its walls, or any other sudden, unexpected event that threatens the well-being of the organization and its members. No matter how well prepared the leader, how earnest the followers, or how successful the organization appears, in today's complex healthcare environment it is inevitable that at some moment, things will go bad. Whether it is an unconscionable error, an economic crash, a disappointing employee, or a painful lawsuit, one day, suddenly, the leader will wish that she or he had aspired to be anything but "in charge."

Such situations may include any of the following and range from the micro to the macro environment, such as when you must deliver a negative performance review; when you must confront unfair treatment, deception, breaches of confidentiality, or lack of commitment; when you must deal with a person who is abusive, needy, or irresponsible; when you must deliver bad news or share the results of a difficult decision; when a safety breach occurred and patients or employees were at risk; when you must say "no"; or when you must surmount enormous barriers (e.g., mixed messages, sabotage) to effective communication. At times you may wonder, "How will I survive this?" It may be a painfully public issue or one that is born in a quiet, hurting heart. Its source may be a circumstance or a person.

It is very important for all leaders of the organization to be engaged in conveying the same message to employees, outside constituencies, and others. This is commonly referred to as being "on the same page." To accomplish this requires a level of transparency between executive leadership and middle-level managers who are most responsible for communicating with employees closest to care delivery. Key message points should be developed jointly and discussed daily during any crisis, and every leader should be comfortable with the messaging. If not, when pointed questions are asked by employees, those conveying the message will not be able to provide genuine answers, even if the answer is, "We don't have any more information than what I have shared about the situation at the current time."

In nearly every case of bad news, it is most effective to own the problem where appropriate, be as transparent as possible, and identify future solutions or corrections as appropriate. And remember, there are always better days ahead. Draw from your personal and professional colleagues for support.

Sharing the Good News

However, when you are doing something great from which others might learn or benefit, do not assume that your good work will be automatically valued and recognized. Indeed, unless you tell your story in an effective manner, it may be barely noticed. Regardless of your initiative, build relationships with others who may help you tell your story. Remember to include your network colleagues. Think about including the public relations or public communications officer of your organization, if one exists, or invite a local journalist to be part of

your team. Invite key policy makers, such as local or state public officials, who might influence resources to translate your work to the larger community. And do not forget to go beyond traditional means of communication by using social media tools such as Twitter, Facebook, and blogging to tell your story.

As you advance in leadership roles, the clinical background that connects you with real patients is invaluable in marketing discussions of your organization. Your stories are grounded in authentic clinical experience. As a DNP-prepared leader in an organization, you have a unique set of skills to contribute to the message about today's healthcare system—especially in conveying how the profession of nursing contributes to increased access, decreased costs, and improved quality of care.

Heinrichs (2009) described the changing face of nursing, the increasing acceptance of NPs, and the future of the DNP. He offered specific suggestions for marketing approaches to invite the public to see the nurse beyond the culture of subservient roles and gender-specific stereotypes without losing the positive attributes that endear nurses to the public trust. The mission was to portray the nurse as a healer educated at the highest level. He asserted that appropriate marketing might follow the success of nurses expanding their scope of practice and influence to become recognized and valued players in healthcare reform. He proposed that such a marketing approach would saturate the markets with positive images of nurses in such advanced roles. Nurse leaders have a unique and valuable story to tell.

DECISION-MAKING: THE ART AND SCIENCE OF ORGANIZATIONAL LEADERSHIP

Regardless of the message, the nature of decisions and the way they are made in the organization are of highest priority. Effective or ineffective decision-making can "make or break" the message, even with the best communication. Decision-making is one of the most studied topics in the social sciences, yet we continue to wonder how good decisions get made. Campbell, Whitehead, and Finkelstein (2009) studied faulty decisions made by otherwise capable leaders from a neuroscience perspective. They confirmed that when faced with a situation calling for a decision, we make assumptions and take a perspective based on earlier experiences, judgments, and emotional patterns. Thus, we may think we understand a pattern based on history or emotional experience when, in fact, we do not *really understand* the new situation. Campbell et al. (2009) identified the following three "red-flag conditions" of distorted patterns or "emotional tagging:"

1. First was inappropriate self-interest or conflict of interest that can bias judgment and decisions even unintentionally. An example of this would be a leader who served on the board of a local nonprofit agency that developed a proposal for a healthcare system to consider in funding a new care model

through which patients from the ED would be cared for at home. If the healthcare system was also where the leader worked, it would be best to recuse, or remove, herself from any final decision-making about the choice of proposals and sharing with others the conflict of interest.

2. The second red flag is distorted attachments to people, places, or things. An example would be the reluctance of a leader to cut a program in which he had been directly involved. In this case, it would be important for the leader to be exceptionally open to other leaders' assessments, while providing information about the history and performance of the unit. When sharing that information, the leader should work to present information as objectively as possible.
3. The third red flag is misleading (or selective) memories that take our thinking in an inappropriate direction, or to a place where we might overlook or overvalue some important factor in a situation. One example might be the leader who, relying on earlier successes in managing conflict with a group of nurses, then assumes that the same strategies can be used successfully with a group of ED physicians who are negotiating with the health system to increase compensation. To counteract such potential flaws, it is helpful to involve another person in the decision. Look to add a fresh mind, a different experience. Invite debate and challenge.

Another systems-level approach to these potential influences on decision-making is to institute governance safeguards, such as a process for ratification of decisions. This can range from board-level decisions to those within the units of the organization. However, Hayashi and Ewert (2006) pointed out the value of instinct and the intuitive skills of wise leaders to make critical decisions. We have all known leaders whose experience, native wisdom, and emotional sensitivity contribute to sound decisions. Some emotional context and business instinct are essential, especially at the highest levels of leadership. Higher levels of emotional intelligence have, in fact, been found to be associated with more effective leadership decisions (Hess & Bacigalupo, 2011; Yip & Côté, 2013).

Many routine, daily tactical decisions can be delegated. In strategic decision-making, however, the stakes are high. There may be novelty or ambiguity, or the decision may represent substantial change or commitment of financial or human resources. Thankfully, most leaders make relatively few life-or-death strategic decisions, but it *is* the leader who makes the strategic decisions. Further, leadership does not end with making the decision, however difficult that decision may be. After the decision is made, the leader must mobilize people and resources, sustain motivation of the entire organization, and navigate the sometimes-troubled waters of disagreements, doubters, resisters, and those who simply do not know how to respond.

Professional relationships and collaborations can be among the most fulfilling areas of your work as a leader. Constant learning in all areas of communication, both informal and formal, can enrich your life personally and

professionally. You learn that you are not alone in the important decisions related to those you serve.

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PART II

BECOMING A TRANSFORMATIONAL LEADER

CHAPTER 6

Shaping Your Own Leadership Journey

Marion E. Broome and Elaine Sorensen Marshall

While many people believe that transforming organizations… is the most difficult, the truth is that transforming ourselves is the hardest job. And if we transform ourselves, we transform our world.

—Dag Hammarskjold

OBJECTIVES

- *To deepen appreciation for two current models: authentic leadership and the leadership challenge model*
- *To identify and explore competencies for leadership*
- *To develop a vision in leadership*
- *To recognize the importance of the use of evidence to support your leadership vision*
- *To define and understand the significance of power and influence as a leader*
- *To consider the role of a leader as an innovator*
- *To consider servant leadership*
- *To recognize the responsibility of a leader for generativity*

LEADERSHIP AS A CAREER JOURNEY

Consequential leadership requires the cultivation of a lifetime of habits that build others and strengthen oneself. Hamric, Spross, and Hanson (2009, p. 254) reviewed leadership models and concluded that only three habits are most important to the transformational leader in clinical practice: (a) empowerment of colleagues and followers, (b) engagement of stakeholders within and outside nursing in the change process, and (c) provision of individual and system support during change initiatives. Although these are critically important skills for any leader, there are many more essential habits for the effective transformational

leader. In Chapter 1, Frameworks for Becoming a Transformational Leader, we reviewed various dimensions of transformational leadership—the focus of this book. At the beginning of this chapter, we introduce two complementary leadership frameworks that you may find useful in thinking about your own personal leadership philosophy, style, and behaviors: authentic leadership (Avolio & Gardner, 2005) and leadership challenge (Kouzes & Posner, 2010). Consideration of these models provides a foundation for examining and developing personal leadership styles. A discussion of how competencies of leadership have evolved over time expands the conversation. We then show how leaders can take these frameworks to build their own leadership skills and competencies.

TWO MODELS TO USE IN BUILDING A FOUNDATION TO BECOME A TRANSFORMATIONAL LEADER

Authentic Leadership Model

Authentic leadership is one of the frameworks that emphasizes relationships between leaders and followers and focuses on the self-development potential of the leader. At the same time, the model reflects a recognition that this potential and subsequent interactions are in service of the larger organization and context, as well as the individuals within the organization. Authentic leaders are perceived as hopeful and optimistic, exhibiting behaviors reflective of a moral compass they can articulate. Such individuals speak with a clear voice for the needs of those in their organization (Avolio & Gardner, 2005). Key characteristics of these leaders include self-awareness, relational transparency, internalized moral perspective, and balanced information processing (Bamford, Wong, & Laschinger, 2013).

Nurse leaders who are authentic are able to be honest and open in their relationships with individuals to whom they report, as well as those who work for them. Their sense of integrity also facilitates, actually mandates, their need to seek diverse perspectives from others and use multiple sources of evidence when making an important decision. Bamford et al. (2013) conducted a secondary analysis of data from 280 nurses who worked with nurse managers. Those nurses who worked for nurse leaders who exhibited higher levels of authentic leadership were more fully engaged in the workplace and reported a greater sense of alignment in multiple areas of their work life. In another study of 273 nurses and 342 new graduates, authentic leadership was associated with lower levels of emotional exhaustion and cynicism for both groups (Laschinger, Wong, & Grau, 2013). Authentic leaders clearly empower others.

Leadership Challenge Model

Kouzes and Posner (2010) developed a model of leadership by analyzing practices of leaders to provide emerging leaders with a description of behaviors and practices that develop strengths. The model consists of five practices: (a) model

the way, (b) inspire a vision, (c) challenge the process, (d) enable others to act, and (e) encourage the heart.

The nurse leader who *models the way* understands his or her own beliefs and can articulate how the mission of the organization is an important responsibility of all. Such leaders are visible and committed to the organization and those who work with them. They are experts in their field. It is through their efforts to connect with others and set an example of how to maximize their own and others' strengths that they can *inspire a vision* for the organization. Their assessment of the group's potential based on listening to the hopes and aspirations of others and enthusiasm about where the organization is capable of going enlists others in working toward a common goal.

However, as the leader begins to set the stage, it becomes clear that traditional ways of being and doing will need to be challenged to develop new thinking and ways of behavior to achieve the goals. The leader will then engage in questioning and *challenging existing processes*. Experimenting with new ways of doing things and challenging others to develop their skills and take risks will enable them to act.

Enabling others to act will require the leader to set a challenge and provide resources for them to draw on to meet the challenge. As they achieve success, others will grow and develop leadership skills themselves. From the collaborations they form while working to solve the challenge, they will learn the value of working with others with complementary knowledge and skills.

The final exemplary practice, to *encourage the heart*, is one threaded throughout the leadership journey although clearly more important at times when the challenges are more difficult. Individuals working with the leader rely on coaching, celebrating small victories, and the presence of the leader when stress runs high in the organization. Kouzes and Posner developed the *Leadership Practices Inventory* series (2016), which allows individuals to assess their own leadership strengths in each of the five exemplary practices and provides tools and activities to use to grow their leadership skills.

These two leadership frameworks reflect a clear emphasis on authentic and meaningful relationships between the leader and others. Leaders in each framework articulate their beliefs that serve as a foundation for their vision for the organization and for how the potential of others can be developed and leveraged for success of all. Leaders who are relationship based have a clear moral compass, are secure in their belief system, and are open to and seek out diverse perspectives to shape how they think about challenges and solutions. These models are broader and more philosophical, and frankly more inspiring from our perspective, than some other approaches that include lists of competencies for leadership performance.

MOTIVATION: LEADING BY INSPIRATION AND MODELING

Motivation is so much more than providing incentive for productivity. It is about inspiring and giving hope to colleagues and followers within the organization. And marketing is so much more than selling. It is also about inspiring

and giving hope to colleagues and the public outside the organization. To motivate others is to listen to their aspirations for themselves and their careers, as well their aspirations for their organization. It is also the responsibility of the leader to listen for the signs of others' fears and to show the way to hope.

For years, motivation experts have argued over whether intrinsic or extrinsic motivators are most effective. But motivation is larger than a polarized paradigm between external and internal rewards. The truth is that everyone responds to *both* extrinsic and intrinsic sources of motivation. Extrinsic factors include such things as power, money, and status; and intrinsic factors include finding meaning, growing, and learning. We all respond to both. Of course, many workers whose basic needs have been satisfied are best motivated by higher needs of achievement, emotional fulfillment through relationships, flexibility, and personal growth (Bal, De Jong, Jansen, & Bakker, 2012).

Intrinsic or internal motivation is personal passion. Behind it is the energy to engage in the work, to set and pursue personal and organizational goals, to overcome obstacles, and to press forward. External incentives, such as money or status, are secondary to the satisfaction of engagement and achievement (Porter-O'Grady & Malloch, 2017). The transformational leader in a healthy organization believes that others respond to both internal and external motivators (Broome, 2013). Thus, the assumption is that people who are valued, encouraged, supported, and provided with the environment and resources to succeed will take initiative and perform creatively and effectively. From such groups will emerge collective wisdom, creativity, and some degree of self-governance.

REFLECTION QUESTIONS

1. What motivates you the most related to your professional career? Identify both intrinsic and extrinsic motivators.
2. How would you respond (think, feel, behave) if one of the extrinsic motivators in your workplace (decrease in pay but more flexibility in role) changed?
3. If one of your colleagues were upset about a change in some factor that clearly motivated him or her (position title, scope of responsibility) and came to talk with you about leaving the organization, what would you say?

Wise leaders *stay in touch* with the people with whom they work. The leader can do this in a variety of ways such as the following:

- Making rounds throughout the organization to be visible
- Talking with employees and other leaders in informal settings such as dining area, elevators, and hallways

- Sending personal congratulatory notes when an individual does something of note
- Calling and/or sending a personal note when something (e.g., a death, an illness) occurs to share condolences or concern

As a leader, you will find what habits and strategies are best for your style and comfort. But it is important to constantly keep in touch personally with colleagues and staff. There is no magic theory, strategy, or practice for motivation that works universally every time. Motivation requires authentic passion about the work, genuine interest in the workers, and vigilance to human needs for encouragement, support, autonomy, and meaning. But workers in any organization, especially those who are professionally young, need the leader to inspire and motivate them. Just sharing a vision is not enough, the leader must reach out and relate to others to effect change, improve the organization, and sustain improvement.

LEADERSHIP COMPETENCIES

There is growing agreement on the need for better leadership in healthcare, but little consensus or evidence regarding which specific areas of knowledge, skills, attitudes, habits, or competencies are best suited to the leaders of the next century (Northouse, 2018) or how they are best acquired. Thus, it seems that every leadership guru creates a list. We have lists of competencies from experts and expert panels, from authorities in business and healthcare, from government agencies, from the Institute of Medicine, and from every practice discipline.

Much of the literature on leadership in healthcare refers to specific management skills with a focus on performance. Competency models originate from private and public sector business and industry as well as academe, each one with its own list of dimensions. The dimensions usually include items related to productivity, personal characteristics, and personnel relationships (Simonet & Tett, 2013). Such models have now found their way into healthcare organizations.

Many of the competency models rely on some sort of 360-degree evaluation model, which refers to regular, formal, and direct leader feedback related to performance on specific goals based on stated organizational values. This model begins with self-evaluation and then integrates formal evaluation from superiors, peers, and subordinates. The critiques are reviewed with an immediate supervisor, and a plan for improvement is developed. This evaluation model is commonly used in business and increasingly incorporated into healthcare environments (Day, Fleenor, Atwater, Sturm, & McKee, 2014).

In healthcare organizations, one of the frequently referenced models of competencies is that produced by the American Organization of Nurse Executives (AONE; 2016), an assessment tool that emerging leaders can use to examine their own competencies and where they are in their leadership journey. Nurse

educators can also use the tool to help guide curricular development. The AONE noted the need to delineate differences in leadership competencies among leaders of healthcare systems, leaders working outside of traditional hospital or inpatient settings, and those who are nurse managers. The organization developed this list of competencies using expert nurse leaders at all levels from nurse managers to health system executives, and their publications are available from the organization.

There is increasing interest in the empirical discovery and measurement of competencies for successful leaders (Day et al., 2014). Guo (2009) promoted a paradigm that identified four essential dimensions: conceptual, participation, interpersonal, and leadership. Guo identified the following core competencies: healthcare system and environment, organization, and interpersonal competencies.

One group of competencies that has been extensively researched originates from the National Center for Healthcare Leadership in Chicago, Illinois. Its *Health Leadership Competency Model* (National Center for Healthcare Leadership, 2015) was developed from extensive academic and clinical study. The model comprises three domains of transformation, execution, and people. Under each domain is a list of the following competencies:

1. *Transformation competencies:* Achievement orientation, analytical thinking, community orientation, financial skills, information seeking, innovative thinking, and strategic orientation
2. *Execution competencies:* Accountability, change leadership, collaboration, communication skills, impact and influence, information technology management, initiative, organizational awareness, performance measurement, process management/organizational design, and project management
3. *People competencies:* Human resources management, interpersonal understanding, professionalism, relationship building, self-confidence, self-development, talent development, and team leadership (Calhoun et al., 2004; National Center for Healthcare Leadership, 2015)

The *Healthcare Leadership Alliance Competency Directory* (2013; Stefl, 2008) lists 300 competences under the five domains of leadership, communications and relationship management, professionalism, business knowledge and skills, and knowledge of the healthcare environment. If leadership performance could be learned from a dictionary, this would be the one of choice. It is a large classification system of knowledge and skill areas searchable by an elaborate system of key words. Sponsored by the American College of Healthcare Executives, the American College of Physician Executives, the AONE, the Healthcare Financial Management Association, the Healthcare Information and Management Systems Society, and the Medical Group Management Association, it provides an impressive inventory of leadership concepts that can enable managers and leaders to meet the challenges of navigating and leading through

the complexities of current healthcare environment (Healthcare Leadership Alliance, 2013). Unfortunately, it does not provide mentorship, role models, personal experience, or inspiration for the soul of the aspiring leader. For nurse leaders, these supports must be found through the many available leadership academies, conferences, short intensive courses, and other similar options.

Huston (2008, p. 906) outlined eight "essential" leadership competencies for the nurse leader of 2020:

1. A global perspective of healthcare and professional nursing issues
2. Technology skills that facilitate mobility and portability of relationships, interactions, and operational processes
3. Expert decision-making skills rooted in empirical science
4. The ability to create organization cultures that permeate quality healthcare and patient/worker safety
5. Understanding and appropriately intervening in political processes
6. Collaborative and team-building skills
7. Ability to balance authenticity and performance expectations
8. Ability to envision and proactively adapt to a healthcare system characterized by rapid change and chaos

A recent study by Shillam et al. (2018) can be used to self-assess one's ability to influence others—one of the most important competencies of overall leadership. This tool was designed to help nurse leaders assess and enhance their ability to influence others by measuring traits and practices and point out the individual areas of strength and need for improvement. The Adams Influence Model was used as the conceptual model that serves as a basis for the tool. This model (Adams & Natarajan, 2018) contains five areas of competence:

- Knowledge-based competence: Reflects individuals' intellectual expertise as measured by empirical knowledge of their field, personal and aesthetic knowledge of their culture, and sociological and ethical understanding of the worlds they work within
- Authority: The right to take action
- Status: Holding a high-standing position *or* prestige
- Communication traits: The proficiency with which one relates and interacts with others
- Use of time and training: The balance between knowing when to act and what time frame is available to act for maximum effectiveness

The tool was developed based on interviews with 15 nurse leaders across academe, clinical practice, policy, and philanthropy. Common themes across all leaders included: authentic leadership, risk-taking, and emotional intelligence. Additional skills included negotiation, sense of micro and macro focus, and integrity. This tool will be very useful for middle- to senior-level leaders as they

plan their next phase of development and will help identify areas on which they could work to strengthen.

As you consider new roles or simply a new perspective for an existing clinical leadership role with advanced preparation at the highest level of clinical practice, it would be most unfortunate if you were to attempt to reinvent the entire concept of competency. This review confirms the abundance of work on healthcare leadership competencies. It is the responsibility of the next generation of leaders to sort, identify, test, and apply most effective competencies that will support the vision of the transformational leader.

REFLECTION QUESTIONS

1. What habits, skills, and competencies must be possessed by the next generation of leaders in nursing?
2. What are common assumptions and expectations related to leadership style and competencies? What needs might be uniquely met by a leader rooted in clinical practice?
3. If you are a leader with responsibilities across both academe and practice, what leadership skills must you possess?
4. Who and where are your role models for leadership? What knowledge, skills, and competencies do you see in them that you admire and would seek to emulate? What are the gaps in skills you see?
5. If you interview one of your role models, what three questions would you ask that person to help you understand how he or she developed leadership skills?

VISION: PERSPECTIVE AND CRITICAL ANALYSIS

Vision is probably one of the most discussed and commonly accepted attributes of leaders. Visionary leaders do not stop at simply holding workers accountable to competencies. They make it their habit to look up and beyond, foreseeing next steps and future challenges, opportunities, and accountabilities. Their own personal vision enlivens formal vision statements and integrates the meaning of the statements into their very beings. Vision releases forces that attract commitment and energize people to create meaning in the lives of others, to establish standards of excellence, and to bridge the present and the future (Kouzes & Posner, 2010).

If you have no vision of where you are going, why should anyone follow you? Followers expect leaders to know where they are going and to strike the path toward a vision. Kouzes and Posner (2007, 2010) are credited with the well-known statement, "There's nothing more demoralizing than a leader who can't clearly articulate why we're doing what we're doing." By the same token, to spare themselves their own personal demoralizing sense of daily drudgery and

burden, visionary leaders take the larger perspective, beyond day-to-day tasks and operations.

What is vision and how do you cultivate the habit of sustaining your own vision? Vision is the image of the future you want to create. It is your picture of what is possible. Vision requires a dream and a perspective that set a direction that others want to follow. Heathfield (2015) proposed the following fundamental requirements for vision to actually make a difference: The vision must clearly set a direction and purpose for the entire organization. It must inspire a commitment, loyalty, caring, and genuine interest in personal involvement in the enterprise. The vision should reflect the unique culture, values, beliefs, strengths, and the direction of the organization. It must "fit" within the culture of the organization and its teams. The vision always promotes the feeling among followers that they are part of something greater than themselves, that their daily work is more than operational, but rather part of some greater future. Such a vision challenges others to stretch, to reach, and to produce beyond their own expectations.

The leader who sets such a vision will have the larger perspective not only of the official vision statement or strategic plan, but also beyond. Nevertheless, the effective visionary leader does not only see the big picture of the vision, but also is able to sensitively support others in the daily work of all members of the organization. To the perceptive leader, the vision is more than a rallying cheer. It represents a substantive direction for action and achievement. The vision is only one aspect of a strategic plan for action, but it is the vital life force of that plan. Inspiring leaders have the courage and the drive to dream. In times of near despair, confusion, chaos, or even routine and boredom, we need dreams. As a leader, you must believe in your dream; you must believe that it can happen. Kouzes and Posner (2007, p. 17) observed:

> Every organization, every social movement, begins with a dream. The dream of vision is the force that invents the future…. Leaders gaze across the horizon of time, imagining the attractive opportunities that are in store…. They envision exciting and ennobling possibilities. Leaders have a desire to make something happen, to change the way things are, to create something that no one else has ever created before.

Dreams that become fulfilled are shared among members of a critical mass. A leader must have followers. Solitary vision that is not shared is only daydreaming. Transformational leaders must be vigilant that they do not follow their own light so far into the distance that followers are left in the dark. Shared dreams "fit," and they grow in the hearts of those committed to the organization. Stichler (2006, pp. 255–256) stated:

> The nurse leader is responsible for creating a vision for the organization and clearly articulating that vision to others. The

> vision must be so compelling that others can feel passionately enough about it to direct their efforts toward achieving the vision. The vision must be viewed as being for the "common good," and the [leader] must foster that sense of common commitment so that others are willing to follow on the quest toward the vision.

Nurse leaders are responsible for how the professional nursing models exemplify the visions of the chief nursing officer and the organization (Pelletier & Stichler, 2014). The leader sets the tone and communicates expectations for patient-centered care that results in positive outcomes.

A vision statement is a helpful way to articulate the dream. The most effective vision statements are short (two to three sentences), reflect the values of the organization, and provide a picture of what the organization is about to become (see Exhibit 6.1).

A shared vision for any project or organization gives perspective. It allows everyone to look up from many lists of competencies and the daily grind that hovers over nearly every team or organization at one time or another. As a leader with a vision in your heart, you are the guardian of perspective. You can critically appraise what is important and what simply appears to be urgent at the time. You help people cut through the daily lists of "stuff" that must be done to see what really might be done for a better future. Sometimes, it involves just a moment of reflection or a reminder; sometimes, a change of schedule or

EXHIBIT 6.1 VISION EXERCISE

Think of a team you are working with on a specific project. Even projects have a vision—that is a desired end state—a common goal—a place where the group wants to end up. It is a helpful exercise to engage people in creating a vision statement. This activity should take no longer than 1 hour of a meeting.

- When brainstorming to develop the vision statement, be bold to use metaphor, poetry, images, stories, and emotion. People need to truly experience the image. Ask each member of the group to draw a picture, an image, or a word that describes how he or she wants his or her project to look like when completed.
- Now ask each participant to take a minute and vividly describe it, discuss it, and encourage all to share their view of it.
- As the last person is done, ask the group to write down a clear, succinct statement that captures what the common theme was across everyone's "vision" or preferred end state.
- At the end, there will be two to three different themes if 10 to 12 people are in the group. So the next step is to come to one understanding that is so clear that the only response is, "Yes! That's who we are. That's what we want to be. That's where we are going!"

procedure; and sometimes, a different use of language. Language is important, particularly in the vision statement. It must be beautiful so that it clearly reflects the image of where you are going, the picture of the desired future.

The leader who believes and constantly carries the vision is able to critically analyze decisions, solve problems, and effectively predict next steps. The vision is not about you, your career goals, or your personal desires. It is about the organization as a living organism, as a community, perhaps even as a family. You are the steward of the vision of the organization. For your vision to be authentic, you must love the place, the people, and the work you are doing.

Because the vision is integrated into your being as the leader, many plans and decisions will seem to automatically flow in the direction of the vision. Opportunities will appear, or you will suddenly see opportunities in a new way to allow you to move toward the vision. The vision becomes your habit. It will not be easy, but a clear vision allows purposeful critical analysis and helps to winnow away issues that cloud direction. It allows you to better trust your decisions because you know where you are going, and your actions are more likely to be trusted because you have the credibility of a clear direction. Critical analysis becomes easier, almost second nature, because you have set your own benchmark. You know where you are going.

USING EVIDENCE AND LEADERSHIP TO MAKE A POSITIVE DIFFERENCE

Vision is only dreaming without the use of evidence to make decisions that make it happen. The use of evidence in healthcare is no longer an option (Malloch & Melnyk, 2013). It must become the intellectual and practice habit of all leaders and clinicians. If use of evidence, or empirical research data, is truly to make a difference, it must be embraced at all levels, from the point of contact to the broadest systems perspective. Furthermore, evidence must be implemented and evaluated from the perspective of all aspects of leader, clinician, and patient experiences. The effects or outcomes of evidence cannot be evaluated from any sole viewpoint. Evidence must be integrated and synthesized into the practice experience, the patient response, and the entire caregiving or healing event.

The recent sweeping movement toward evidence-based practice (EBP) has been largely promoted by academics and targeted to clinicians in direct patient care. Nurse leaders have long been accustomed to the challenges of promoting research utilization within healthcare organizations. Current care settings are often laden with practices of habit, tradition, and routine. Nevertheless, Porter-O'Grady and Malloch (2010) warned against joining "the evidence-based practice fad," that the current surge toward use of evidence should "not exclude other non-quantitative sources of evidence," and cautioned not to oversimplify clinical nursing knowledge. It is important as we embrace EBP that we do not lose, but rather empirically document, other significant ways of knowing and practice such as clinical intuition, attention to individual differences, the art of

practice based on clinical expertise, and professional autonomy. Indeed, Råholm (2009, p. 168) "challenged the wisdom of basing the practice of leadership on a narrow, reductionist understanding" of evidence and defended the meaning of context in the definition of evidence. With the emerging focus on implications of genetic testing and genomics, healthcare practice is poised to move from the application of evidence-based protocols to a focus on individualized or customized care.

Although the development, discovery, and use of evidence for clinical practice continue to mount, there is a continuing need to close the gap between evidence and practice (Meljak, Gallagher-Ford, Thomas, Troseth, & Szalacha, 2016). In most clinical settings, truly integrated EBP is still not second nature. In the past several years, much emphasis has been placed on the role of leadership for implementation of EBP. Aarons, Farahnak, Ehrhart, and Sklar (2014) discussed the critical importance of the leader in shaping a culture in which all clinicians value evidence versus tradition-based practices in their work. The leader's mandate is to expect, support, and reward those who demonstrate that value through their work. Examples of clinicians who demonstrate these behaviors include the following:

- The nurse who consults the pharmacist on the unit after a patient mentions that his wife brought his anti-nausea drug from home, and a check of the medication triggers an alert when entered into the electronic health record (EHR)
- The new graduate who questions the use of 48-hour dressing changes in the manager's staff meeting after reading a related research study in a journal on the unit
- An experienced nurse who suggests a new procedure for communicating physician messages to nurses who are administering medications after reading new evidence on the relationship between information overload and medication errors

Nurse managers are critical to the sustainment of an evidence-based nursing culture. Cheng, Feng, Hu, and Broome (2018) found that nurse leaders who helped staff nurses by challenging processes, modeling the way, and encouraging nurses were most effective. Nurses looked to the leader to support their efforts to improve patient care through evidence and to praise their "over and above" efforts. Leaders who focus on influencing others to achieve positive patient outcomes use their relationship with others to communicate clear expectations, include them in decision-making, and help them see their own strengths (Cheng et al., 2018).

It is the role of the leader to remove barriers and provide resources for clinicians to access the best research evidence. Such practice often represents a change of culture and total integration of use of evidence in clinical communications (Aarons et al., 2014; Cheng et al., 2018). All nursing leaders, from

managers to executives, must be aligned in their expectations about implementation of innovative approaches (O'Reilly, Caldwell, Chatman, Lapiz, & Self, 2010). If they are not engaged and aligned, nurses at the bedside may revert to become traditional and trial-and-error bound in their practices caring for patients.

It continues to be largely the responsibility of the leader to break the path, to facilitate the culture for EBP to be comprehensive throughout all systems. Use of evidence must simply become a way of doing and being in clinical practice. The entire organizational culture, especially its leadership, must support the ongoing practice of evidence-based decision-making, actions, and evaluation of outcomes.

Leaders must incorporate the language and concepts of EBP into the organizational mission and strategic plans, establish clear performance expectations related to the use of evidence, integrate the work of EBP into the governance structures of the system, and recognize and reward performance and outcomes based on the use of evidence. The transformational leader coaches and promotes collaboration among clinicians, patients, and researchers to create a "professional culture and transformed environment of care in which decisions are made on the basis of best evidence, patient preferences and needs, and expert clinical judgment" (Worral, 2006, p. 339).

Thus, it is well established that EBP will not thrive without leadership support (Aarons et al., 2014; Berwick, 2003; Everett & Titler, 2006). Leaders must provide access to evidence, authority to change practice, an environment of collaboration, and policies that support EBP (Malloch & Melnyk, 2013).

Although we have become more careful to seek and use research for aspects of patient care, with all our attention on the trend of the past decade toward EBP we have largely neglected the need to generate and use evidence specifically related to leadership practices. A growing body of clinical guidelines are in use internationally, but we are just beginning to assemble an empirically tested knowledge base for best practices in leadership. Day et al. (2014) recently reviewed 25 years of research on leadership development and called for a continuing focus on gathering data that support the effectiveness of certain leadership strategies and education/training programs. In healthcare, we are just beginning to document and promote models for evidence-based decision-making in leadership (Aarons et al., 2014; Uzarski & Broome, 2019). Effective leaders pay attention to the need to recruit nurses who enjoy innovative approaches to old challenges, support those nurses who can influence others using positive evidence-based strategies for change in policies and procedures, and provide vision and time to teams who invest in the work culture (Broome, Everett, & Wocial, 2014). The next generation of transformational leaders must continue the task of discovering and utilizing best evidence for successful leadership. Valid use of evidence for leadership will define and strengthen the entire concept of power to leaders of the future. See Box 6.1 for leadership in action.

BOX 6.1 LEADERSHIP IN ACTION: INNOVATION

Mary W., BSN, is a nurse working in urgent care (UC) in Johnston County. She realizes that many of the patients who call in are calling after an ED visit and are experiencing some untoward event (symptom, reaction to medication, etc.). Due to the nature of the previous inpatient visit or stay, she does not feel comfortable telling them to come to UC to be seen. She knows they are concerned about returning to the hospital and ED due to exposure to infectious disease in their community, such as influenza. Many of them live an hour away from the hospital. They usually have referred to their discharge instructions but do not believe their questions are answered. So she feels she has no option but to ask them to return to the ED or hospital.

On Monday Mary decides to talk with the clinic APRN, Mark R., FNP-BC, who finished his DNP at the state university last year. She knows there has to be a better way to address these patients' concerns and to increase their access to providers who can answer their questions before the situation does become urgent and requires costly care. Mark listens carefully to her concerns and validates them as something they need to think through and then discuss alternatives with the clinic leadership as well as the health system leadership.

1. Mark asks Mary to go back to the call log the UC keeps of all incoming calls and to document the reason and disposition of the calls. In this way, he tells her she can provide leadership with some data about the prevalence and importance of the problem. Her analysis of the last 3 months reveals that 35% of the calls that are made to the UC fit Mary's observations. All are referred back to the ED and hospital system and the disposition is unknown.
2. Mark himself also calls his counterparts in the ED and health system admissions area to discuss what options may already be available for these patients that the UC staff are not aware of. There is currently no question asked of the patients calling that would provide any information about whether they already called UC or not.
3. Mary and Mark then think about what could be a way to address this issue and decrease overall cost and increase access for these patients, while providing quality care based on the context of their previous hospital visit. They decide to propose to the UC, ED, and hospital leaders that they trial a tele-visit concept in which one APRN would be brought in for assessment with any patient calling the UC with a question. Mary will pull up the previous record of the visit for the APRN's assessment and then set up a time to talk with the patient via Facetime, Facebook Messenger Lite, or an equivalent app so the provider can assess the patient as well as communicate. They will trial this for 3 months.
4. At the end of 3 months, the follow-up data revealed that 85% of the calls (again 33% of all calls coming to UC) were able to connect via a TeleCare app. The APRN was then able to resolve 75% of the questions and concerns of the patient, while 25% were referred for further assessment to the ED or hospital.

(*continued*)

BOX 6.1 LEADERSHIP IN ACTION: INNOVATION (*continued*)

When the patient was called by the UC staff 2 days later, 100% of the patients and/or their caregiver were satisfied with the care.

5. A follow-up discussion among all leaders in the three entities decided to ask the patient to pay $35 for the tele visit for the next 3 months, detail the costs of implementing this program (i.e., cost of APRN salary, aversion of a visit to the ED or hospital and subsequent savings), and then determine how to finance this for the future.
6. Mark congratulates Mary on her innovative approach to dealing with a problem in care delivery and encourages her to continue to expand her leadership skills.

What do you think was the most important leadership skills evidenced by Mark in this case as he mentored Mary, an emerging leader in practice?

USING YOUR POWER AND INFLUENCE EFFECTIVELY

Leadership, authority, power, and influence are often confused. *Leadership* may be formal or informal and is always characterized by the ability to influence others toward the attainment of some task or goal. We have already described transformational leadership as value driven and grounded from an ethical foundation. It includes the personal qualities and behaviors of the leader. *Authority* is a formally designated or organizationally endowed ability, accountability, or right to act and make decisions. *Power* is the ability to exert influence, but it may or may not be rooted in an ethical value system. It may also be formal or informal. Gardner is said to have defined power as "the basic energy needed to initiate and sustain action or … the capacity to translate intention into reality and sustain it" (National Defense University, n.d., p. 2). Positional power "confers the ability to influence decisions about who gets what resources, what goals are pursued, what philosophy the organization adopts, what actions are taken, who succeeds and who fails" (National Defense University, n.d., p. 4). The source and use of power by world leaders have been a fascination throughout the centuries.

Power is key to leadership. It is its underlying energy. To become an effective leader, you must become comfortable with power. It takes many forms. There is power of position, power of personality, power in presence or of charisma, power of informal authority, and power by relationships with others of greater power. Power is the ability to move others, to move causes forward, and to extend both energy and assurance or confidence. No matter what the external source of authority, power is eventually ineffective if some sense of personal power does not burn from within. It emanates from conviction,

drive, and confidence in self, from a greater self, and from the direction of the organization.

To lead with power, you must understand yourself and build a power base. Genuine leaders use any formal power; they must understand each aspect of a challenge. They can only do this through the knowledge and understanding about a challenge if they think you will not give them credit *and* use it to make good things happen.

Some leaders may struggle with seeing themselves as powerful and may interpret "power" as being above others. This could not be further from the truth, that power is best when used for good. Powerful leaders work *with* others to accomplish goals, relying on their followers in any organization for their knowledge, commitment, and creativity as well as their own (Speedy & Jackson, 2015). Speedy and Jackson (2015) described 13 strategic influences you as a leader can use to enhance your power.

Individuals who acquire managerial power seek to maintain or enhance their power by using several strategies. These may include the following:

- Increasing their centrality and criticality to the organization
- Augmenting their personal discretion and flexibility in their job
- Building into their job tasks that are difficult to evaluate
- Expanding the visibility of their job performance, resulting in increased contact with the senior people they seek to impress (from Wood et al., 2012).

There are several other common strategies used to enhance one's power and influence. These include the following:

- Building and developing personal resources
- Using of reason (using evidence to support a logical argument)
- Being friendly
- Developing coalitions or relationships with other people
- Bargaining with others, which involves using the exchange of benefits as a basis for negotiation
- Being assertive, which requires a direct personal approach
- Appealing to a higher authority, which results in high-level support
- Continually increasing one's own skills and knowledge
- Using of sanctions as appropriate, which are organizationally derived rewards and punishments (Wood et al., 2012)

The network and power base you build is both a process and a structure of connecting to personal attributes, skills, organizations, and people to contribute to the creation and control of strategic goals, direction, and resources (Broome, Bowersox, & Relf, 2018; Uzarski & Broome, 2019). A power base is built by engaging in communication, information, and personal networks; reaching out

to influential others for mentorship; acquiring your own reputation as powerful; and reflecting the influence and reputation of your own organization (National Defense University, n.d.).

Pfeffer (1992, 2015) outlined the following attributes of a leader to acquire and sustain a strategic power base:

- Having high energy and physical endurance, including the ability and motivation to personally contribute long and sometimes grueling hours to the work of the organization
- Directing energy to focus on clear strategic objectives, with attention to logistical details embedded with the objectives
- Successfully reading the behavior of others to understand key players, including the ability to assess willingness and resistance to following the leader's direction
- Employing adaptability and flexibility to redirect energy, abandon a course of action that is not working, and manage emotional responses to such situations
- Motivating to confront conflict, willing to face difficult issues, and the ability to challenge difficult people to execute a successful strategic decision
- Subordinating the personal ego to the collective good of the organization, by exercising discipline, restraint, and humility

Authentic, transforming power emanates from values and principles. Such principles carry their own form of power to be expanded by the person who carries them forward. Principle-based power is not self-aggrandizement or self-advancement. Rather, the more one empowers others, the more power is generated.

In new paradigms of self-organization and transformational leadership, power is generated from sharing, enhanced by a shared vision, and becomes the amplified energy for change when understood and used as the secret treasure of the leader who shares it strategically within the organization. In fact, the judicious and other-centered use of power and influence are often defined as empowerment of others (Broome, 2012; MacPhee, Skelton-Green, Bouthillette, & Suryaprakash, 2012). Giving the gift of power actually expands the power of the giver. When people feel that power is being taken from them, they engage in actions to "hoard" power: sabotage, passive resistance, withdrawal, or outright rebellion. But a sense of having power frees energy and promotes a sense of self-efficacy, positive influence, commitment, and greater willingness to give. Conflict is reduced as influence becomes more positive and shared. This discussion makes the process sound reasonable and easy. It is not easy. However, it is worth the effort to cultivate skills in sharing power and influence, and empowering others (see Box 6.2). Transformative leaders use their power in helpful ways to grow others and their organization.

BOX 6.2 NEW MEDIA: USING LEADERSHIP POWER TO INFLUENCE OTHERS

TED Talks

Sheryl Sandberg. 2010. "Why We Have Too Few Women Leaders." TEDWomen.

Lars Sudman. June 2016. "Great Leadership Starts With Self-Leadership."

Roselinda Torres. September 2014. "What It Takes to Be a Great Leader."

Videos

Todd Dewett. "Delivering Employee Feedback." Lynda.com. May 2019.

Colin Powell. "The Essence of Leadership." YouTube.

Ashwin, PP. "BEST LEADERSHIP VIDEO EVER!!!" YouTube. July 2, 2013.

Blogs

Lolly Daskall. "Two Rare Skills You Need to Be a Great Leader." www.lollydaskall.com

Randy Grieser. "Know Yourself—Self-Awareness for Strong Leadership." https://theordinaryleader.com

Michael Hyatt. "Seven Steps to Think Big." www.michaelhyatt.com/leadership

REFLECTION QUESTIONS

1. Think of a challenge you faced recently in your workplace. Who were using their power to help others to bring solutions to the discussion?
2. What leadership behaviors should have been demonstrated by those in power that would have motivated *you* to be part of the solution for that challenge?
3. What sources of evidence would leaders, both formal and informal, have used to help facilitate (a) assessment and understanding of the problems context, (b) generate some strategies, and (c) create some solutions to address the problem.

THINKING AS AN ENTREPRENEUR AND INNOVATOR

Appropriate use of power releases freedom to innovate and tap into your entrepreneurial learnings. Yet, preparation as a healthcare professional is not rooted in entrepreneurial thinking. Entrepreneurship is largely absent in American professional clinical curricula. Marshall remembers when a creative, nonconformist

nurse asked, while they were at work years ago, "Do you ever think of your entrepreneurial self?"

> I did not have a clue what she was talking about. I have often wondered what happened to her. I always imagined that she started her own care business or consulting firm. I have always assumed that entrepreneurs either had patrons to support their inventive habits or put their family fortunes at risks on whimsical new business ideas. I was wrong. Entrepreneurial habits are ways of thinking, creating, and solving problems.

Never have there been more opportunities for innovative entrepreneurial thinking in healthcare. The U.S. system cries out for innovative answers to difficult, complex problems. It may be a new kind of independent practice; it may be a consultation service to solve unique problems; or it may be a new kind of business relationship between the practitioner and the agency (Broome et al., 2018). However, we need more independent, creative approaches to solve problems. Some outstanding examples of entrepreneurial nurses who developed businesses to improve health are highlighted by the American Academy of Nursing (2016).

You can be a system employee and still be an entrepreneur. Synonyms for entrepreneur include adventurer, promoter, producer, explorer, hero, opportunist, voyager, risk taker, and innovator. Our healthcare systems need innovators and thinkers. We need those willing to risk a new idea, provide evidence for its value, take the responsibility for its implementation and evaluation, and nurture teams to risk innovative practices for positive outcomes. An innovative thinker resists habits of "stuck" thinking and forms new habits of looking at old problems in new ways. If such approaches are adopted within the system effectively, the entrepreneur may become even more valued by the system. When you see a problem, before lamenting its existence, reflect on the problem, let it simmer, then brainstorm at least three ways to solve it. Search for evidence on the problem. Think some more. Create a plan to address the problem, marshal the team to commit, implement the new idea, and then test the outcomes. The process is as old and familiar as practice, but it is the reframing of problems and search for ideas and solutions that call for some adventure.

Given the pioneering roots of professional nursing, in general, and of advanced practice nursing it is ironic that the entrepreneurial spirit seems so foreign to current daily practice. Lillian Wald dared to envision, champion, and create public health nursing. Following the loss of her own two children and the heartache of observing the lack of healthcare in rural America, Mary Breckinridge did not hesitate to nearly single-handedly bring the independent practice of nurse-midwifery to the United States. And Loretta Ford legitimized the primary care practice of public health nurses by establishing the first nurse

practitioner program. Why, then, is entrepreneurial nursing not evident in the everyday practice of every nurse leader today? Several authors have pointed out that worldwide, although expertise among nurses is increasingly recognized, traditional organizational bureaucratic and hierarchical mechanisms, ingrained cultures, and ambivalence and ambiguity among practitioners in shaping "new" identities and practices continue to restrain entrepreneurial activities that might improve healthcare (Aranda & Jones, 2008; Austin, Luker, & Roland, 2006; Exton, 2008).

Innovative habits need to be fed. Ideas are not born of nothing. They come from watching, listening, and reading widely. Begin today with the habit of reading within and outside the healthcare literature. Read business magazines and newspapers.

When something innovative is happening in one part of your own organization, it is sometimes difficult to spread the word and even more challenging to spread the positive action. Make an appointment with your communications and marketing department and find out what media channels they use. Can you write a story for their annual magazine that goes to patients and donors to the system? Are you involved in a healthcare innovation project that needs to be shared as the results and impact on patient care, family satisfaction, and employee retention is impressive (Chaudoir, Dugan, & Barr, 2013; Ireland, 2016)? It sometimes requires an entire change of culture to accept innovation as a way of living, working, and serving. When you are frustrated with the slow rate of change, remember the following guidelines to promote diffusion of innovation:

- Promote the idea: The innovation must be perceived as better than what people are already doing, so you have some selling to do.
- Provide a reliable source or channel of communication to spread the news that the new idea is better.
- Give people a little time to learn about the innovation, to participate in the decision, and to implement change.
- Make your institution a place of learning. (Newhouse & Melnyk, 2009)

To be able to encourage others to be innovative, you must provide a culture that encourages others to think big and take small risks. Innovators respond to transformative leaders who support their diverse (and sometimes divergent) perspectives on things (Broome, 2016). To facilitate the diffusion of innovations the leader must be visible in adoption and support of new innovations. The Duke University School of Nursing innovation initiative has been developed over several years. For example, Ryan Shaw, director of the Health Innovation Laboratory at Duke University School of Nursing has partnered with colleagues in the Schools of Engineering and Medicine to foster an innovative approach to healing for students, faculty, and nurses in practice complex problems they face every day. His model is shown in Figure 6.1.

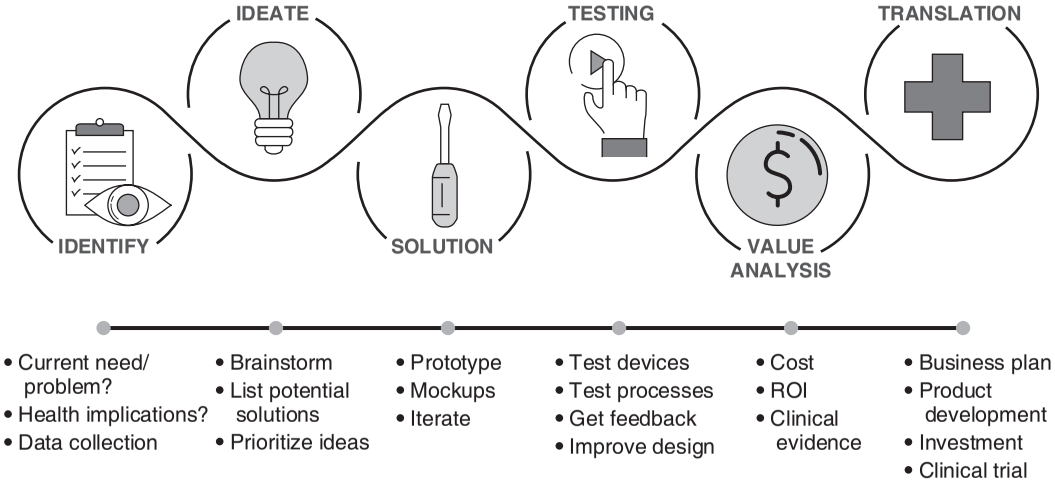

FIGURE 6.1 Example of a specific innovation.

Source: © 2019 Ryan Shaw.
ROI, return on investment.

This model illustrates the importance of new ideas, balanced with resources and support, for successful outcomes to occur. It also "takes a village" to encourage new ways of thinking about old problems and supporting the inevitable small failures that occur and any leader should expect. The important thing to remember is failure is just feedback and one must be open to learning how to "tweak" ideas and improve them as a successful innovator!

Once you are committed to a new idea, passion alone is not enough for success. Nurses are generally not prepared to face the challenges of an entrepreneurial practice. You must commit to becoming an expert in securing resources and relationships to help with legal issues, financial management, marketing strategies, payment plans, defining your role and niche, time management, and outcomes measurement. It takes courage and the willingness to risk, but the world needs more nurses willing to break new paths in healthcare leadership in entrepreneurial ways.

CARING FOR OTHERS: WHAT SERVANT LEADERSHIP REALLY MEANS

As should be obvious by now, we believe at the root of effective healthcare leadership is caring for and about others, as well as yourself as leaders. No industry is more appropriate for servant leadership.

"Leadership is giving. Leadership is an ethic, a gift of oneself to a common cause, a higher calling" (Bolman & Deal, 2001, p. 106). The unique power and prerogative of a leader is the freedom to share yourself, your style, your values, and your influence for a better future. Bolman and Deal (2001, p. 106) continued:

> The essence of leadership is not giving things or even providing visions. It is offering oneself and one's spirit. Material gifts are not unimportant. We need both bread and roses. Soul and spirit are no substitute for wages and working conditions. But … the most important thing about a gift is the spirit behind it…. The gifts of authorship, love, power, and significance work only when they are freely given and freely received. Leaders cannot give what they do not have…. When they try, they breed disappointment and cynicism. When their gifts are genuine and the spirit is right, their giving transforms an organization from a mere place of work to a shared way of life.

The concept of servant leadership was introduced by Robert Greenleaf in the 1970s (1977, 1998) and has been further developed by Spears (1995). Servant leadership releases powerful energy and proposes skills that are particularly effective in healthcare disciplines, at the heart of which is some degree of altruism. It resonates in special ways within the discipline of nursing (Howatson-Jones, 2004; Swearingen & Liberman, 2004). It encourages the professional growth of the leader and clinician and promotes positive health outcomes. It

facilitates collaboration, teamwork, shared decision-making, values, and ethical behavior (Barbuto & Wheeler, 2007).

Some people are natural servant-leaders. You know who they are in your own life. But more important, one can learn to become a servant-leader. It begins with commitment to and practice of lifelong personal and professional learning. Personal mastery is the first step. It means to commit to continual engagement in redefining and clarifying your own personal mission. It means that you cultivate exquisite self-knowledge and personal growth, that you set personal goals related more to the advancement of others than to self-aggrandizement, and that you take time for reflection and feeding your inner self. You come to see your work with a sense of calling.

To be aware of mental models means that you are sensitive to your own personal biases, viewpoints, history, and style, and that you strive to use your best self to promote the effective work of others to achieve organizational goals. You examine your own thinking and strive to create a clear vision that you can valiantly communicate and defend. You cultivate exquisite sensitivity in listening, awareness, and empathy. You approach your work and relationships from a perspective of healing.

Servant leadership has also been called selfless leadership (Hougaard & Carter, 2018). Selfless leadership requires one to surrender control of people and processes and lead through vision, energy, support, and guidance. Selfless leaders are present with "their people." They are visible in the workplace to mid-level managers and those on the front lines. It is about making sure you know enough about what good thing or bad thing has happened to someone so that next time you see them you can say something—share your praise or concern. Selfless leaders are committed to their people, sharing their experience, hope, and wisdom so that individuals can excel at what they do and feel *good* about the organization (Hougaard & Carter, 2018). This is precisely how a shared vision is created.

The shared vision is the common and persuasive image of the future. As the leader, you conceptualize and facilitate that picture with foresight and empower others to share the dream and focus energies to make the changes and do the work to achieve shared goals.

Team learning reflects your ability to suspend your personal assumptions and pace to bring the team together to listen to each other and to work in synchrony or harmony. It means that your focus is on the needs and strengths of the team and that you create ways to develop the team to foster collaboration and effectiveness. You lead the team with a sense of stewardship and interest in the growth of its members and help them build a community together. Systems thinking allows you to see the whole as a synergistic concept rather than simply as parts put together. It allows you to see the influence of your own actions and the work of the team on the entire system.

Secretan (2016) identified the following five "shifts" in servant leadership: (a) from self to other, (b) from things to people, (c) from breakthrough to "kaizen" (celebration of doing things differently rather than simply doing things

better), (d) from weakness to strength, (e) and from competition and fear to love. He reminded leaders to ask how we use our gifts to serve. He further outlined six values or principles for Higher Ground Leadership®: courage, authenticity, service, truthfulness, love, and effectiveness.

When a leader adopts the transformational stance, along with efforts to transform the organization is a tacit promise to transform others. This is an unspoken covenant to promote and model integrity, respect, and good works of others. This can be achieved in myriad ways. Create traditions replete with ceremonies and rituals that provide a sense of community and belonging and reinforce the message that significant things are happening and that the people involved are important. Celebrate successes and rejoice in the achievements of others. Find ways to distinguish good work and reward it. Create an environment of high standards to which people are drawn with assurance that their work is appreciated. Servant leadership is based on the assumption that people are more important than the task and that authentic service to people gets the task done.

GENERATIVITY: PREPARING THE NEXT GENERATION

The transformational leader in healthcare has an eye on and a heart for the next generation of leaders. Leadership development, coaching, and mentoring are integrated into the very life of the transformational leader. This is the only hope of society for a better future. It is how you leave a living legacy. As the number of experienced managers and leaders in healthcare continues to diminish, at the same time that demand for competent and visionary leaders is increasing; entire organizations are now beginning to integrate leadership development into the everyday life of clinical practice.

Drucker (2000) proposed four ways to motivate and develop future leaders: (a) know people's strengths, (b) place them where they can make the greatest contributions, (c) treat them as associates, and (d) expose them to challenges. This advice is still timely. Wells and Hijna (2009) proposed five key elements to develop new talent for leadership in healthcare: (a) identification of leader competencies; (b) effective job design; (c) a strong focus on leadership recruitment, development, and retention; (d) leadership training and development throughout all levels of the organization; and (e) ongoing leadership assessment and performance management. Of course, this is common-sense jargon, but how do we do it in a way that inspires the dreams and hopes of new leadership?

One way to inspire the next generation for leadership is to tell your own story. Stories need to be related to the context of current situations and at the level understood by the potential leader. Effective stories are told by respected role models. Share the passion and drama of your experiences, how you failed and learned from the failure, what your successes were, and how you learned to survive. And listen to the stories of aspiring leaders. What is their context and where are they going? How can you help them get there?

All seasoned leaders need to give some time to thinking about their own legacy as they help shape others as leaders for the future. Generative leaders are solution focused, outcome oriented, and excel at framing and reframing (Pesut, 2015). They ask themselves the following questions:

1. What kind of climate do I want to create here for others?
2. How do I help others to "see the view" I see so they can frame the problems they identify in a longer context?
3. How can I encourage young emerging leaders who come to me for advice to believe in themselves and their strengths?

Griffith (2012) conducted a review of the literature on succession planning in nursing to address the impending drain on leadership capital. She stressed how succession planning spans recruitment of new nurses through those in the C-suite. Coaching, formal instruction in leadership, and mentoring must be used to plan effectively.

One nurse leader suggested specific steps to approach succession management as a professional obligation, calling it a "migration risk assessment" (Ponti, 2009). First, assess potential attrition and emerging leaders within the organization, establish core competencies for leadership positions, and develop individual plans while identifying critical success factors for upcoming leaders. Then prioritize, coach, and mentor aspiring leaders.

The transformational leader with a constant eye on developing others for leadership is investing in the future. Generativity is a characteristic of leaders with passion for what they do, a vision for a better future, and a genuine interest in helping others to grow. By enabling the next generation, you extend a living legacy of your own efforts, enliven our own experiences, and contribute to a positive human investment in making the world a better place.

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CHAPTER 7

Building Cohesive and Effective Teams

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If your actions inspire others to dream more, learn more,
do more and become more, you are a leader.
—John Quincy Adams

OBJECTIVES

- *To discuss the centrality of teams and teamwork to the success of any healthcare organization*
- *To describe the importance of team-based care in value-based healthcare*
- *To discuss the significance of core values in building effective networks in organizations*
- *To describe the essential components of followership and how leaders cultivate engaged followers*
- *To identify phases of team development, nurturance, and sustenance*
- *To describe techniques for mentoring leaders in the organization of others who are building teams*
- *To discuss strategies to manage conflict within and across teams*

INTRODUCTION

Leadership by team is the most common functional structure and expectation across business and healthcare. The power of a leader is magnified by an effective team, and the leader who empowers team members expands the capacity of the whole organization at all levels. In the ideal context of complexity science, self-organizing interprofessional teams work on significant issues across systems to accomplish specific goals of the organization. Such a structure has enormous potential to release energy, encourage commitment and accountability, and promote creativity. New interest in interprofessional collaboration, along with technological possibilities for virtual team membership (Orchard, King,

Khalili, & Bezzina, 2012), offer the promise to expand the concept of teamwork to include consulting experts, community members, patients, and others. The full potential of this kind of teamwork has yet to be realized.

Teams can be found throughout the healthcare organization. In the broadest sense, the concept of team refers to any group of professionals and others working toward a purpose of service in healthcare. Numerous studies provide rationales for team approaches to governing and decision-making in healthcare (Clark, 2009; Humphrey, Morgeson, & Mannor, 2009; Kearney & Gebert, 2009; Mitchell et al., 2012; Reeves, Perrier, Goldman, Freeth, & Zwarenstein, 2013). Yet, inspiring members of different disciplines to work together naturally and maximize their functioning and effectiveness is not easy.

The Interprofessional Education Collaborative (IPEC), which consists of leaders from six of the national health professions associations, including the American Association of Colleges of Nursing (AACN), outlined four domains of competency for collaborative practice (Interprofessional Education Collaborative Expert Panel, 2016). They are the following:

1. Interprofessional work with individuals of other professions to maintain a climate of mutual respect and shared values (Values or Ethics for Interprofessional Practice)
2. Use the knowledge of one's own role and those of other professions to appropriately assess and address the healthcare needs of patients and to promote and advance the health of populations (Roles or Responsibilities)
3. Communicate with patients, families, communities, and professionals in health and other fields in a responsive and responsible manner that supports a team approach to the promotion and maintenance of health and the prevention and treatment of disease (Interprofessional Communication)
4. Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan, deliver, and evaluate patient- or population-centered care and population health programs and policies that are safe, timely, efficient, effective, and equitable (Teams and Teamwork)

In 2016, the IPEC Board reaffirmed these competencies, grounded the competency model firmly under the singular domain of interprofessional collaboration, and broadened the competencies to better integrate population health approaches across the health and partner professions so as to enhance collaboration for improving both individual care and population health outcomes (Interprofessional Education Collaborative Expert Panel, 2016). There are 39 subcompetencies across these four board competencies that all health profession schools should review and integrate as appropriate into their curricula and experiential team-based learning opportunities.

For instance, based on a framework developed at the Medical University of South Carolina, a collaborative group of health professionals described four key behaviors required for each team member to transform individual "ways

of knowing" regarding how to interact with each other within a team. These behaviors are (a) prepare, (b) think, (c) practice, and (d) act. Successful transformation will rely heavily on a leader who can truly inspire others to move beyond personal professional territories and biases and change personal perspectives of power and influence. The outcome will be improved quality indicators for patients and clients and satisfaction for providers who work on the teams. As a whole, the team must be able to perform as a patient-centered unit whose practice is based on evidence. These teams use information systems in the environment to maximize their efficiency and tailor their interventions to the individual patient to provide the highest quality care.

Interprofessional education begins during health professions training and must include clinical training opportunities for students in teams. Currently, there are a few models of care delivery that reflect the core principles of interprofessional care. That is changing and will continue to change as we move toward value-based care models. Critical to this transition will be leaders who can model collaborative practices in interactions and decision-making, or students will fail to learn the most important message: that patient-centered care requires the knowledge, skills, and experience of many team members.

BUILDING EFFECTIVE TEAMS: RECRUITING, RETAINING, AND DEVELOPING

In many situations, it is the work of the leader to build the team. In others, the leader must learn to work with existing personnel who are logically, by virtue of their position and scope of responsibility, members of a team. Leadership by team can be inspiring and fulfilling to both the leader and the team members. The leader must balance efforts between building team member satisfaction and pushing for team productivity. It is often tempting to focus on building team processes and dynamics, but the leader who places too great an emphasis on this component risks losing sight of the actual work to be accomplished by the team. Evidence-based practice (EBP) and current outcomes perspectives require that the team be evaluated primarily in terms of its productivity, patient outcomes, and the success of its work (Körner, Ehrhardt, & Steger, 2013). Individual commitment, team satisfaction, or impressive team processes cannot substitute for positive effects on clinical and organizational outcomes. Thus, the transformational leader always carries a vision not only for team spirit and activities, but also for the actual accomplishments of the team to improve the lives of the people being served. Leading a successful team is not for the fainthearted.

Among the most important activities for the leader are recruitment, development, coaching, and retention of team members. Indeed, in hospitals, poor management of human resources has been linked to patient mortality and exceptional costs in turnover (Needleman et al., 2011). The concept of team in healthcare is important in the context of acute care hospital environments as well as ambulatory and community care settings. Some of the most effective

team models are found in community health and primary care, as well as across settings. In fact, interprofessional collaboration is often stronger and healthier in community environments (Reeves, Lewin, Espin, & Zwarenstein, 2011; Thistlethwaite, 2012). The very complexity and pace of healthcare organizations demand team approaches to problem-solving and leaders who understand and promote team achievement. Contemporary and future healthcare challenges require changes in the way care is delivered, evaluated, and compensated. As technology evolves, new ways of delivering care will emerge, and leaders must think through how new care models need to be implemented. No single individual can negotiate such complex issues of caring for individuals with complex chronic conditions, nor can even multiple individuals from any single discipline. Varied and diverse perspectives are needed, and it is incumbent on the leader to not only manage that diversity but embrace it.

Regardless of the setting or task at hand, a recruitment plan for the best team members is critical. The leader's plan for recruitment and assignment of teams should include clear objectives, long-term projections, analysis of potential pools of candidates, and specific strategies to attract and keep the best individuals functioning on the team. Occasionally, a leader may hire just the right person to lead an important team-based initiative. But in other cases, one either inherits a team or has limited resources to build the right team. These situations require different approaches.

Recruitment of the best team members is one area where there is a careful dance between immediate needs for effective management and long-term investments in human capital for the future. Every team should have at least one individual who is relatively new to the healthcare professions or problems being addressed. There are two reasons for this. First, inclusion on the team offers an opportunity for that person to grow and develop team-based skills; and second, the person will likely have a fresh perspective for solutions to problems. Unfortunately, when selecting potential team members, we usually default to the person in an administrative position with experience and responsibilities in the specific area. Although an administrative leader who can guide the team is critical, that alone is not sufficient for innovative solutions to challenges. In fact, one needs people close to the process and problem who have a vested interest in solving it. This will mean that the leader must build on the strengths of individuals, as well as their ability to work with others to achieve a common goal or reach a common objective.

So how does one assess the strengths of an individual as a potential team member? Furthermore, how does one "sell" that busy person on the need to use those strengths to work with others on a team to achieve an organizational objective? This is where the strategic leader's vision and plan are most useful.

Your responses to the reflection questions are important because they can guide you to recruit members of your team. For instance, you may identify strengths of which a person is unaware, and he or she will be pleased to hear your opinion. That team member most likely will not initially recognize

REFLECTION QUESTIONS

Think about a problem or issue where you work. Assume that you need to recruit a team to solve the problem. As you think about how and who to select as the best members of your team, ask yourself the following:

- What is the overall preferred outcome for this team?
- What kinds of skills are needed to achieve that outcome (e.g., process skills to analyze the current problem; financial acumen to examine costs; organizational skills, including time management; consensus-building skills)?
- What individuals in your sphere of influence have each of those skills?
- Whose goals are aligned with learning from a team of diverse individuals to achieve the desired outcome (e.g., someone who has expressed an interest in participating in the leadership of the organization)?
- What would be possible gains or advantages for each individual to join the team?

the benefits to be derived from such an experience. Your success at recruiting the best people will be enhanced if you are able to articulate the answers to the reflection questions.

LEADING THE TEAM

Teams Working in Cohesive, Forward-Thinking Cultures

Why is an effective team important to promote a forward-thinking culture? One might ask, "What is a cohesive, forward-thinking culture?" A culture that is forward thinking looks to the future and has clear vision and mission statements about the work it does and the level at which the work is expected to have an effect. These are organizations where individuals think proactively about alternative scenarios that may promote the ability of the organization to seize important opportunities. When problems or challenges arise, the leaders in a forward-thinking culture do not explain away or deny the problem but rather discuss ways the organization should approach the challenge to maintain stability and remain effective in meeting its mission. A cohesive culture is transparent about these challenges, and most individuals in the organizations are interested in contributing their efforts to work toward finding solutions for the issue.

This is where teams and their leaders can play a major role. A large part of the job of any leader is to build the team. By building the team, you are building a community that becomes the culture of the organization. Important functions of leaders in such a setting include providing a clear vision and expected

outcomes to guide team members in their work, coaching team members and leaders as they go through the inevitable conflict about processes to get to outcomes, motivating the team if energy lags, modeling collaboration and shared leadership when appropriate (Wang, Waldman, & Zhang, 2013; West, Lyubovnikova, Eckert, & Denis, 2014).

These team-building functions require that the team leader be highly respected and viewed as credible by team members. But leading a team also requires that one selectively and honestly share weaknesses. When a leader demonstrates vulnerability, he or she becomes more approachable and humble. Do not hesitate to rely on intuition (experience and wisdom) to interpret cues in the environment that help team members know when and how to approach problems and make decisions. Manage members of the team with compassion and firmness, a kind of "tough empathy." Team members need to know that the leader is passionate and cares about them and the work they do. Further, do not be afraid to reveal your own differences as a leader, and learn to share what is unique about yourself (Goffee & Jones, 2011).

Effective teams work together over time, sometimes in phases, to create a respectful, shared subculture through the identification of core values. This process allows team members to analyze the evidence that underlies and supports challenges under examination. Team members will come to encourage individual ideas and contributions, mutually think through the unintended consequences of proposed solutions and decisions, and be willing to oversee and champion the implementation of decisions.

Core Values of Organizations and Teams

It is difficult for individuals to work together if they lack shared values and regard for each other. Core values differ from individual to individual and organization to organization and often depend on the vision and mission of the organization. Such values serve as a foundation and guiding principles for how people work, and especially how they work *together*. Examples of core values commonly found in organizations are listed in Box 7.1.

The leader of any team must be ready to lead a discussion about core values of the team and how those values align with the larger organization. Core values influence a team's work in the following ways:

- Guides the way the team asks questions and addresses challenges
- Positively influence how the team holds discussions with others in the organization as they collect data about the problem and then with each other about what they found
- Helps the leader to determine what kind of information and guidance is needed by the team
- Helps the leader to coach the team as it makes decisions, especially when there is diversity of perspectives and opinions

Hence, two different teams, guided by different core values or even different leaders, may reach different solutions for the same problem on a different timetable. This is the leadership-in-action scenario presented in Box 7.2.

Despite the prevailing discussions about the need for team-based care in healthcare organizations, some colleagues remind us of their challenges related to sharing leadership and sharing decision-making, particularly in

BOX 7.1 EXAMPLES OF CORE VALUES COMMON TO ORGANIZATIONS

Transparency

Accountability

Trust

Openness to new ideas

Flexibility

Caring

Responsibility

BOX 7.2 LEADERSHIP IN ACTION: CORE VALUES

After reading the case example, discuss with a classmate or coworker your responses to the reflection questions that follow.

Teams A and B are asked to develop a process to improve triage and care in the ED to decrease wait times and improve satisfaction of patients and families. At an initial meeting, Team A identifies its core values as innovation, transparency, flexibility, and consensus. Team B's core values are teamwork, evidence, inclusiveness, and transparency.

Team A: At the second meeting, Team A's leader encourages the team members to review the data they requested (current wait times, current processes, etc.) and to think about all the factors that slow the process of placing patients in rooms for care (e.g., the length of time in the room, what they do throughout their visit, etc.). Team members are asked individually to list strategies addressing each factor that leads to increased time and decreased satisfaction. After each person shares his or her ideas, commonalities across factors are sought and common strategies are identified.

At the third team meeting, the entire group devises pilot tests of changes that could be implemented and evaluated one at a time. At a fourth meeting a week

(*continued*)

BOX 7.2 LEADERSHIP IN ACTION: CORE VALUES (*continued*)

later, the group analyzes the "cost" of time, effort, and disruption each small test of change would require and decides how to evaluate the effectiveness of each change to achieve the goals of increased satisfaction of patients and decreased wait time. They also decide that provider satisfaction is critical, and incorporate this into their evaluation scheme. Finally, based on these decisions, they prioritize which test of change should be implemented first, second, and so on. This process took 4 weeks, with one 2-hour meeting each week.

Team B: Team B also asks for data on the basis of which to make decisions. Team members spend their time during the second meeting talking about how the data are incomplete and do not capture the entire situation. At the second meeting, the leader asks them to brainstorm about the factors involved and potential strategies. Two members of the group who have worked in the ED the longest, and another member who is in the highest position of authority, speak most often and take notes, while others nod their heads in agreement. When the team leader asks if there are any additional ideas, none are offered.

At the third meeting a week later, one third of the original team does not return due to "time conflicts"; however, both of the experienced individuals return and lead the meeting. One new approach to the problem is identified, and it is decided that this approach will be implemented and evaluated. The formal leader thanks everyone for coming and for thinking about how to work so efficiently "within the constraints we had." This process took 3 weeks.

complex healthcare organizations (West et al., 2014). Many report that there are relatively few times throughout the day when members of the interdisciplinary team actually function as a team. Most often, they work as individual advocates for the patient through their individual roles, and only in rare instances, such as clinical emergencies, do they step out of the role and truly work together as a synergistic team. Turf battles, differences of knowledge level and experience, and rare opportunities for group conversation can lead to a competitive atmosphere where everyone is struggling to do the right thing (Gerardi, 2010). Among explanations given for this common situation are the following:

- Today's healthcare professionals did not train together while learning to be a nurse, physician, physical therapist, or other member of the team.
- After individual professionals joined the healthcare workforce they were not rewarded for their performance as a team member.
- Care delivery and outcomes have not been compensated based on success of team care; rather, care provided by nurses, physicians, and other health providers entails separate costs and charges.

- In many cases, core values of the professions differ and must be shared and discussed if effective and high-performing teams are ever to become hard-wired into healthcare organizations.

New graduates across disciplines report that while they may have been exposed to faculty teams working together in healthcare, there are a few exemplars in practice. In one study by Thomson, Outram, Gilligan, and Levett-Jones (2015), participants shared that they observed negative stereotyping of other professionals, hierarchical communication, and competition for time with the patient resulting in profession-focused and not patient-centered care. So, we still have much work to do as leaders, reminding health professionals that the patient is at the center of what we do.

There is no such thing as the "correct" or "perfect" team member. The very reason we work in teams is that a combination of several people with individual characteristics and strengths is better than any particular person, no matter how exceptional. Certainly, team members need to have the basic qualities of honesty, respect, and accountability and be willing to participate, but teams do not benefit by selecting dominant personality styles, however apparently competent.

REFLECTION QUESTIONS

1. How do you think the core values of each team in Box 7.2 influenced the way they approached the challenge they were given?
2. Did any of the core values self-identified by either team as important to them seem less readily apparent to you?
3. One team took less time to devise a solution, and its implementation of the solution appears as if it, too, will take less time. How do you think the members of each team felt about the experience of participating in this effort? What might be some core values that guided their work together?
4. Do you think both teams' approaches are equally effective, or would one team's approach produce better results than the other's? Why?

SUSTAINING HIGH-PERFORMING TEAMS

Leader characteristics are important to the effectiveness of any team. Several studies have confirmed that transformational qualities in the leader contribute to more effective team function. Effective teams require enormous amounts of energy, planning, communication, and investment in others. This is contributed by the identified team leader as well as organizational leaders "at the top." The fine art of team leadership is commonly discussed but uncommonly done with

excellence. The work of the team needs to be seamless, with a purpose whose results are greater than the sum of individual efforts. The team leader is critical in setting the tone to ensure that each team member clearly understands his or her role, and that individual members have the resources needed to achieve their goals.

The following are the key requisites for any high-performing team:

- Expectations and communications should be clear and open—between leader and all members, and among all members.
- Team consensus must be met about the goal to be achieved, the core values by which dialogue and disagreements will be managed, who will be responsible for bringing what information to the group, and how often and for how long the group will meet before the task is completed.
- Each team member should have full accountability for decision-making within his or her team role, and those decisions should be openly shared at each meeting.
- The entire team must be included in the wider strategic decision-making.

Highly effective and high-performing teams are diverse. That is, the members must bring to the group different perspectives based on their age, ethnicity, gender, work experience, and culture. Page (2017) explored research that has demonstrated that diversity across decision-making teams leads members to ask different questions, come up with more varied solutions to a problem. He also points to studies that have demonstrated how the different processes lead to higher profits (based on better business decisions). Yet, bringing members of a team from diverse backgrounds together can be expected to bring with them a certain level of disagreement or conflict as the team engages in its work.

Teams differ in how they approach challenge or conflict. Some teams make decisions by simple majority vote. This method carries the risk of being less about the team and more about the collection of individuals. In this case, once the vote is taken it is important that all team members support the decision. Other teams are able to work by consensus, which is more challenging but often more effective when the time comes to implement a change. Consensus requires team members to work together until a decision is crafted that reflects the entire team membership without a vote. It has the advantage of engaging team members in coming to mutual decisions. It requires discussion, listening, and compromise. At some point, the entire team must be behind all decisions. A good decision means little without the full support of the team.

Effective teams have a purpose. Members understand their roles and the priorities of their work. They feel appreciated for their contribution. Norms for behavior and conflict management are understood. The decision-making authority of the team is clear, and team members have a vision for what constitutes success. Team members feel free to contribute, recognize, and

appreciate differences among members, and they participate. Teams that are high-performing and effective engage in the following behaviors:

- Manage boundaries among their tasks and responsibilities. Effective teams recognize assignments they can assume and others that are not appropriate.
- Challenge the process and be open to change.
- Ask for resources using realistic assessments of what is needed to accomplish their goals.
- Self-manage and support their social climate (Morgeson, DeRue, & Karam, 2010).

Communication and information sharing are probably the most important aspects of team leading and teamwork. It is critical to success that team members individually and collectively use all available sources of information, including members of the team itself. Mesmer-Magnus and DeChurch (2009) performed a meta-analysis of 72 independent studies, totaling 4,795 work teams, and a total of 17,279 individuals. The studies explored team information sharing. They found information sharing to be critical to team performance, cohesion, decision satisfaction, and knowledge integration. Information sharing positively predicted team performance across all levels of related factors. In another meta-analysis of studies in healthcare and team functioning, West et al. (2014) found that leaders at all levels of the organization must be aligned around values, behaviors, and practices that will change a culture and promote safety and high-quality care.

REFLECTION QUESTIONS

The truth is that from a transformational perspective, we have not even begun to think creatively about teams.

1. Consider an organization with which you are familiar. Why are there so few truly interprofessional teams with clinicians of all kinds, including staff nurses, nurse practitioners, physicians, leaders, community members, patients, and students? What "old" ways of thinking, what values, and what hierarchical structures impede us from thinking inclusively?
2. For areas in which teams do function at a high level, what does that look like to others? How do team members behave? How effective are their outcomes?
3. What current challenge is your organization facing that could be better assessed and managed by an interprofessional team empowered to understand the problem in depth, generate solutions, and oversee implementation of changes?
4. Who would you recruit for that team? How would you evaluate its effectiveness? What role would you play as a transformative leader in its success?

SHARED LEADERSHIP AND MANAGING TEAM CONFLICT

Shared leadership reflects the complexity of the organizations in which most of us work. In one study (Grille, Schulte, & Kauffeld, 2015), the similarity of the leader with members of the team and the individuals' perceptions of their own psychological empowerment and being rewarded fairly were all associated with shared leadership. This would suggest that team leaders must have strong credibility with their team members and engage all in decision-making processes using fair and equitable access to the leader and to information in the organization. In a meta-analysis of studies on shared leadership (D'Innocenzo, Matthieu, & Kukenberger, 2014), scientists found that the degree of complexity of processes and the outcomes expected of a team were not always straightforward. That is, the more complex the task given to a team, the more guidance must be provided from higher authorities in the organization—even with shared leadership on a team.

Despite the strength of shared leadership, when one pulls together or assigns individuals in an organization to achieve goals and engage in regular interaction, conflict results. Diverse teams naturally bring perspectives that vary. One of the challenges of successful team-building is the potential discrepancy of perceptions and expectations among team members. Divergent views may exist between team members and the leader (Gibson, Cooper, & Conger, 2009) or among team members—as between physicians and nurses, or among other representatives of different distinct disciplines. In fact, current perspectives suggest that healthy, respectful disagreements among team members ensure open, transparent, and broad-based decision-making—sometimes referred to as creative abrasion (Broome, 2015). Yet, many team disagreements are anything but open and transparent! Rather, disagreements are often talked about after the meeting—in small groups, in the coffee room, or in hallway conversations—a process that can be disruptive to team functioning and may occasionally become toxic. The leader must bravely face these behaviors and model to the team that it will move forward.

All human dynamics carry the potential for conflict. In any work situation, conflict is inevitable (Greer, Caruso, & Jehn, 2011). Furthermore, to recognize the diversity and fundamental differences in personal experiences, viewpoints, and values among human beings is to acknowledge conflict to be a normal characteristic of human interaction. Conflict is a human experience. Especially in complex environments with a highly diverse workforce and laden with high-risk situations, conflict happens.

Nursing and healthcare organizations can be particularly vulnerable to conflict given the larger number of interactions that occur among individuals with daily varied expectations, roles, and responsibilities. These interactions, when conflictual, may affect safety in the workplace for both patients and professionals (Rosenstein, Dinklin, & Munro, 2014). Conflict cannot be eliminated, particularly in healthcare organizations, which have a vast range of stressors and

diversity of disciplines and professions. A professional mediator observed why the healthcare environment is particularly fraught with potential for conflict:

> The health care professional's typical day involves a frenetic race to coordinate resources, provide care, perform procedures, gather data, integrate information, respond to emergencies, solve problems, and interact with diverse groups of people. Regardless of the role of the professional…, as a group, health care professionals face more conflict and greater complexity than any other profession. Despite the challenges of balancing competing interests, philosophies, training backgrounds, the endless question for adequate resources, and the emotional quality of the work that they do, very few health care professionals have had the opportunity to learn the skills and processes necessary for negotiating their environments. (Gerardi, 2010)

Other reasons for conflict include (a) disagreements sparked by differences in perspective, competencies, access to information, and strategic focus; (b) lack of clarity about purpose and roles (Rosenstein et al., 2014); and (c) information overload, inaccurate information, and variation in understanding of critical situations (Broome & Gilbert, 2014). The increasing complexity of clinical decision-making and range of people making clinical decisions for any particular patient can also create misunderstanding and conflict based on information and practice issues of ambiguity (Sitterding & Broome, 2015).

A positive, healthy professional care environment makes a difference in reducing error, improving safety, alleviating stress, and generally enhancing the patient and caregiver experience (Doucette, 2008). Few individuals have had experience or training in resolving conflict. Thus, fundamental to the role of a

REFLECTION QUESTIONS

1. How do you *feel* when individuals who hold differing opinions voice them strongly in a meeting?
2. What strategies have you or others used to diffuse a situation in which differing opinions make other team members uncomfortable?
3. As leader of a team, can you envision yourself using the power of negotiation between conflicting perspectives, encouraging those members who are silent to share their ideas, and outlining some potential solutions?
4. If you are not comfortable, or cannot envision yourself using those strategies, are there other leaders you know to be effective from whom you can learn?

leader is the ability to understand, embrace, and deal effectively with conflict. Conflict is more than a "necessary nuisance" and can be a resource for learning and insight, and most importantly, creative solutions (Broome, 2015). Thus, it is in the leader's best interest for the organization not to eliminate conflict but to embrace it and "institutionalize mechanisms for managing it." Unfortunately, neither the clinical nor the leadership training of most healthcare professionals prepares them for the realities of conflict management and resolution.

Managing conflict well is a fine art. There are a few basic general principles. First, as a leader, it is important to bracket your own emotional responses. Draw on your highest levels of emotional intelligence, which can help you frame conflict situations as opportunities for learning.

The effective leader manages conflict with sensitivity, serenity, and wisdom. Useful strategies to employ in conflict situations include the following:

- Stand back, stand firm, reflect the perspectives of both sides, and approach the situation as a compassionate mediator or therapist.
- Remember that you are *the leader*, not the parent or the referee. Examine your own thoughts and feelings about conflict. If it is helpful, share them with a trusted person outside the conflict to ensure that your thinking is rational.
- The aim is to support others to work through their disagreements. Plan your response to the people involved in the conflict carefully and fairly.
- Do not respond to ambushes, except to listen. Then listen carefully and responsively, reflecting the viewpoint of the parties in a verbal or written summary.
- As the leader, you set the time, place, and agenda for any official meeting to facilitate resolution. Ask questions and listen again. Separate fact from opinion, including your own, while considering the perspective of all parties involved.
- Separate people from problems in your own mind. It is rare that a person is simply "being difficult," although frustration may cause you or others to interpret it that way. It is often helpful to think about the context from which the "difficult person" functions to better understand the perspective.
- Finally, hang on to the goal of preserving human respect and working relationships.

Sometimes providing wise interpretation of each other's viewpoints to conflicting parties is enough. If not, take time to plan your response, record it in writing, hold parties accountable, follow up, consult internal or outside experts as appropriate, and be firm but gentle where possible. Promote compromise and collaboration. Help others move out of damaging entrenched positions by constructing graceful ways out of those corners into which acrimony sometimes backs a person. You may need to resort to reassignment or other means to simply separate the parties. Whatever the approach, emphasize the strengths

of each person, allow face-saving positive responses, and do not respond to grudges.

You may find it useful to assess your own comfort with conflict before you begin employing any of the tactics described in this section. Among the most common tools for this purpose is the Thomas–Kilmann Conflict Mode Instrument (Thomas & Kilmann, 1974), also called the Conflict Resolution Scale, which has been used for decades in research and business. It is available online, and there is a small charge for analyzing the results of the tool, but the information gleaned from the assessment may be worth the cost.

Occasionally, conflicts may escalate beyond your ability, as the local leader, to resolve them. If the issue is particularly complex or hazardous, it may be helpful to bring in a mediator to avoid full-blown litigation, which is costly to organizational and human resources. Once conflicting parties engage attorneys, the rules change, and you are required to work only through your own counsel.

Novice leaders soon learn that part of the mantle of their stewardship as leaders is the burden of carrying confidential knowledge of conflicts, misbehaviors, and mischief of some workers in the organization. Some of that mischief can be directed toward the leader. Hall talk stemming from grudges that may have little to do with you as an individual can generate sentiments directed against you as the leader. Others can talk, but you must carry the burden of confidentiality and simply bear it gracefully.

Intervening in Conflict Situations

Beyond case-by-case real-world conflict resolution, the wise leader provides staff training and education in dealing with conflict. Because the topic is so conspicuously absent or underplayed in the educational programs preparing health professionals, it becomes your responsibility as the leader to raise awareness and educate colleagues. This can be done proactively through grand rounds, continuing education programs, invited experts, staff meetings, retreats, and other programs. It is topically at least as important as any clinical update. Role playing and training across disciplines may be especially helpful.

Health professionals are trained to solve problems. They are experts at assessing problems; developing plans, strategies, and tactics; securing resources; and curing the disease. Engage others in resolving issues that produce conflict:

- Put colleagues to work to identify and address problems related to interpersonal conflicts in their own teams and units using nonthreatening, collaborative goal setting and processes.
- Model openness to alternative solutions to resolve complex problems.
- Encourage creativity beyond a new policy, guideline, or program.
- Provide an environment of trust and support.

- Adding a healthy dose of humor does not hurt and often can help facilitate difficult conversations.

A key aim is to provide a clear process for people to use in resolving issues independently without any damage to relationships or organizational morale. Without a dependable structured process, individuals can become mired not only in the end result, but also in how to approach a solution. Furthermore, a systematic approach may promote goodwill and prevent less-optimal outcomes in which parties "split-the-difference" or remain deadlocked.

Providing workable mechanisms and fostering openness, support, goodwill, and encouragement of thoughtful refection to solve problems across the entire interpersonal environment and across all hierarchical levels of leadership are challenging tasks but worth the effort. Successful conflict resolution can result in improved therapeutic environments, strengthened human relationships, innovation in processes, shared meaning, and new stories (Rahim, 2011). Box 7.3 lists resources for encouraging teamwork and resolving conflict in the workplace.

BOX 7.3 NEW MEDIA: PROMOTING TEAMWORK AND RESOLVING CONFLICT

TED Talks

Edmondson, Amy. "How to Turn a Group of Strangers Into a Team" (13 minutes). October 2017.

Conley, C. "What Baby Boomers Can Learn From Baby Boomers–and Vice Versa." (22 minutes). September 2018.

Lorenzo, R. "How Diversity Makes Teams More Innovative" (11 minutes). October 2017.

Blogs

Attfield, Bev. "7 Ways to Create a Culture of Teamwork in the Workplace." *JOSTLE: Employee Engagement & Internal Communication*. www.blog.jostle.me

Kim, Larry. The WordStream Blog. "Twenty Ways to Improve Your Presentations." April 13, 2018.

Wachtel, T. Element Three Blog. "5 Companies With Core Values That Stand Above the Rest." April 9, 2019.

Online Resources

TeamSTEPPS: https://www. AHRQ.gov

TeamSTEPPS app store (free)

Is There Such a Thing as Positive Conflict?

In healthy work environments, sparring, disagreeing, and even constructive conflict release creative energy, invite consensus, and promote effective decisions. Beware of a "culture of yes," in which people tell you only what they think you want to hear, or people who disagree sit quietly in meetings, saying nothing, and then undermine leadership and decisions in the hallways. Or, they sit quietly, saying nothing, then passively resist progress or change efforts. Those who are the least likely to express disagreement may be the very ones to whom you should be listening!

Think about it. Knowing who disagrees with a decision and why that person disagrees may actually help you make a different decision, implement a decision in a more effective way, clarify your rationale, or invite change to a better way. However, a culture of too much "no," in which workers have all power to veto or resist every decision, can stifle progress. Roberto (cited in Lagace, 2005) also described a "culture of maybe," in which leaders and followers become mired in analysis, resist ambiguity, and continue to gather information, striving for the certainty of just the right answer. Such an environment can immobilize the leader and an entire organization. A bit of constructive conflict in such a situation can move the process toward a decision. A well-managed conflict allows others to be more creative and innovative in their approaches to solving conflicts and problems. Creative abrasion, mentioned earlier, relies on diverse perspectives and provides for "safe spaces," where those with differing perspectives can express their views. It is critical in these conversations that personal attacks on others and their ideas be prohibited.

Remember, however, that it is *constructive* conflict you seek. This is where the art lies: in determining how to make disagreement and sparring constructive. Constructive conflict that fosters critical thinking, active engagement, vigorous debate, and commitment can enhance the quality of decisions while building consensus. (See Box 7.4, which describes one framework, termed *Collective Genius*, for achieving creative resolution of conflict.)

Consensus must be goal- and activity-oriented rather than emotion-based. When conflicts are high in an organization it is imperative that the leaders, both formal and informal, be honest and transparent, naming the issues for what they are. It helps establish ground rules for civil dialogue, clarify roles, recognize differences in cognitive and communication styles, and build mutual respect. The process must be fair to promote ultimate commitment to decisions. Constructive conflict will not result in everyone achieving the outcomes they want.

When conflict arises in an organization it will be crucial that all at the table feel free to express their views. Almost et al. (2016) describe antecedents that influence conflict and choice of conflict management style including individual characteristics, contextual factors, and interpersonal conditions. Sources most frequently identified include lack of emotional intelligence, certain

BOX 7.4 COLLECTIVE GENIUS

The complex problems of contemporary healthcare across all settings present many challenges that must be solved to achieve the goals of nurses in practice, education, and research. Our highly regulated profession often reflects rigid approaches to achieving quality and consistency that have unintended consequences, which often results in less educational innovation and higher cost for the innovation and training (Broome, 2015). Resolution of these complex issues requires a more flexible, cohesive, and inclusive approach to ensuring greater access to and higher quality of care for patients. Hill, Bandeau, Truelove, and Lineback (2014) proposed a framework that could promote a process by which such resolution could occur. The framework has three main components.

Creative discourse refers to discussion, debate, and discovery-driven learning about the scope of the complex issue at hand. But discourse goes beyond just talking about the problem. It involves honest, open examinations of the various factors that have contributed to the current situation, as well as the desired future state. To achieve this level of conversation, individuals must let go of their territoriality around ideas and solutions. Transformative leaders must call for, encourage, and then engage in these discussions to motivate and provide role models for others.

Creative agility refers to approaches that are created and implemented using "rapid-cycle" pilots—or small tests of change—that are closely monitored and evaluated to assess their effectiveness in achieving objectives for change. This particular aspect of the collective genius framework has never been a strength of the nursing profession. We tend to prolong discussions about the problem and debate proposed solutions for extended periods of time without coming to "action" and implementation. To adopt creative agility, we need leaders who not only allow pilots of projects for change to move forward, but also hold those testing the pilot projects accountable for assessing their impact, and then communicating the process and outcomes to others.

Creative resolution requires engaged leaders and followers who work together with individuals with different perspectives and agendas but who can identify common goals and outcomes. Resolution of complex problems comes with a cost to individuals in that no single group or faction achieves the entire outcome wanted. Rather, creative resolutions reflect disparate and opposing views that come together in a way that allows for, and even promotes, innovative approaches to these complex issues.

personality traits, poor work environment, role ambiguity, lack of support, and poor communication.

Sometimes, as loud and verbal members can often monopolize the discussion, it will be important for the leader of the group to ask specifically what

each team member thinks. Each member must feel respected and understand the criteria that will guide a final decision. In addition, the following "behavior" guidelines should be discussed during conflictual discussions.

1. Every member should have the opportunity to speak his or her mind and describe to the group feelings about the topic being discussed.
2. No outside-the-meeting conversations should be held with members outside the group without the express permission of the group.
3. Under no circumstances should individuals within the group be identified outside of the meeting to others related to what their stance and opinion was during the discussions.
4. All team members should have ample opportunity to express their views and to discuss how and why they disagree with other group members.
5. Team members should feel that the decision-making process has been transparent; that is, that deliberations have been relatively free of secretive, behind-the-scenes maneuvering.
6. Team members should believe that the leader listened carefully to them and considered their views thoughtfully and seriously before making a decision.
7. Members need to perceive that they had a genuine opportunity to influence the leader's final decision.
8. All members need a clear understanding of the rationale for the final decision (Lagace, 2005, p. 3).

LEADERS STRIVE FOR CONSENUS

It is reassuring for both leaders and followers to know that they are working together. Consensus is not blind. It is achieved through social convergence (Stephen, Zubasek, & Goldenberg, 2015). Consensus is a process that occurs after individuals are able to offer their initial ideas in small groups of two or three, explaining why they think the ideas are useful in addressing the problem at hand. The ideas of these small groups are then fielded within a larger group, and a convergence occurs in which consensus can be reached.

Consensus is generally more effective than a majority vote that automatically elicits the dissenting opinion after the decision is made. Consensus represents a generally high level of commitment to the course of action, a buy-in to the process, and shared understanding of the direction of the work. It is through consensus that teams can move the vision and mission of the organization forward.

Building and sustaining effective teams may be among the most challenging of tasks for the leader. But the rewards of achieving consensus on thorny problems among a variety of minds and hearts go far beyond any unique creative

approach offered by an individual. Teamwork is the norm and requirement of decision-making and progress in healthcare. Make it a practice to observe healthy, effective teams and examine the characteristics of their leaders and how they function. Your contribution to a better future in healthcare may be the work of your own team.

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PART III

LEADING THE DESIGN OF NEW MODELS OF CARE

CHAPTER 8

Creating and Shaping the Organizational Environment and Culture to Support Practice Excellence

Megan R. Winkler and Elaine Sorensen Marshall

There are two ways of being creative. One can sing and dance. Or one can create an environment in which singers and dancers flourish.

—Warren G. Bennis

OBJECTIVES

- *To describe the importance of organizational environments and cultures and how these relate to positive patient, healthcare provider, and organizational outcomes*
- *To provide an overview of the components of and ways to create a culture of practice excellence in a healthcare organization*
- *To identify approaches to building safe environments for all individuals within a healthcare system*
- *To describe mentoring approaches to support the next generation of healthcare leaders*

INTRODUCTION

Environment and culture matter. They matter to patients and families, healthcare providers, and other healthcare staff. The importance of place and culture as dynamic aspects of individual health and behavior is not new (Alter, 2013; Cummins, Curtis, Diez-Roux, & Macintyre, 2007). Who we are is inextricably related to where we are (Torkington, 2012) and, thus, signifies the critical implications landscapes have for the health and well-being of patients, families, staff, and providers. The challenge for the healthcare leader is to ensure not only that the complex holistic links between people and their environment are recognized

but that organizational environments and cultures are built to enhance health and healing for all.

Challenges and obstacles abound to successfully build and manage environments in healthcare systems (Dixon-Woods, McNicol, & Martin, 2012; Parmelli et al., 2011). Several of these challenges, in part, relate to the rapid cultural and structural evolution of U.S. hospitals from the authoritarian—yet caring—local landmarks of progress, science, and technical procedures to the much more corporate and complex health system businesses they are today. These changes require a shift in organizational leadership—from top-down approaches focused on control to leadership approaches that create conditions and environments that foster relationships and collaboration for productive, adaptive outcomes (Ford, 2009; Shi & Singh, 2015).

This chapter introduces some of the ways that leaders can nurture relationships and build the conditions to promote best care for patients and families and best working conditions for providers and staff. Specifically, we review how to build and maintain a culture of practice excellence, how to build safe environments for all people to thrive, and interpersonal and organizational techniques useful to develop and mentor the future leaders of healthcare.

CREATING AND SUSTAINING A CULTURE OF EXCELLENCE IN CARE DELIVERY AND PROFESSIONAL SUPPORT

Among the many important areas that a leader in healthcare must influence, the shaping and preservation of an organizational culture of excellence is one of the most fundamental. Culture includes nearly every aspect of our lives. It involves values, knowledge, beliefs, and attitudes that are shared within a social group and learned through processes of social interaction. It assists us in making sense of the behavior of others and helps us to know what behaviors are appropriate or accepted in various life domains (Schein, 2012). In healthcare organizations:

> Culture rules. The point of service is driven by the culture of the patient population, and the system is driven by the culture of its community, which gives it purpose, and the culture of its members or workers, who give it focus. These constituencies converge to drive the system to thrive. (Porter-O'Grady & Malloch, 2015, p. 60)

Healthcare organizational cultures possess highly unique features. Individuals and populations of patients (indeed, the very experience of being a patient) contribute their own subculture to the entire gestalt of the organization. The significant interchange, characterized by an intimacy and urgency known only to healthcare leaders, caregivers, and patients, creates a supernal uniqueness to the culture. Such a culture merits the most rigorous scrutiny, best thinking, and most devoted commitment to it truly becoming a culture of excellence for patient care and healing.

And just as important as the culture of excellence created for patient care is the culture of excellence created for supporting those who devote their professional lives to promoting health and providing care for the suffering. The environment must be as healthy for those who work in it as it is for those who are cared for. For the past 30 years, leaders in nursing have been investigating work environments that support nursing practice, recruitment, and retention. They have begun to identify how such factors are critical not only to workforce outcomes, such as productivity, turnover/burnout, and satisfaction (Aiken et al., 2011b; Baernholdt & Mark, 2009; Gunnarsdottir, Clarke, Rafferty, & Nutbeam, 2009; Lewis & Malecha, 2011; Warshawsky & Sullivan Havens, 2011), but to the patient outcomes, such as reduced falls and medication errors, quality care, hospital-acquired infections, and mortality (Aiken et al., 2011a, 2011b; Duffield et al., 2011; Wong, Cummings, & Ducharme, 2013). Indeed, the fourth leg that changed the Triple Aim to the Quadruple Aim is the importance of improving the work experience and environment of the healthcare provider (Morrow, Call, Marcus, & Locke, 2018).

Culture of Excellence

To understand how a culture of excellence needs to be built, leaders in healthcare must first understand what a culture of excellence looks like. One model that is helpful in conceptualizing this is the American Nurses' Credentialing Center (ANCC) Magnet® Model, discussed in an earlier chapter. In this model, a culture of excellence has five connected components:

1. Transformational leadership
2. Structural empowerment
3. Exemplary professional practice
4. New knowledge, innovations, and improvements
5. Empirical outcomes

Each component possesses several crucial elements, some of which include (a) having strategically positioned nursing leadership advocating on behalf of staff and patients; (b) creating decision-making structures and processes that facilitate the influence of direct care to boardroom nurses on the organization's operations and patient care practices; (c) ensuring that effective and efficient care is provided through interprofessional collaboration to produce high-quality patient outcomes; (d) integrating research and evidence-based practice (EBP) to generate innovations and improvements in clinical care and organizational processes; and (e) obtaining reliable and valid empirical measurements of quality outcomes related to leadership and patient care (ANCC, 2016).

It is important to distinguish that we refer here to the *ANCC Magnet Model*, rather than *Magnet status*—a recognition limited to hospital-based organizations providing acute care services. Despite data demonstrating that Magnet

status hospitals show a 14% lower mortality risk, 12% lower fail-to-rescue rates, a more highly educated nursing workforce, and better work environments than non-Magnet hospitals (Kelly, McHugh, & Aiken, 2011; McHugh et al., 2013), other research demonstrates better outcomes in terms of patient care, staffing, and nurse satisfaction among non-Magnet facilities (Goode, Blegen, Park, Vaughn, & Spetz, 2011). Several explanations for these variations may exist, but one to consider is that leaders do not necessarily need Magnet recognition to implement the important components of practice excellence from the Magnet Model. Striving to build a culture of excellence rather than obtaining a particular status allows leadership to avoid viewing the Magnet status as a destination, as "too often the standards are treated as a maximum possible achievement instead of a continuing journey toward nursing excellence" (Summers & Summers, 2015, para. 2).

Moreover, accepting the ANCC Magnet Model as a framework for building and sustaining of a culture of excellence carries a simultaneous risk of oversimplifying this goal and the process to get there. Therefore, it is crucial that leaders—even those of Magnet-recognized facilities—judiciously examine the limitations and gaps of the model (Summers, 2012; Summers & Summers, 2015). Transformational leaders will consider how they can move their organizations to fill these important gaps and continue to improve patient health and provider well-being beyond that required of the recognition. Individual principles of excellence and unique initiatives toward the highest standards are the hallmarks of transformational leaders.

Creating and Sustaining a Culture of Excellence

Building or supporting any culture, let alone one of excellence, takes a reorientation on the part of healthcare leaders to first recognize the presence and power of an organization's culture. Regardless of the qualifications of the leader, no proposed mission, vision, or strategy for change that is not consistent with the existing organizational culture has a chance of success. Why? Because *culture eats strategy and structure for breakfast every day* (Wesley, 2014). Despite our common orientation to solve problems as leaders (and as healthcare providers), culture has a way of defending against anything that changes its tradition or comfort and will fight at every turn to maintain itself (Wesley, 2014). Thus, as a transformational leader, you must identify an organization's culture; recognize that many of its characteristics, strengths, and challenges are likely long standing; and understand that creating sustainable positive changes in the organizational culture is one of the most important approaches to achieving any outcomes you desire.

Second, effective organizational leaders realize that we are often not fully aware or even conscious of the organizational culture in which we work. Values, assumptions, beliefs, patterns of behavior, and relationships are often woven

so deeply into the organization that we may take them for granted. "We get so deeply entrenched in the cultures that we are a part of that we don't even realize how much they are informing the way *we* do things" (Ross, 2011, p. 184) and how our behaviors and actions contribute to the perpetuation of the organizational culture's norms and values. This lack of awareness can create even greater challenges for leaders as they attempt to make cultural changes. The transformational leader is informed, visionary, and able to see beyond and outside self and setting.

Ross (2011, 2014) proposed an organizational change model that is helpful in thinking about the continual process of constructing cultural change. Resistant organizational cultures can confine leaders to tactical and operational decisions, preventing them from directing energy toward vision or strategic decisions. Therefore, having strategies available to use in creating and sustaining cultural change is crucial for any organizational leader. While Ross (2011) developed this phase-oriented process specifically to promote organizational diversity and inclusion, it is presented here as a way of creating a change in culture to one of practice excellence.

Ross (2011) explained that to create change we must first shift consciousness in how we approach the work of creating a culture of excellence. A positive, favorable vision or collective identity that is integrated into the fabric of the organization must first be developed—not by leaders in solitude, but rather by collecting a group who represent a microcosm of the organization. Once a vision is created of where the organization wants to go toward practice excellence, the next phase is to comprehend where the organization is at present. All too often, "we are oriented toward finding the things we can do rather than really working to understand the system that is in place and the ways that various aspects of that system affect one another" (Ross, 2011, p. 180).

Assessing the culture of an organization can be a lengthy process but is vital. Transformational leaders listen and engage organizational members in honest exchange and generative dialogue. This is facilitated by communication methods, such as inviting all to participate in negotiations, building on previous ideas, clarifying ideas, and affirming alternative ideas proposed by others (Thomas, Sargent, & Hardy, 2011). Effective leaders also create other avenues for assessment and evaluation of the organization's history, mission and values, legends, stories, culture, environment, and other leverage points. They observe who and how people enter the organization, how people learn within the organization, and how people fail or thrive in the organization. Leaders learn from their followers, value them, build on their experiences, and continually act on the intention to promote a culturally diverse workplace (Hiemstra, Derous, & Born, 2017).

In addition to other phases required for cultural change (e.g., strategic planning, building new systems and structures, and overcoming "this-is-the-way-we-do-it-here" syndromes), providing stakeholder education and development, developing trust, and moving a culture of excellence from one created to one

sustained requires an ongoing structure in place to measure accountability to the vision and its goals. Organizational cultures are not fixed elements; thus, consistent feedback as to how the cultural change is progressing or regressing is essential. Moreover, regeneration, which is regular renewal of the organizational culture by acknowledging accomplishments and building on them, is important to keeping the culture energetic, vibrant, and ready to react to the needs of the workforce, patients, and community.

Organizational cultures are always creating themselves—whether you are aware or unaware of their existence or want them to or not. But leadership does matter. Therefore, the important question for leaders is, "Will you consciously create the culture in your organization, or will it unconsciously create itself while you try to survive it?" (Ross, 2011, p. 212).

REFLECTION QUESTIONS

1. The ANCC Magnet Model helps reframe the question for an organization from "What do you do?" to "What difference have you made?" (Drenkard, 2010). While understanding that outcomes accomplished are important, what other questions should be asked? Why are these other questions as or more important than identifying the differences in patient outcomes you and your organization have made?
2. Why is it important for leaders to avoid framing the Magnet status as a destination? If you have worked at a Magnet-recognized organization, how did the leadership and workforce frame this recognition? Is it an ongoing journey or a destination?
3. Does the leadership in your current or most recent work setting recognize the power of organizational culture? If they do, what behaviors or actions do leaders take that make it evident they value the significance of culture? If you perceive that they do not, what makes you think that?
4. What are the first three "cultural messages" nurses new to your organization learn about their practice and those they care for? Are these messages supportive of a culture of excellence?

GENERATING AND NURTURING SAFE ENVIRONMENTS WHERE PEOPLE CAN THRIVE

Along the leadership journey to build and sustain a culture of excellence, one of the most important tasks is the creation of a safe environment where all people can thrive—including an organization's providers, staff, patients, and

families. While the phrase *safe environment* may conjure images of personal protective equipment, safety programs to avoid back injury or needle sticks, hand hygiene, and clean worksites (which are clearly important), the focus here is on the socio-environmental features of an organization that protect against stress, disempowerment, and dissatisfaction among patients and healthcare workers. Such issues may include disruptive behavior, inequalities, bias, discrimination, or harassment of various sorts. The leader can make a positive difference in the entire environment, depending on how such issues are managed (Syed, Redmond, Bussey-Jones, Price-Haywood, & Genao, 2018). Protecting against these threats to well-being is critical not only to improve outcomes for healthcare workers, but to prevent adverse outcomes for patients and the organization (see Box 8.1).

Multiple approaches can be used to prevent these adverse outcomes and create safe environments. One of the primary ways healthcare leaders appear to be doing this work is by building individual resiliency among the workforce through engagement and wellness initiatives (e.g., programs to reduce stress and build resiliency; Nursing Executive Center, 2018; Pipe et al., 2012). Such initiatives are important and demonstrate some evidence for improving individual outcomes (Gilmartin et al., 2017; Pipe et al., 2012). However, at a time when healthcare organizations have never been more committed to these initiatives (Nursing Executive Center, 2018), rates of stress and burnout remain high among health professionals and in some cases may be increasing (Chuang, Tseng, Lin, Lin, & Chen, 2016; McHugh, Kutney-Lee, Cimiotti, Sloane, & Aiken, 2011; Shanafelt et al., 2015). Such a contradiction suggests that interventions targeted to individuals may not be fully addressing the circumstances that are leading to these adverse outcomes (McCann et al., 2013) and that a focus on developing and sustaining *safe environments* may be a missing piece. Here, we present four approaches that attend to building social relationships and environments that protect, encourage, liberate, and support the health and well-being of all individuals within an organization and as such may promote the rebuilding of a resilient workforce by generating *safe* settings. Specifically, these approaches include the following:

a. Understanding the principles of providing cultural care for patients and families
b. Creating an equitable and inclusive environment for healthcare workers
c. Addressing power inequities inherent in interprofessional practice
d. Eliminating incivility and workplace violence to develop a culture of respect and trust

Providing Cultural Care for Patients and Families

Often, when healthcare providers and leaders discuss *culture*, we refer to the diverse personal, ethnic, and community contexts of patients and not the *cultures* that exist within the workplace. This focus on cultural care for patients and

BOX 8.1 NEW MEDIA: BUILDING SAFE ENVIRONMENTS FOR ALL INDIVIDUALS TO THRIVE

TED Talks

Brigit Carter, PhD, MSN, RN, CCRN. "Addressing the Gap in Nursing Workforce Diversity." https://www.youtube.com/watch?v=TD-p-xiG3e0

Bryan Stevenson, JD. "We Need to Talk About an Injustice." https://www.ted.com/talks/bryan_stevenson_we_need_to_talk_about_an_injustice/transcript#t-617836

Podcast

SelfPerspective—JohnGSelf. May 19, 2016. "Population Health Management: Importance of Having Diverse Leadership Teams," with Fred Hobby, president of the Institute for Diversity in Healthcare Management. http://johngself.com/self-perspective/2016/05/population-health-management-importance-diverse-leadership-teams/

families is one that has received ever-increasing attention over the past several decades. In fact, it is now commonly accepted that two important steps toward the elimination of health disparities among diverse populations are to (a) create a healthcare workforce that better reflects the general population in terms of gender, race, and ethnicity, and (b) better prepare healthcare leaders and providers in culturally competent care (Dogra, Reitmanova, & Carter-Pokras, 2010; Institute of Medicine [IOM], 2010). It is critical, especially for healthcare providers, to improve cultural sensitivity and inclusion to all regarding race, gender, ethnicity, sexual orientation, religion, socioeconomic status, and all other ways that represent us as members of humanity. The transformational leader will break paths to full inclusion among our patients and our professional colleagues.

Although these requirements may be recognized, the action steps needed to fully accomplish them are slow-paced at best. Further, it is unclear whether some predominantly White healthcare faculty is prepared to teach cultural competence and to integrate it into pedagogies that can further increase the diversity of our healthcare workforce (Beard, 2013, 2014).

The health effects of cultural bias in our communities related to health disparities are astounding. For example, in the last 20 years survival rates for cancer, heart disease, and childbirth continue to be lower for non-White populations in the United States (Hostetter & Klein, 2018).

The concept of "implicit bias" (or unconscious bias) is important to understand throughout the organization (see Bedford, 2018; Fitzgerald & Hurst, 2017; National LGBT Health Education Center, 2018; Zestcott, Blair, & Stone,

2016). Among the many factors related to health disparities is the troubling issue of implicit bias of healthcare providers. Sometimes we may think we have grown beyond some of our unfortunate history of discrimination. Unfortunately, evidence confirms too many areas of concern. Some forms of discrimination are "deeply ingrained in the social, political, and economic structures of our society" (Hardeman, Medina, & Kozhimannil, 2016; King & Redwood, 2016; Tello, 2017, p. 1). Fitzgerald and Hurst (2017) and Stewart and O'Reilly (2017) found no differences in the levels of implicit bias between healthcare providers and the general population. Zestcott et al. (2016, p. 532) proposed a model that shows that provider bias influences judgments and decisions, communication, and trust that diminish patient engagement, understanding, and adherence to treatment that eventually contribute to disparities in health.

Further, evidence shows that simple training is not enough, that individual care providers need practice in self-reflection, strategies in perspective taking, and affirming personal egalitarian goals (Blair et al., 2011; Lai et al., 2014; Zestcott et al., 2016). Other personal strategies are to recognize your own stereotypical thinking, replace assumptions, understand the individual, explore a new perspective, and increase opportunities for positive contact (Bedford, 2018). The American Nurses Association (ANA; 2018a, 2018b) has released two recent position statements on specific nursing advocacy for LGBTQ+ and on the nurse's role in addressing discrimination in practice settings.

It is also important for every leader to become acquainted with and implement the standards published by the Office of Minority Health of the U.S. Department of Health and Human Services: the National Culturally and Linguistically Appropriate Services Standards (called CLAS Standards; 2019). See Box 8.2.

It is no surprise that the concept of cultural competence continues to be such a predominant topic of discussion in healthcare education and practice (Jeffreys, 2010). Unfortunately, its vague and numerous definitions along with an overuse of the phrase have sustained uncertainty about its original meaning. Meanwhile, other terms have been promoted to extend beyond cultural competence, such as *cultural proficiency, cultural humility*, and *cultural sensitivity* (Chang, Simon, & Dong, 2012; Foster, 2009; Kosoko-Lasaki & Cook, 2009; Purnell, 2013). But these concepts may also run the risk of eventually losing their meaning. Thus, instead of providing a list of definitions and characteristics related to different terminology, it may be more helpful to present some of the underlying principles basic to cultural care among patients and families.

The goal of cultural care is not simply to learn and appreciate the culture *of others*, it must also include examining *one's own* biases, blind spots, and cultural limitations (Chang et al., 2012; Dogra et al., 2009; Hawala-Druy & Hill, 2012; Levi, 2009; Sabin & Greenwald, 2012). Rather, those who desire to provide the

BOX 8.2 THE NATIONAL CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES STANDARDS (CLAS STANDARDS)

Principal Standard

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all healthcare and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountabiltiy, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities, and integrate CLAS-related measures into measurement and continuous quality-improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

(*continued*)

BOX 8.2 THE NATIONAL CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES STANDARDS (CLAS STANDARDS) (*continued*)

13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Source: Office of Minority Health, U.S. Department of Health and Human Services. (2019). *National culturally & linguistically appropriate services standards (CLAS standards).* Retrieved from https://thinkculturalhealth.hhs.gov/clas/standards.

most excellent cultural care must be willing to engage in lifelong self-awareness and self-critique of the limitations of their own cultural perspectives as well as openness to new ideas and new cultures. This is *especially* important for those who occupy one or more positions within social hierarchies that grant everyday (though often unrecognized) power, privileges, and resources (e.g., White people, men, and the wealthy).

Similarly, sensitive leaders and providers recognize the individual heterogeneity inherent in any cultural group and interact with patients as individuals, not as representatives from a group (Nacoste, 2015). Not all people of a particular racial, ethnic, religious, linguistic, regional, or socioeconomic group possess identical cultural views and values; rather, views and values are learned and held by individuals who see themselves as members of a certain group (Thagard, 2012). Thus, the sensitive leader and provider examines and addresses his or her unconscious bias or prejudice to ascribe cultural characteristics to all from a certain group (see Bahaji & Grenwald, 2016; DiAngelo & Dyson, 2018; Ross, 2014).

Moreover, cultural care is not a static state that one achieves, but rather a process (Beard, Gwanmesia, & Miranda-Diaz, 2015). It is impossible to know everything about another's culture, and providers will constantly be interacting with patients whose various cultures affect the patient–provider relationship in different ways. As a result, effective leaders must commit to modeling and supporting care providers in a lifetime of learning and openness to experiences, lifelong self-reflection and sensitivity to power imbalances in culture within the patient–provider relationship, and recognizing the value of cultural differences (Kumagai & Lypson, 2009; PricewaterhouseCoopers, 2014; Simon, Chang, & Dong, 2010; Tervalon & Murray-Garcia, 1998).

Creating an Equitable and Inclusive Environment for Healthcare Workers

The principles and approaches to cultural care between healthcare providers and patients extend to our direct relationships with staff and colleagues. Creating an organizational culture that is respectful and inclusive of all individuals requires much more effort and time, and growth continues to be a challenge among American healthcare organizations (see Devine, 2017; Neal, 2013). Dramatic examples of organizational failures in this area are demonstrated by persistent lower retention rates among women and people of color in the workplace (Ross, 2011, 2014). For example, in 2015, we noted that among Fortune 500 companies only 24 (4.8%) women (Swanson, 2015) and five (1%) Black Americans (Wallace, 2015) were chief executive officers. By 2018, the number of women in those positions dropped by 25% (Stewart, 2018). The "glass-ceiling" and other effects persist for women and people of color at all senior levels in industry and higher education, including healthcare (Cook & Glass, 2013; Jackson, O'Callaghan, & Leon, 2014). Although not apparent in the outcomes of these examples, U.S. academic institutions, healthcare organizations, and other businesses have increased the focus on diversity and inclusion efforts over the past generation. Despite these investments of time and resources, "organizations continue to struggle to find effective ways to bring people from diverse backgrounds together with a sense of common purpose and commitment to create new possibilities for action" (Ross, 2011, p. 13).

The reasons for this predicament, and the numerous strategies necessary to change it, are beyond the scope of this work, except to point to some efforts to improve our current situation. Education and healthcare institutions are increasing the work to recognize needs, offer training, and improve diversity and cultural competence (see Betsch & Böhm, 2016; Cuellar, Miller, Knappen, & Visina, 2016; Young & Guo, 2016). This work benefits workers and patients (see Hiemstra et al., 2017; Johnston & Villa, 2018; Scherman, 2017). As a leader, it is your responsibility to offer or mandate bias training and to serve as a model to ensure full inclusion.

Begin with a look at the current state of affairs in your own organization. Likely, it is not much different from most, which have invested significant time and money into incremental approaches to diversity and inclusion programs, to limited effect (Ross, 2011, 2014). If so, you have a critical opportunity to recognize these circumstances and commit to changing them by (a) supporting your organization through an ongoing cultural shift to become an equitable, inclusive, respectful, antiracist, multicultural institution accepting of neo-diversity, and (b) taking and persevering through the crucial steps required to create and sustain these changes (see Box 8.3). Nearly a decade ago, Ross declared a state fraught with challenges that continue today:

> The state of diversity in our country and in our organizations is at a point of crisis…. at an incipient point of history in which

BOX 8.3 SELECTED TOOLS TO ASSESS EQUITY AND INCLUSION IN THE ORGANIZATION

An ever-growing number of tools are being developed to assess equity and inclusion at an individual level (e.g., implicit bias) as well as within an organization. We encourage you to access one of these tools, complete the questionnaire/assessment, and reflect on what this means for you, your organization, or both. Following are some tools and websites to consider:

- A Diversity, Equity and Cultural Competency Assessment Tool for Leaders: Does Your Hospital Reflect the Community It Serves? Available at: http://www.diversityconnection.org/diversityconnection/membership/Resource%20Center%20Docs/Assessment%20Tool%20v4(20-page%20bklt).pdf
- Project Implicit. Available at: https://implicit.harvard.edu/implicit/
- Racial Equity Resource Guide. Available at: http://www.racialequityresourceguide.org/
- Organizational Assessment Tools and Resources. Available at: http://www.racialequitytools.org/plan/informing-the-plan/organizational-assessment-tools-and-resources

> we have the opportunity to either move into a new future in which we effectively deal with the inevitable and irrevocable movement to a more diverse society and an ever-changing world, or one in which we decline into a deeper and deeper sense of tribalism, one that threatens to tear our society apart. (Ross, 2011, p. 18)

O'Shanassy (2019) described specific areas where nurses continue to experience discrimination in the workplace: religion, race, gender (uniquely felt among males in nursing), and disability. Other significant areas of discrimination are sexual orientation and gender identity (Human Rights Campaign, 2019), age, pregnancy, marital or family status, political opinion, and union activities (MDC Legal, 2017). These can be exhibited by job refusal or cutting of shifts for no apparent reason, denial of training opportunities or promotions, unequal pay, isolation, withholding of information, impossible tasks, or harassment or bullying (MDC Legal, 2017).

If you experience discrimination, following are appropriate actions:

- Take action immediately.
- Let the person know you feel offended.
- Keep your performance high.
- Network with others for support. (O'Shanassy, 2019)

As a leader, following are effective actions within your organization:

- Study employment law and use the resources of your human resources department and risk manager.
- Set up training, networking, diversity recruitment, and mentoring groups.
- Be proactive and advocate for good.
- Contribute to and be proactive to support and inform others about your anti-discrimination policy (see O'Shanassy, 2019).

See Box 8.4 for leadership in action.

Addressing the Power Inequities Inherent in Interprofessional Practice

There is an ongoing movement that supports interprofessional practice to improve patient care. Yet, a growing body of evidence provides insight into the complex assortment of issues inherent in this type of collaboration (Alexanian, Kitto, Rak, & Reeves, 2015; Goldman et al., 2016; Liberati, Gorli, & Scaratti, 2016; Nugus, Greenfield, Travaglia, Westbrook, & Braithewaite, 2010; Reeves et al., 2009), some of which relate to subtle forms of discrimination or inequities in power and authority. For instance, despite goals for authentic interprofessional collaboration, physicians continue to dominate patient-management decisions in acute hospital settings, often leaving other health clinicians to believe their opportunities for input are at best ad hoc (Goldman et al., 2016; Reeves et al., 2009). Interprofessional case conferences, where many patient management decisions are discussed, are a particularly relevant example as they are commonly led by physicians, managed authoritatively, and dominated by a biomedical discourse and physicians' "talk time." A decade ago, Nugus et al. (2010), found that physicians talked 67.9% of the time compared with 6.6% by nurses, 2.7% by physiotherapists, 0.5% by dieticians, and 0.5% by occupational therapists. What would the data show in our workplaces today? Similar commanding communication has also been observed during informal and unplanned interprofessional interactions, including terse, unidirectional interactions from physicians to other health professionals (Reeves et al., 2009). More recently, Manojlovich et al. (2019) found that nurses used more indirect communication with physicians and that physicians were more direct and less sensitive. Flaherty (2017) found that men spoke twice as much as women in academic seminars. Other studies have found that the impact of medical dominance in interprofessional practice extends beyond communication and a single interprofessional team, and rather shapes the routines and informal governing practices of the organization's interprofessional work (Alexanian et al., 2015).

Among the many explanations for current interactions and barriers to genuine interprofessional practice, unequal power relations certainly are key. Simply,

BOX 8.4 LEADERSHIP IN ACTION: CREATING AND SUSTAINING SAFE ENVIRONMENTS WHERE PEOPLE CAN THRIVE

Carrie J. is a 44-year-old White woman who has moved up the ranks of her health system and is now the Director of Nursing Education. Occasionally, she visits former colleagues with whom she worked a decade ago in the ambulatory surgery department. One day, she passed such a friend in the hall: Rhonda W., an African American, 15-year-veteran of the hospital, and one of the best nurses she knew, still in the same department.

Carrie: Hey, Rhonda! How's it going?
Rhonda: Terrible. It's clear that I have no future here!
Carrie: Hold on, what happened?
Rhonda: I just came from another interview for a manager position in the OR. Just like all the others in Ambulatory Surgery and Outpatient Procedures, it was clear that I have no future as a leader in this hospital.
Carrie: I am so sorry. What do you mean?
Rhonda: It's so unbelievable. I just graduated with my DNP and have been loyal to this hospital for 15 years. They are so racist! I am being kept from advancing.
Carrie: Maybe I could help?
Rhonda: You don't get it! That's so easy for you to say. You just don't get discrimination. All this talk about "increasing diversity" and no action.
Carrie: Maybe it was something else—something you don't know?
Rhonda: No! This is racism, and I can't do anything about it.

1. What would you do if you were Carrie?
2. Do you think Carrie has the knowledge, skills, and/or authority (formal or informal) to not only advocate for Rhonda, but to address issues of diversity and racism in the organization?
3. What would you do if you were Rhonda?
4. Do you think Rhonda has the knowledge, skills, and/or authority (formal or informal) to advocate for herself and address issues of diversity and racism in the organization?
5. What needs to happen in this organization?

Source: Scenario inspired by Kivel, P. (2011). *Uprooting racism: How White people can work for racial justice* (3rd ed.). Gabriola Island, BC, Canada: New Society Publishers.

the ability to work effectively in interprofessional teams is constrained when there is imbalance in power. As the preceding examples illustrate, the balance of power remains situated with the more established medical professionals rather than more recently professionalized disciplines, such as nursing (Liberati et al., 2016; Roberts, DeMarco, & Griffin, 2009). In fact, medicine professionalized

nearly a century before nursing, and acknowledging this acts as an important reminder that today's interprofessional issues remain embedded within a larger sociohistorical context (Reeves, Macmillan, & Van Soeren, 2010). As a leader, being aware of relevant historical events for the healthcare professions and their timing will serve as an important foundation to addressing interprofessional issues in your future organizations (see Box 8.5).

Through the history of healthcare, differences in values, learning styles, and beliefs were produced among the health professions, which may be visible through ongoing education and regulation practices (e.g., separate educational programs with specific curricular patterns and accreditation requirements; Hall, 2005; Reeves et al., 2010). Such practices continue to perpetuate a focus on professional *separateness* rather than *togetherness* (Reeves et al., 2010). While the barriers and challenges historically built and maintained among the health professions are great, they are not insurmountable to visionary, effective leaders of the future. At an organizational level, leaders can facilitate collaborative interprofessional practice by building a common frame of reference from mutually held values of holistic patient and family outcomes rather than one driven by different professional goals and ideologies (Caldwell & Atwal, 2003; Ross, 2011, 2014). Further, healthcare leaders can ensure that the interprofessional team is prepared with the skills (e.g., conflict resolution, cross-professional communication) to navigate not only challenges related to blending different professional cultures (e.g., different vocabularies, different problem-solving approaches), but the individual personalities that impact group dynamics.

In most organizations, there are exemplary examples of interprofessional teams already fostering a status-equal basis among members to produce improved patient outcomes (Nugus et al., 2010). Such endeavors are increasing in a variety of settings and countries (Reeves, Pelone, Harrison, Goldman, & Zwarenstein, 2017). Specific successful examples include interprofessional models in cancer care (Knoop, Wujcik, & Wujcik, 2017), palliative care (Wahab et al., 2016), and in nursing and medical education (Tang, Zhou, Chan, & Liaw, 2018). Leaders who can recognize these teams and discern how to extend their strategies to interprofessional teams throughout their organization may be best positioned to effectively address these persistent interdisciplinary challenges.

Many of the preceding suggestions may help leaders to advance interprofessional collaboration in their organizations. However, it is important to remember that the structural configuration of the health professions is *based on a more than 500-year-old system*; and it "will continue to make the role of leadership a difficult one, especially as long as this history remains a largely unacknowledged factor" (Reeves et al., 2010, p. 263). Thus, it is critical that on the road ahead, healthcare leaders constantly evaluate their organization's progress to combat interprofessional *separateness* and shape environments that can reinforce our *togetherness*.

BOX 8.5 TIMELINE: RELEVANT PROFESSIONAL DEVELOPMENT EVENTS FOR NURSING AND MEDICINE IN EUROPE/NORTH AMERICA

TIME PERIOD	RELEVANT EVENTS
1500s	• Emergence of European craft guilds, which were male dominated and lawfully established through political authority or a monarch. • The purpose of guilds was to restrict trade in goods and protect guild members' interests; this was achieved by controlled ownership of the knowledge and tools to create the goods. • Medical organizations, such as the Barber Surgeons of Edinburgh, were formally incorporated as guilds during this time, conferring privileges (e.g., surgical practice) only to its members. • Meanwhile, nurses organized largely in religious orders to serve the poor and needy. Among them were The Hospitaller Brothers of St. John of God in Spain, St. Camillus de Lellis at St. James Hospital in Rome, founding of the Daughters of Charity by Saint Vincent de Paul, and Hôtel-Dieu de Montréal by Jeanne Mance.
1800s	• Medicine moved from a guild to a profession, by creating national medical associations (e.g., Canadian Medical Association, British Medical Association), which further sanctioned and restricted access to the physician role. • As the first health guild to professionalize, medicine was positioned to structure and control healthcare (i.e., hospitals) as well as lobby for legislation that promoted members' interests. • In 1858, Britain passed the Medical Registration Act, which regulated that only individuals who passed the medical examination could practice medicine. • In the later decades, women were finally allowed to enter the workforce at-large. • In 1860, the first formal training school for nursing was initiated by Nightingale. • Over 2,000 volunteer women served as nurses in the American Civil War. Among them was Walt Whitman and Louisa May Alcott, Sally Tompkins, and Sojourner Truth. • In 1873, Linda Richards became the first American nurse to graduate from a nursing school.

(*continued*)

BOX 8.5 TIMELINE: RELEVANT PROFESSIONAL DEVELOPMENT EVENTS FOR NURSING AND MEDICINE IN EUROPE/NORTH AMERICA (*continued*)

TIME PERIOD	RELEVANT EVENTS
1900–1910s	• In 1910, a review of North American medical schools was conducted called the Flexner Report. Implementation of the report led to the establishment of a *single* standard of medical education focused on allopathic medicine (i.e., the body as a repairable machine) versus other holistic approaches. It also led to the closure of many small, rural schools and all but two African American medical colleges. • In 1901, the first board of nursing established to set standards and licensure (that followed later in each state)
1920s	• Cambridge and Oxford allowed women to attend and obtain a degree, granting them access to university education (and thus employment in professions, such as medicine) for the first time. • The first professional registration of nursing occurred in England and Ontario. • Frontier Nursing Service was established by Mary Breckinridge. The first U.S. organization to use nurses as midwives
1960s	• Professional self-regulation (i.e., professional status) for nursing finally allowed in Ontario via the Health Disciplines Act • 1965, the first nurse practitioner program founded by Loretta Ford and Henry Silver.

Sources: Caldwell, K., & Atwal, A. (2003). The problems of interprofessional healthcare practice in hospitals. *British Journal of Nursing, 12*(20), 1212–1218. doi:10.12968/bjon.2003.12.20.11844; Hall, P. (2005). Interprofessional teamwork: Professional cultures as barriers. *Journal of Interprofessional Care, 19*(Suppl. 1), 188–196. doi:10.1080/13561820500081745; Keeling, A. W., Hehman, M. C., & Kirchgessner, J. C. (2018). *History of nursing in the United States.* New York, NY: Springer Publishing Company; Reeves, S., MacMillan, K., & Van Soeren, M. (2010). Leadership of interprofessional health and social care teams: A sociohistorical analysis. *Journal of Nursing Management, 18*(3), 258–264. doi:10.1111/j.1365-2834.2010.01077.x; Roberts, S. J., DeMarco, R., & Griffin, M. (2009). The effect of oppressed group behaviors on the culture of the nursing workplace: A review of the evidence and interventions for change. *Journal of Nursing Management, 17*, 288–293. doi:10.1111/j.1365-2834.2008.00959.x.

Eliminating Incivility and Workplace Violence and Developing a Culture of Respect and Trust

Workplace violence, incivility, and bullying are barriers to developing safe environments for providers. These can occur within and across professional boundaries as well as in any work setting (Luparell, 2011). These harmful events range from overt (e.g., verbally intimidating a coworker) to covert (e.g., withholding vital information to safe work) and occur through several actions and inactions (ANA, 2015). Too many nurses have been touched by some form of violence, bullying, and incivility, as self-report rates of these experiences consistently range from one quarter to two thirds of study samples (Johnson & Rea, 2009; Pompeii et al., 2013; Simons, 2008). While the level of disrespect varies across these different harmful events—from refusing to assist a coworker to hostile remarks and threats to physically and psychologically damaging actions—all produce well-documented negative outcomes for victims. Some of these include physiological or psychological distress, intention to leave the organization and nursing, and decreased personal health (ANA, 2015; Clark, Farnsworth, & Landrum, 2009; Johnson & Rea, 2009; Lanctôt & Guay, 2014; Nielsen & Einarsen, 2012; Ortega, Christensen, Hogh, Rugulies, & Borg, 2011; Wilson, Diedrich, Phelps, & Choi, 2011). Subsequently, all these outcomes can have real impacts on the care provided to patients, increasing risks to patient safety and quality care (ANA, 2015; Roche, Diers, Duffield, & Catling-Paull, 2010).

So, what can be done? Leaders must work to develop and sustain a culture of respect (ANA, 2015). Respect is defined as "open-minded willingness to accept, acknowledge, and value the uniqueness of an individual and her or his knowledge, experiences, and perceptions" (Antoniazzi, 2011, p. 752), and this must be fostered in every work environment. The ANA (2015) has created a position statement to articulate the shared roles and responsibilities of nurses and employers (including nursing leaders) to create environments free of incivility, bullying, and workplace violence. Many recommendations provide strategies to prevent and mitigate these harmful events and are divided by the responsibilities of nurses and those of employers. Some recommendations call on the self-reflection of leaders to recognize any of their own vulnerabilities to acts of bullying and incivility (ANA, 2015). Some in leadership positions (e.g., managers, directors, and charge nurses) have been reported as primary sources of workplace bullying (Johnson & Rea, 2009). Thus, as an introductory step, future leaders should review and adopt these recommendations as they provide tactical strategies to creating respectful work environments for healthcare providers. See Box 8.6 for selected ANA recommendations and Table 8.1 for additional resources from other national healthcare organizations for addressing workplace incivility and violence.

While the ANA and other organizations provide helpful coverage of strategies and resources that may prevent and manage incidences of incivility, future leaders are challenged to go beyond these recommendations to identify the

BOX 8.6 SELECTED PREVENTION RECOMMENDATIONS FROM THE AMERICAN NURSES ASSOCIATION POSITION STATEMENT ON INCIVILITY, BULLYING, AND WORKPLACE VIOLENCE

- **Primary Prevention Interventions (for RNs)**
  - Commit to and accept responsibility for establishing and promoting healthy interpersonal relationships with all members of the healthcare team.
  - Be cognizant of own interactions, including actions taken and not taken and communication with others.
  - Practice using suggested predetermined phrases of responses so one is prepared to deflect incivility and bullying.
- **Primary Prevention Interventions (for Employers and Formal Leaders)**
  - Provide a mechanism for RNs to seek support when feeling threatened.
  - Orient employees to conflict resolution and respectful communication strategies.
  - Make available education sessions that define incivility and bullying, introduce prevention strategies, and review the organization's policy around bullying and incivility.
- **Secondary Prevention Interventions (for RNs)**
  - Use pre-established code words or phrases to seek support when feeling threatened.
  - If observing incivility or bullying, offer support to the target and let the perpetrator know his or her actions are not consistent with the organization's culture.
- **Secondary Prevention Interventions (for Employers and Formal Leaders)**
  - Recognize and evaluate personal vulnerabilities to incivility and bullying and act in accordance with the organization's policy and culture.
  - Implement strategies to reduce both fatigue among employees and incivility associated with fatigue.
  - Offer trainings that enhance employees' psychological hardiness and resilience, self-care measures, and self-reflection practices.

Source: Adapted from American Nurses Association. (2015). *Incivility, bullying, and workplace violence.* Retrieved from http://www.nursingworld.org/MainMenuCategories/WorkplaceSafety/Healthy-Nurse/bullyingworkplaceviolence/Incivility-Bullying-and-Workplace-Violence.html.

problems in specific workplace environments. Zero-tolerance policies and recommendations are often instituted and may seem to be effective approaches, but in reality, their success is limited as they have not addressed the root causes of incivility, bullying, and violence (Croft & Cash, 2012; Farrell, Shafiei, & Salmon, 2010). Effective leaders will need to broadly consider the organizational rules,

TABLE 8.1 Examples of Resources to Prevent and Manage Issues Related to Workforce Violence or Incivility

ORGANIZATION	RESOURCE
National Institute for Occupational Safety and Health (2018)	*Workplace Violence Training for Nurses*
Robert Wood Johnson Executive Nurse Fellows (Passionate About Creating Environments of Respect and Civility, 2015)	*Civility Tool Kit: Resources to Empower Healthcare Leaders to Identify, Intervene, and Prevent Workplace Bullying*
American Association of Critical Care Nurses (2005)	*AACN Standards for Establishing and Sustaining Healthy Work Environments: A Journey to Excellence*

norms, and power structures that contribute to these events. For instance, consider overtime, high staff turnover, improper patient-to-nurse ratios, constant changes in policies and procedures, and disregard from other health professionals: Do all burden and potentially exhaust nurses' time, emotional coping resources, and well-being? Might such burdens contribute to incivility? This example is not offered to "condone or excuse dysfunctional or disruptive behaviors in the workplace, but rather to problematize the reasons why 'self—and profession—defeating behavior' exist and flourish" (Croft & Cash, 2012, p. 231). It is the ethical responsibility of leaders to critically examine their organizational practices to not only identify and condemn individuals acting in uncivil and violent ways, but to "seek to eradicate those conditions that support the acts of those individuals" (Rhodes, Pullen, Vickers, Clegg, & Pitsis, 2010, p. 110).

The potential eradication of contributors does not mean that conflict and disagreements will never occur in an organization again. Rather, true communities include conflict as the people involved know the environment is safe enough "for conflicts and controversy to be aired, engaged in, and resolved" (Ross, 2011, p. 203). But, "the emphasis on cost containment, downsizing, skill mix changes, and decentralization" (Croft & Cash, 2012, p. 237) at an organizational level has resulted in nurses' and other health providers' lived reality being "increased workload, overtime, absenteeism, and feelings of disenfranchisement" (Croft & Cash, 2012, p. 237). This reality is often incongruent with organizational mission statements and branding, which may convey a caring and supportive milieu. The dissonance and discord between organizational positions and actual practices leave workers with an inability to believe in the organization, decreases their emotional well-being, and creates feelings of weakness due to a lack of support in resources and in leadership (Croft & Cash, 2012; Goldman & Tabak, 2010; Rodwell & Gulyas, 2013).

Therefore, at the root of much of this discussion on *safe environments* is *trust*, and it is critical for leaders of healthcare organizations to work constantly to

build a culture of trust among all members of the organization—between leaders and workers, providers and patients, and among colleagues. The growth of mutual trust may finally contribute to creating an environment where all people can thrive.

REFLECTION QUESTIONS

Cox (1995) suggested that civil societies (or workplaces) are those in which "trust, reciprocity, mutuality, co-operation, time, social fabric and social capital are important and cultivated elements" (p. 5). Conversely, "organizations that are authoritarian, top-down, rule bound, and competitive run the risk of creating communities in which… [there is] often reward through patronage, where cliques are formed, change is resisted, and those who criticize are excluded" (Croft & Cash, 2012, p. 239).

Take a moment to critically examine your own organization.

1. What are the characteristics of the work culture?
2. Does the workplace reflect the kind of nursing environment in which you want to practice? If not, what is constraining leaders and other workers within the organization from adopting a safe and nurturing culture?
3. Are there particular hegemonies (i.e., social, cultural, ideological, or economic influences exerted by a dominant group) that are taken for granted within the organization? Can you think of concrete examples that illustrate some of these in your organization?
4. How should you move forward to achieve the kind of institution you would like to see? How should this be done collectively?

MENTORING THE NEXT GENERATION OF LEADERS TO CREATE A SUSTAINABLE CULTURE OF EXCELLENCE

The transformational leader in healthcare has a constant eye on and heart for the next generation of leaders. To ensure that any culture of practice excellence is sustained, leaders must habitually look beyond the present-day items at hand and focus on developing the leaders of tomorrow. The ever-changing healthcare industry requires that we cultivate the skillset for future leaders to navigate these dynamic and complex environments. Unfortunately, too many disciplines within healthcare have a kind of professional hazing (as in, "if I did it, so should you"), and too many of us are still involved in these practices, such as long hours with assigned shift work; sink-or-swim approaches; or see-one, teach-one, do-one. Such traditions simply will not work in complex environments

that are constantly striving for safe, effective, and quality patient care. In addition, the skillsets and competencies that future leaders need are likely different than those previously required. There are new requirements of leadership, such as having a global mind-set regarding nursing and healthcare, an ability to appropriately intervene in policy development and political processes, a highly developed team-building and collaboration skillset, and an aptitude to actively adapt to constant change and to lead their organizations to become just as adaptive (Huston, 2008).

There are several approaches that leaders can use to prepare future leaders. One of the most foundational methods is active mentoring. Leaders who mentor effectively seem to have a growing generativity or concern for the next generation (Crisp & Alvarado-Young, 2018). The leader who mentors is not only interested in helping others grow, but the leader who mentors today is a leader of tomorrow—as she or he, too, has a vision for a better future and contributes to this by developing the future's leaders. Personal mentoring should be a way of life for the leader and is a growing consideration in medicine and nursing (Gandhi & Johnson, 2016; Geraci & Thigpen, 2017; Wadhwa, Nagy, Chhabra & Lee, 2017).

Mentoring the next generation is a huge task, but immensely beneficial for all involved. It helps to develop leadership skills; promote empowerment; advance and expand individual vision past individual success to the future of the nursing profession; promote greater career mobility and job satisfaction; and provide valuable feedback, insight, and support (Ensher & Murphy, 2011; Hart, 2010; Hodgson & Scanlan, 2013). For leaders, mentoring allows them to extend a living legacy of their own efforts, enliven their own everyday experiences, develop a renewed sense of commitment to their profession and organization, and contribute to a positive human investment in making the world a better place (Ensher & Murphy, 2011; Hodgson & Scanlan, 2013). Further, mentoring relationships can also provide positive outcomes to the organization (e.g., improved support, productivity, environment stability, and nursing retention; Gilbert & Broome, 2015).

As a future leader, it may be useful to think of mentorship at two levels: (a) the type of mentorship you will engage in directly at the interpersonal level with future leaders you want to cultivate, and (b) the type of mentoring culture you want to create throughout your entire organization (Grossman, 2013; Jakubik, Eliades, Gavriloff, & Weese, 2011; Latham, Hogan, & Ringl, 2008; Race & Skees, 2010). Although the foci may be discrete, both types of mentorship involve work that cares about and develops the next generation of leaders. Mentor-leaders who are mindful, selfless, *and* compassionate have the best chances of developing this next generation and a successful organization. Hougaard and Carter (2018) argued that mentor-leaders who are present and attentive, people-centric (rather than serving their own ego and needs over others'), express empathy and kindness, and have a willingness to support people (even when a mistake

is made) are indeed creating the conditions for their people to be content, committed, and thus perform to the best of their abilities.

Mentoring at the Interpersonal Level

Mentorship is described as a natural extension of nurse leaders (McCloughen, O'Brien, & Jackson, 2014). However, what mentorship is should not be limited to the conceptualization of a formal mentor–mentee relationship. Even singular, random acts of generosity and guidance can be as valuable as multiple acts within a formal professional relationship (Jackson, 2008; McCloughen et al., 2014). As such, it may useful to consider most of your future relationships as a leader as possible opportunities for interpersonal mentoring.

In the following, we address some of the key competencies and skills that effective mentors exhibit to develop the leaders of tomorrow. As a mentor you will not be required to include these concurrently; rather, as mentorship is a fluid and flowing process influenced both by a mentor and mentee (Jacobson & Sherrod, 2012), your approach will shift based on the relationship and each mentee's needs and goals.

- *Develop a trusting mentoring relationship:* As a mentor it is critical to develop a relationship that facilitates trust. Treat the mentee as your colleague and equal. Be open, approachable, and accessible. Assure the person that you are interested in his or her views and feelings and that a relationship has been created in which it is safe and encouraged to ask questions. Periodically checking-in on how the relationship is meeting the mentee's goals and needs is a vital strategy to maintain the relationship. Remember that mentoring is always shared, and thus as the mentor, you are not the only one responsible for creating a successful relationship. The mentee will also need to be flexible, honest, and receptive to feedback and insight (Hart, 2010; Jacobson & Sherrod, 2012).
- *Advocate and provide opportunities:* Opening doors can have a huge impact for the mentee to develop new leadership skills and gain visibility. Involve the person in committees, work groups, or task forces, and attempt to create opportunities that best place the mentee as a colleague where he or she can make the greatest contribution. Similarly, monitor the social environment. Are colleagues talking or not talking about your mentee? What is or is not being said? This will allow you to identify potential opportunities for your mentee or potential threats that may require you to act as an advocate (Davis, 2015; Hart, 2010).
- *Guide and counsel:* As the relationship develops over time, the mentor may begin to serve as a confidant or sounding board. On occasion, the mentor may have information about a particular event or circumstance, which was experienced negatively by the mentee, that may need to be shared to help the mentee more fully understand and/or reframe the experience. This can also

be an opportune time for mentors to help mentees understand conflict and various ways to deal with it—particularly when holding a leadership role. In some situations, it may also be necessary to advise the mentee to make a particular decision or choice, but this should be based on the needs of the mentee or your mutually established goals (Hart, 2010).

- *Teach:* Teaching involves not only imparting knowledge but also sharing personal experiences. Personal stories can be effective. Share the passion and drama of your leadership experiences, how you failed and learned from the failure, what your successes were, and how you learned to survive and thrive (Hart, 2010).
- *Model:* Shadowing can be a great benefit to future leaders. Your mentee will pick up many of your idiosyncrasies simply through observation—from your values and beliefs to your style and methods. Therefore, be profoundly aware of your own behavior, for you are *always* teaching by example (Davis, 2015; Hart, 2010).
- *Motivate, inspire, and encourage:* Positive reinforcement, or telling mentees you see them as future leaders, is critically important to developing their confidence to see this in themselves. At times it may be important to validate a mentee's feelings and experiences. Continue to support and encourage them while letting them know you appreciate their experience (Hart, 2010).
- *Challenge:* Challenging a mentee is a critical responsibility of the mentor and one that must be performed only when trusting relationships exist. Challenging can occur by posing thought-provoking questions that may allow mentees to see new solutions or self-reflect on their own professional blind spots. Challenging can also occur by providing experiences for mentees to develop new skills. Encourage them to take charge of a project at your organization. Provide them with the resources they will need; but then trust in them to take it from there. Strong mentoring focuses more on "teaching people *how* to think rather than telling them *what* to think" (Thompson, 2010, "Skill 1: Mentoring Questions," para. 1). However, challenging is only successful in the appropriate context. Mentees should not feel like these are sink-or-swim exercises. Thus, it is critical to know your mentees' strengths and weaknesses and provide challenges that supportively coach them just to their limits—each time allowing them to grow a little bit more (Davis, 2015; Thompson, 2010). See Box 8.7 for related new media resources.

Developing a Mentoring Culture at the Organizational Level

As a leader, consider the opportunities you are building in your organization for mentoring and future leadership development to thrive. In response to issues of horizontal violence and poor retention, some organizations are realizing the

BOX 8.7 NEW MEDIA: MENTORING AND LEADING THE GENERATION OF LEADERS

Ted Talk

"How to Be a Good Mentor." https://www.ted.com/playlists/400/how_to_be_a_good_mentor

Web Presentation

Bolton, L. B. "Gift to the World: Human Caring Leadership." In this presentation, Dr. Bolton, director of Cedars-Sinai Medical Center, shares *how the gift of teaching others* and *how to care for humans* can be sustained by leadership in a healthcare organization. https://www.youtube.com/watch?time_continue=4&v=KcEwIs6Rnjg

Podcast

Hidden Brain. Maggie Penman and Shankar Vedantam. October 20, 2015. "The Science of Compassion." https://www.npr.org/2015/10/20/448075446/the-science-of-compassion

Self-Assessment

Hougaard, R., Carter, J., & Beck, J. (May 15, 2018). *Assessment: Are you a compassionate leader?* In this assessment (available here at *Harvard Business Review*: https://hbr.org/2018/05/assessment-are-you-a-compassionate-leader), you will evaluate how wisely compassionate you are and may be as a future leader. As compassionate leadership can be learned, areas for improving and practical tips are provided following the assessment.

importance of mentoring programs, which can stimulate professional growth and improvements in staff morale, and thus produce positive outcomes related to nursing care (Chen & Lou, 2014; Grossman, 2013; Latham et al., 2008; Race & Skees, 2010). In this view, mentoring and leadership are not seen as mutually exclusive roles, but leadership is rather understood as a collective venture and practice among all people who work together to accomplish mutual work (Ford, 2009; Latham et al., 2008; Raelin, 2015).

Critical to the success of such mentorship programs in a workplace is a culture that promotes and sustains mentoring (Grossman, 2013; Jakubik et al., 2011; Latham et al., 2008; Race & Skees, 2010). Work environments where acts of professional generosity and supportive attitudes and behaviors are promoted are ideal settings for formal and informal mentorship programs (McCloughen et al., 2014). Contrastingly, if the organizational culture does not fit with the goals of a mentoring program, then such a program cannot be initiated or sustained. Thus, mentoring goals and values must be embedded and aligned with the organization's values, practices, and cultural environment. Additional considerations

and strategies for implementing successful mentorship programs in your organization are provided in Box 8.8.

In addition, there have been ever-increasing opportunities for formalized mentoring outside an individual organization, especially for new and emerging leaders. A few examples of these national and state-based mentorship programs targeted to nurse leaders are provided in Table 8.2. Participating in these programs initially as a mentee and eventually as a mentor could also help in building and refining your own mentorship skills and implementing a successful mentorship program within your organization.

This entire book is about becoming a transformational leader, and throughout this chapter, we argue that transformational leadership requires *compassionate* leadership. If, as a leader, you want to change the culture of your

BOX 8.8 STRATEGIES TO IMPLEMENTING A SUCCESSFUL ORGANIZATIONAL MENTORING PROGRAM

- Collaborate with and empower staff to develop a mission statement for the work environment that incorporates and guides mentoring activities.
- Provide an infrastructure that supports mentoring, including administrative support, financial resources, rewards and recognition, staff and scheduling flexibility, and protected time to mentor.
- Establish committees or a dedicated coordinator/liaison that can consistently support mentorship relationships and mentoring skill development and training.
- Ensure that a firm commitment exists across all levels of an organization's leadership to support the mentoring program

Sources: Bally, J. M. G. (2007). The role of nursing leadership in creating a mentoring culture in acute care environments. *Nursing Economics, 25*(3), 143–148; Chen, C., & Lou, M. (2014). The effectiveness and application of mentorship programmes for recently registered nurses: A systematic review. *Journal of Nursing Management, 22*(4), 433–442. doi:10.1111/jonm.12102; Grindel, C. G., & Hagerstrom, G. (2009). Nurses nurturing nurses: Outcomes and lessons learned. *Medsurg Nursing, 18*(3), 183–194; Grossman, S. C. (2013). *Mentoring in nursing: A dynamic and collaborative process* (2nd ed.). New York, NY: Springer Publishing Company; Jakubik, L. D., Eliades, A. B., Gavriloff, C. L., & Weese, M. M. (2011). Nurse mentoring study demonstrates a magnetic work environment: Predictors of mentoring benefits among pediatric nurses. *Journal of Pediatric Nursing, 26*(2), 156–164. doi:10.1016/j.pedn.2010.12.006; Latham, C. L., Hogan, M., & Ringl, K. (2008). Nurses supporting nurses: Creating a mentoring program for staff nurses to improve the workforce environment. *Nursing Administration Quarterly, 32*(1), 27–39. doi:10.1097/01.NAQ.0000305945.23569.2b; Race, T. K., & Skees, J. (2010). Changing tides: Improving outcomes through mentorship on all levels of nursing. *Critical Care Nursing Quarterly, 33*(2), 163–176. doi:10.1097/CNQ.0b013e3181d91475.

TABLE 8.2 Selected Mentorship Programs to Develop Leadership Skills

MENTORSHIP PROGRAM/ ORGANIZATION	DESCRIPTION	TARGET AUDIENCE
Leader2Leader Mentorship Program. American Organization of Nurse Executives (2018)	• Six-month online mentorship program to develop nursing leadership skills via mentoring and personal relationships • Provides opportunities for long-time leaders to share experiences and emerging leaders to obtain professional guidance • Matching of mentors and mentees based on questions and interests an individual identifies • Communication occurs through online message boards and private messaging system	Experienced nurse leaders and new and emerging nurse leaders who are AONE members
NONPF Leadership Mentoring Program. National Organization of Nurse Practitioner Faculties (2018)	• One-year program via in-person education meetings, virtual-based programs, and periodic check-ins to prepare and empower new and emerging leaders in nurse practitioner education • Mentorship occurs from NONPF members with advanced leadership training • The program goal is to guide nurse practitioner faculty in developing academic transformational leadership capacity	Nurse practitioner faculty members who have assumed leadership roles in their academic institution
State-Based Mentorship Program/Organization of Nurse Leaders of New Jersey (2018)	• 12-month program to further promote the personal and professional growth of nurse leaders • Involves an initiating workshop to lay groundwork for successful mentor–mentee dyads and uses a toolkit to guide and provide resources for mentorship teams	Aspiring and existing nursing leaders in the state of New Jersey

AONE: American Organization of Nurse Executives; NONPF: National Organization of Nurse Practitioner Faculties

organization to one of practice excellence, to develop safe environments in which all people thrive, and effectively mentor the emerging leaders of tomorrow—then the underlying assumption through all of this work is that the people are more important than the task, and that authentically serving the people will indeed get the task done.

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CHAPTER 9

Economics and Finance of Healthcare

Brenda Talley

We are in a position of financial and social power, and we could be agents of change in our society. Without pretension, I believe we could be a nice little gardener who takes care of the garden, and hopefully our neighbor will do the same. Then, maybe we'll achieve a better world.

—Guy Laliberté

OBJECTIVES

- *To appreciate the power inherent in effective use of resources*
- *To articulate the interrelationship between quality of care (processes and outcomes) and healthcare finance models*
- *To utilize financial management tools, such as budgeting, to support the best use of resources*
- *To determine various means of revenue and resource generation for the delivery of healthcare*
- *To recognize financial and practice opportunities related to emerging patterns in the provision of care*

INTRODUCTION

Effectively dealing with scarce resources is a perennial concern and perhaps should be the first sentence in the job description of the healthcare leader. Financial pressures are among the most significant challenges many hospital leaders face. Additionally, increasing complexity and diversity of care environments and settings as well as the loss of leadership through retirement have resulted in a net loss of nursing leadership (American Hospital Association [AHA], 2014a; Dyess, Sherman, Pratt, & Chiang-Hanisko, 2016). This exodus marks an unfortunate loss of experience but offers the opportunity for new

talent to introduce new ways to think about healthcare and finance. Also, recent changes in reimbursement methods have influenced clinical practice models. The expert practitioner must be an active participant in changes that affect approaches to clinical care as well as the financial viability of practice.

This chapter introduces selected topics related to financial issues and essential concepts of financial management for those in the leadership role and for clinicians who, as we will see, also carry a responsibility for the financial health of the organization. The relationships among power and influence, decision-making, achieving goals, and leadership growth are related to finance. Entire texts, courses, and experts are devoted to teaching economics, finance, accounting, and budgeting. While no attempt is made here to include every aspect of financial management that you will need, effort is made to connect the skills of financial management to leadership, to change, and to emerging practice patterns and opportunities.

LEADERSHIP AND FINANCE

Healthcare leaders, providers, and members of our communities currently face many critical economic challenges, including reductions in funding, changes in budget allocations, and elimination of or reductions in programs and services. Independent and collaborative partnerships, horizontal expansion of inpatient acute care facilities and innovative initiatives offer different models of care, such as outpatient centers, primary care centers, chronic disease management, home health services, hospice, and other care delivery opportunities that must operate under different rules and regulations and that receive payment in different configurations and challenges. Nurses prepared at advanced levels are looking for alternative methods of care delivery and changes in practice environments.

Attention to financial planning, careful mapping of strategy, relevant marketing that is correctly targeted, accurate estimations of revenue and expenditures, and adherence to a vision can result not only in financial success, but in personal fulfillment as a leader. Further, it can be the beginning of your personal contribution toward transforming healthcare.

THE HISTORICAL BASIS OF FINANCING OF HEALTHCARE

In the traditional fee-for-service model of payment, providers were paid without regard to the outcome of care. Charges were submitted and in only more recent years were charges mitigated by payers' determination of "usual and customary charges" for a geographical area. Revenue was grounded in the volume of services provided. Other models of payment, such as those of Health Maintenance Organizations (HMOs) and capitation approaches, eventually arose in which a set amount of compensation was provided for all care required for an individual. This step was the beginning of attaching the outcomes of clinical care to financial net gain. Payment amounts did not differentiate according

to specific definitions of quality, but there was increased liability for providers if services delivered less than optimal outcomes. These models remain active but are slowly being replaced by other models.

THE PRESENT STATE OF HEALTHCARE FINANCE

The last few decades of the 20th century brought a shift in reimbursement for healthcare services instigated by Medicare (and soon followed by other payers) that tied provider reimbursement to outcomes related to individual patient experience. The Centers for Medicare & Medicaid Services (CMS), the health insurance arm of the U.S. government and the biggest insurer in the country, continues to be among the most significant influences on payment for healthcare. Using diagnosis-related groups (DRGs), reimbursements for services were determined by analysis of payment histories of certain conditions, beginning with inpatient acute care facilities, with adjustments related to individual patient characteristics, population mix, geography, and hospital types (CMS, 2014). Volume-based reimbursement remains the focus, though services for complications related to patient safety indicators, such as falls and nosocomial infections in hospitals, are ineligible for payment. The major difference lies with the uniform determination of reimbursement (with the described adjustments) based on "normalized" averages of the cost of care, rather than the charges for care (interim reimbursement rates) as determined by the submitted cost reports of facilities and related factors, which are then reconciled by judgment of allowable costs on the filed reports. Quality concerns focus on selected outcomes: the aforementioned patient safety indicators, mortality rates, and 30-day readmission rates (CMS, 2015c).

The Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (ACA) of 2010, commonly known as Obamacare, provided healthcare coverage to many people who had lacked the opportunity to obtain health insurance. The payment of services for Medicare recipients also changed dramatically under this legislation. The influence of the ACA is pervasive in healthcare delivery, and no attempt will be made here to fully describe all aspects. Instead, the focus is on the relationship to financial concerns in the provision of care.

The ACA aims to reduce costs as well as improve the processes and outcomes of care by supporting value-based programs. The original five value-based programs of the CMS allow for distinctions among payment amounts as well as payment reduction potential on the basis of institutional metrics (Box 9.1). The goal is to link provider performance on specific quality measures to payment to the provider. This reform has led to some progress toward adequate healthcare, but continues to be limited in its application.

BOX 9.1 CENTERS FOR MEDICARE & MEDICAID SERVICES

Value-Based Programs, Medicare
Current programs

End-Stage Renal Disease Quality Incentive Program (ESRD QIP)

Hospital-Acquired Conditions (HAC) Reduction Program (CMS, 2018)

Hospital Value-Based Purchasing (HVBP) Program

Hospital Readmission Reduction (HRR) Program

Value Modifier (VM) Program (also called the Physician Value-Based Modifier [PVBM])

Additional CMS programs implemented in 2018 and 2019

Home Health Value-Based Program (HHVBP; CMS, 2018)

Skilled Nursing Facility Value-Based Program (SNFVBP)

Source: Centers for Medicare & Medicaid Services. (2018). *Medicare quality initiatives*. Retrieved from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html

CMS Programs

New designs for care that are consistent with new systems for payment must be developed. Practice issues and financial concerns are firmly linked in this healthcare reform movement (Harris, Holm, & Inninger, 2015). It is the expert clinician who will collaborate with financial leaders to ensure that both processes and outcomes of care are optimal in terms of patient needs and that financial well-being is achieved. Finding the exquisite balance between quality and efficiency, on the basis of community values related to health, will be the challenge for visionary leaders. Value-based programs do not function inside their own parameters; they are linked to other supported programs, including the transitions to care projects, and community-based projects. Figure 9.1 shows current CMS programs and activities.

Among the most familiar of the programs are the Hospital Value-Based Purchasing (HVBP) Program, the Hospital Readmission Reduction (HRR), and the Hospital-Acquired Conditions (HAC) reduction program (CMS, 2018). Since 2012, inpatient HVBP payment has been calculated by incorporating in hospital performance scores, including reductions for HRR and HAC metrics. These scores are calculated annually and are compared with those of other hospitals and a hospital's own year-to-year performance. Of the 34 quality indicators

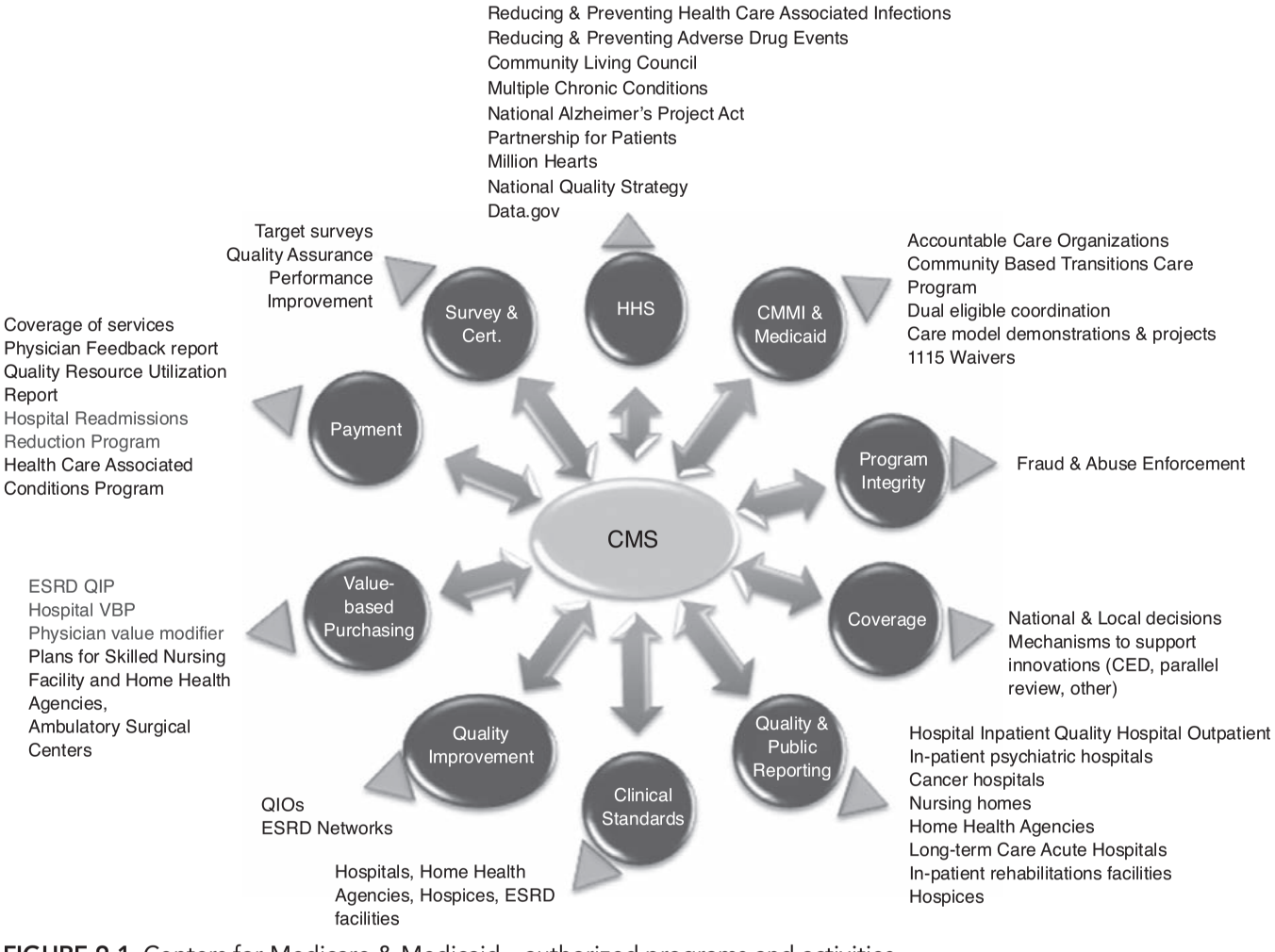

FIGURE 9.1 Centers for Medicare & Medicaid—authorized programs and activities.

CED, coverage with evidence development; CMMI, Center for Medicare and Medicaid Innovation; ESRD, end-stage renal disease; HHS, Department of Health and Human Services; QIO, quality improvement organization.

Source: Centers for Medicare & Medicaid Services. (2018, July). *Medicare quality initiatives*. Retrieved from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html

considered, seven are *outcomes* and 27 are *processes* (CMS, 2013). These measures, weighted, are calculated into the performance scores; top scorers are rewarded with financial incentives while poor performers are penalized. Although some measures will eventually "top out" (i.e., there is no room for improvement) and others will be added, the rapidly changing and complex requirements need constant attention (Wilson, 2011). While most of these measures affect the acute care inpatient setting, note that others do and will in the near future affect payment, and most certainly the means of care delivery in outpatient and community settings.

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey is a national, standardized survey of patients' perspectives of hospital care introduced by the CMS. Hospitals participating in Medicare are required to administer the survey to a sampling of patients soon after discharge. The results are reported to the public and are used as a scoring factor for reimbursements (CMS, 2014). This measure is currently limited to inpatient hospital settings, a similar plan will be factored into reimbursement for other settings, including primary care (see Edwards & Landon, 2014; Ryan et al., 2015). Private insurance companies and other providers usually follow the lead of Medicare in determining policy and coverage changes.

Patient satisfaction scores represent one of the more controversial indicators of quality that are factored into ratings for reimbursement. Data analysis produces a strong correlation between patient satisfaction scores and more global indicators of quality (Isaac, Zaslavsky, Cleary, & Landon, 2010), though some argue that patient satisfaction scores are not reliable determinants of quality in care processes and, indeed, have the potential for harm (Nix, 2013; Ryan et al., 2015). One concern is that smaller, rural, and resource-poor facilities will fail to meet comparisons with other institutions due to financial constraints and other factors not within their control (Nix, 2013).

At present, the valued-based program that affects outpatient care most significantly is the Physician Value-Based Payment Modifier (VM) Program.

In 2017, the CMS merged its earlier physician quality programs into the Merit-based Incentive Payment System (MIPS) for healthcare providers including nurse practitioners. MIPS includes four components:

1. Quality, formerly the Physician Quality Reporting System (PQRS)
2. Promoting interoperability, formerly the Advancing Care Information (ACI) or the Electronic Health Record (EHR) Incentive Payment Program
3. Cost, formerly known as the Physician Value-Based Payment Modifier (VM) Program
4. Improvement activities, a new category (American College of Surgeons [ACS], 2019)

These four components are combined to form a MIPS final score that determines a MIPS-Eligible Clinician's Medicare Part B Incentive payment (ACS,

BOX 9.2 TIMELINE TO PHASE IN THE VALUE-BASED PAYMENT MODIFIER (PHYSICIAN FEES [PF])

Expectations in 2018

January 1: Application of the Value-Based Payment Modifier (Value Modifier)

The Physician Value-Based Payment Modifier (VM) Program applies to payments under the Medicare Physician Fee Schedule (PFS) to:

- Physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists who are solo practitioners
- Physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists in groups with two or more eligible professionals (EPs) based on their performance in CY 2016

CY 2018 was the final payment adjustment period under the VM.

Source: Centers for Medicare & Medicaid Services. (2017b). *Timeline to phase in the value-based payment modifier*. Retrieved from: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Timeline.html

2018). This program has multiple phases, and some have been delayed. See Box 9.2 for 2018 expectations.

Medicaid Reform

Medicaid is, of course, a federally supported state-based payment program that varies depending upon options of the state and federal rules and regulations. It is, in essence, an insurance program for people with lower incomes and is a collaboration of the federal and state government. Some Medicaid services are required as conditions of the state's participation, while others are optional. The ACA offered even deeper options; states could expand eligibility for coverage under Medicaid and acceptance of this option came with funding. However, not all states elected to participate. The most recent information indicates that 14 states did not elect to do so (Henry J. Kaiser Family Foundation, 2018).

Along with Medicare and private insurance companies, Medicaid innovative programs for service provision are in development and are emerging due to unfolding opportunities. As Medicaid continues to move from quantity-based to value-based payment, this is a momentum toward managed care for the 74 million Americans who are now covered under Medicaid (Mann, 2018). As more states expand Medicaid eligibility (i.e., 35 as of December 2019), and others do not, the concern is that there will be negative impacts on the most vulnerable—those with high needs and high cost. APRNs and nursing leaders should investigate the ongoing and emerging roles required to meet these needs, for example, the complex coordination needed for successful case management

and a focus on population health. The ideas of patient- and family-centric care will become germane to innovative approaches to improving outcomes and reducing expenditures (Salmond, & Echevarria, 2017).

CULTIVATING CONFIDENCE IN FINANCIAL MATTERS

Because financial matters are not often emphasized in the educational preparation of nurses, some may be intimidated by financial management and may avoid engagement in activities that require knowledge of financial dynamics. But the days are long gone when nurses might come forward with good ideas simply because they are good for patients or clinicians. Transformational leaders always make a strong business case for new models of care.

Must a successful leader have the skills of a financial manager? While those who describe successful leaders cite their ability to create a vision, communicate that vision, and support and motivate others to accomplish it, leaders must be able to control resources, interpret and implement policies, organize work, and focus on short-term goals (Yoder-Wise, 2011).

As we noted earlier, the American Organization of Nurse Executives (AONE, 2015, p. 3) developed a model of core competencies for the nurse leader that includes five domains: the overarching domain of leadership and the competencies of communication and relationship building, professionalism, knowledge of heathcare environment and business skills, and principles. Although skills and knowledge integral with financial leadership are threaded throughout the domains, some speak specifically to the expectations and responsibilities of financial leadership. Delivery models/work design addresses care delivery systems and models in terms of effectiveness, advantages and disadvantages, as well as involvement in the development of new care delivery models. The subdomain of Health Care Economics and Policy explains key concerns related to payment issues, regulations, payer mix, value-based purchasing, and bundled payments (AONE, 2015).

The domain of business skills and principles adds even more specific areas of competencies (see Box 9.3; AONE, 2015). Acquisition of these competencies enhances the ability of the nurse leader to fully participate in strategic planning to fully support the mission of the healthcare organization, and the development and implementation of innovative approaches to care.

Moseley (2018) identified the critical connection between financial management and a leader's ability to meet strategic goals, pointing out that lack of such connection may result in the following:

- Lack of integration of the strategic planning and capital allocation processes may inhibit the initiation of strategic actions. This is not only inefficient, but it can result in unrecognized opportunities and missed strategic targets.

BOX 9.3 AMERICAN ORGANIZATION OF NURSE EXECUTIVE (AONE) COMPETENCIES RELATED TO FINANCIAL MANAGEMENT (5A BUSINESS SKILLS AND PRINCIPLES)

- Develop and manage an annual operating budget and long-term capital expenditure plan.
- Use business models for healthcare organizations and apply fundamental concepts of economics.
- Interpret financial statements.
- Manage financial resources.
- Ensure the use of accurate charging mechanisms.
- Educate patient care team members on financial implications of patient care decisions.
- Participate in the negotiation and monitoring of contract compliance (e.g., physicians, service providers).

Source: American Organization of Nurse Executives. (2015). *AONE nurse executive competencies*. Chicago, IL: Author. Retrieved from http://www.aone.org/resources/nec.pd

- Due to the differing time frames for strategic planning (usually 3–5 years) and the budget process (annual), the processes may become divorced and no longer work in concert. The financial planning may be removed from the strategic planning process.
- Strategic initiatives may not be justified by the financial prospects of the organization and the credit rating. Strategic plans not appropriately budgeted for both expenditures and for acceptable returns can result in a drain on capital reserves.
- Inadequate oversight of strategic financial performance is a serious issue. An effective financial monitoring process is necessary to avoid lost capital, cash flow issues, and failure to reach strategic objectives.

Power struggles over resources have consumed individuals' lives, divided families and friends, initiated wars and rebellions, and resulted in upheavals of social, political, and economic systems. It is no wonder, then, that conflict can erupt over how best to allocate an organization's resources. Priorities differ, and poor communication among disciplines and specialties exacerbates the problem. The considerations of business managers can conflict with those of clinicians. Values may not differ so much as perspectives.

Effective leadership requires creativity and the ability to work with others to fulfill a vision. While doctorally prepared nurses may or may not actually be developing the budget, there is much to know about overseeing or supporting

REFLECTION QUESTIONS

Caring is not restricted to nurses. Those in other roles, such as financial management, have concerns that may not be in the forefront of thought for nurses. Consider the statement: *Values may not differ so much as perspectives.*

1. What values may be held in common between nurses and business managers?
2. How might perceptions between those responsible for financial management and resources differ from those of clinicians?
3. How might caring be manifested from a *financial perspective?*
4. How might reaching an appreciation of the other's perceptions be a positive force in interdisciplinary collaborations that involve a significant investment of financial resources?

the process, validating the inputs, setting priorities, enabling evaluative mechanisms, or responding to variances and deviants from financial and output goals. Financial management and planning tools provide the vehicle by which vision can be realized. The ability to communicate effectively and collaborate synergistically with healthcare providers *and* with financial experts on knowledgeable levels is a powerful means toward providing both efficient and effective healthcare.

UNDERSTANDING THE LANGUAGE OF FINANCE

Although it is not necessary for you to *be* an accountant, to take the initiative in financial matters as the leader it may be wise to seek the counsel of experts in finance. As in any profession, finance has its own terminology. Knowledge of basic terms used by financial officers demonstrates an ability and willingness to learn about finance and can convey an intention to be "hands on" in making decisions. Frankly speaking, knowledge of basic accounting concepts and terms is empowering. Once you learn the terminology, applications, and meanings, your confidence will soar and your role in the financial matters of the organization will become increasingly significant (see United States Small Business Administration, 2016).

Many resources are available online that explain the terminology of finance. More importantly, by keeping abreast of relevant, current literature you will be introduced to new concepts and newly coined words and acronyms. Indeed, because of the increasing connections between approaches to healthcare delivery and reimbursement, some emerging terms reflect this very connection. New phrases, such as the following, arise related to collaborative practice arrangements and what is identified as improvement opportunities:

- Practice sustainability
- Clinical documentation
- Shared savings
- Employed practices; streamlined workflows; and enhanced patient access, quality, and satisfaction
- Transparent and equitable compensation methodology (Harris et al., 2015, p. 71)

Indeed, it may be the responsibility of the expert clinician to fully explain the meaning of these phrases *in the terms of* practice conditions, standards, and patient needs. You can be an important interpreter to those whose expertise lies solely within the financial framework, as new practice models are explored

BOX 9.4 NEW MEDIA: FINANCE AND HEALTHCARE

Videos

As medicine advances, so does the complexity and price of healthcare. For inspiration on ways to keep healthcare affordable, Jan Denecker shares three simple, yet effective innovations from the developing world, where constraints on resources have caused the healthcare industry to adopt a mentality of doing more with less. https://www.ted.com/talks/jan_denecker_how_to_do_more_with_less_in_healthcare

Andrew Hargadon, U. C. Davis Professor. "Getting From Ideas to Innovation in Healthcare." https://www.youtube.com/watch?v=9bbJBa266mI

Dan Michelson, CEO of Strata Decision Technology, demonstrates the value of cost accounting in managing healthcare costs. https://www.youtube.com/watch?v=ueuC374ljHM

Healthcare Finance and Leadership Blogs

American Hospital Association Resources Center blog https://aharesourcecenter.wordpress.com/
Healthcare Finance News blog https://www.healthcarefinancenews.com/blog
Notes From the Nurses' Station http://www.rncentral.com/blog/2012/getting-your-rn-invention-from-the-drawing-board-to-market-shelves/
Nurse Money Talk blog
https://nursemoneytalk.com/blog/

Useful Links

Business Plan Template for a Startup Business https://www.score.org/resource/business-plan-template-startup-business
Example of a Business Plan. Employee Wellness Program for VA Hospital
https://www.publichealth.va.gov/docs/employeehealth/12-sample-business.pdf
Simple Business Plan Template for Entrepreneurs https://www.thebalancesmb.com/entrepreneur-simple-business-plan-template-4126711

in response to pervasive and innovative payment models. As you continue your adventure to learn more about financial matters, take advantage of every opportunity and resource. Box 9.4 provides online resources related to financial matters.

COMFORT IN COLLABORATIVE FINANCIAL RELATIONSHIPS

Rarely do individuals enter into business ventures totally alone. Even when an individual does not have business partners, he or she must collaborate with funding institutions, affiliated and associated agencies and providers, governmental agencies, or other members of the community. Nurses, especially, know the stories of healthcare and can make the need for services real to other collaborators. While standards of care and levels or types of services provided may not appear negotiable, they do warrant open discussion. In such negotiations, leaders must always examine and weigh the need to have control for control's sake and the need to maintain standards and employ expertise. Developing confidence in one's own ability to listen, contemplate, and make informed, collaborative decisions in areas such as practice or education will improve confidence in working with others on financial matters. Such collaboration can add to knowledge and confidence in all matters, including risks related to financial issues.

ASSESSING THE CONTEXT OF CARE FROM A FINANCIAL PERSPECTIVE

Effective projections and management of resources require some ability to understand history, including business history of the organization, history of the community or context of the business, and history of the services of the business within the business community as well as the general social geography. It is also necessary to connect with current affairs in business and in the community, and you must be able to predict the future to some degree. There are several mechanisms that can help you in such assessments, such as the environmental scan.

Environmental Scans

An environmental scan is a critical and intentional review of information available to make appropriate resource decisions related to the organization. Information is categorized and used to help guide planning, decision-making, and use of resources. It is a critical step in financial management and necessary for strategic planning.

Conducting a full-scale environmental scan to include national issues is time-consuming and requires skills. Many organizations regularly conduct

environmental scans. The information published from such studies is applicable in many healthcare settings. One example of this is the environmental scan conducted by the AHA. The 2015 AHA Environmental Scan:

> identifies emerging trends to help hospital and health care leaders plan strategically. The annual Scan serves as the foundation of the AHA's rolling three-year strategic plan. Topics include consumers and patients; economy and finance; information technology and e-health; insurance and coverage; physicians; political issues; provider organizations; quality and patient safety; transforming care delivery; science and technology; and workforce. (AHA, 2014b)

The AHA Environmental Scan is compiled from nationally recognized sources with recommendations from select AHA governance committees. Emerging or potential problems related to resources as well as opportunities can be recognized by a critical and systematic evaluation of information from an environmental scan. An example of a financial issue identified in the most recent AHA scan is an increase in the deductible amounts in insurance plans. The analysis cited this as the root cause of increased cost shifting (AHA, 2014b). Cost shifting as it relates to healthcare organizations occurs when organizations attempt to achieve a positive profit margin by enhancing revenues received from best payers, such as insurance companies, to make up shortfalls left by payers whose reimbursements are inadequate related to costs, such as Medicaid (Robinson, 2011). Although results are mixed and favor larger hospitals, in 2018 hospitals faced with such reductions improved payment by 1.6% by shifting to better paying insurance companies (Darden, McCarthy, & Barrette, 2018).

External Trends in the Community

Changes in demographics of the local community can result in a shift in healthcare needs and affect potential revenue. For example, nearby construction of a high-rise residential building for the elderly may result in a greater demand for geriatric services. An increase in the number of manufacturing plants in the community may increase the need for services for young families with small children. Increased unemployment rates could mean that families no longer have health insurance and have fewer resources to pay for care. Changes in the economy on a local, regional, or national level can result in decreased funding or changes in reimbursement levels.

Trends Within the Organization

An environmental scan of the internal environment, such as past experiences, present conditions, and expressions of future expectations, is important. The

internal political climate should be assessed to place appropriate issues on the "front burner." Potential conflicts within multiple agendas may be identified, and alliances and areas of competition should also be defined.

Current terminology refers to this internal assessment as a microsystem analysis. A microsystem is a subsystem of a larger complex system that is the point of care and part of a larger infrasystem (Roussel, 2014). The present climate of dynamic change, requiring a merging of clinical and financial concerns, demands that leaders identify, analyze, and manage critical metrics related to both processes and outcomes. This is essential to improve care delivery, develop innovations, and meet expected benchmarks. The need to increase efficiency and effectiveness at the point of care is valued for its own sake, but also as a critical necessity for financial well-being.

That redesign at the microsystem level is necessary is no longer in question: Evaluating small tests of change is critical to determine improvements in quality, safety, and reduce costs. Analysis of microsystems informs the patterns and processes in which are embedded medication errors, clinical misjudgments, fragmentation in care transitions, and ineffective teamwork. Failure to understand the clinical microsystems leads to "patchwork" fixes and harm to patients (Likosky, 2014). Clearly, the importance of microsystem analysis is critical to the financial health of the organization, given links among payment methods and processes and outcomes.

The American Recovery and Reinvestment Act of 2009 (ARRA) supports the widespread use of EHRs by the use of incentives. Stage 1 focuses on the collection of clinical data and sharing this information with individuals and other providers, and stage 2 is designed to use captured data to improve quality (CMS 2015b). Given the dependency of financial reimbursement upon quality measures (in addition to the financial incentive of participation in the EHR program), utilization of these data within a microsystem analysis will help to identify and remedy conditions operating in less than desired capacities. In addition, information systems can be modified to collect data needed for more precise collection of metrics. For example, a recent graduate of a DNP program developed an information system add-on for her primary care practice that allows her to continually evaluate whether performance standards are met for diabetic patients. The systems vendor is interested in incorporating this and other applications into the information systems package for other practices (Shea, 2014). In addition to supporting compliance of practice standards—an actual requirement in some settings for maximum payment and a potential payment factor in others—this approach is also useful in verifying capture of charges, noting omissions, and providing adequate follow-up and continuity of care. The clinical and the financial aspects of care are no longer separate entities, but rather intertwined and interdependent.

Metrics obtained must be systematically organized before analysis and evaluation can take place. In addition to metrics on processes and outcomes, financial data can be integrated into the system. Some of these data can be

linked to the clinical experience; for example, the amount of waiting time in the ED, the time before release or admission, or the patterns in utilization of services by demographics, payment methods or mix, or diagnosis, all in real time. Still other measures can be added to an integrated information system.

The 5 P Framework as a Visual Scan

The 5 Ps have been incorporated into a structured diagram providing a method to visually look into multiple aspects of a clinical microsystem and to make assessments. The concept originated at the Lucile Packard Children's Hospital at Sanford University Medical Center (Dartmouth Institute for Health Care Policy and Clinical Practice, n.d.; Godfrey, 2010).

The 5 Ps include the following: (1) "purpose," or desired outcomes; (2) "patients," referring to specific patient populations; (3) "professionals," or care providers; (4) "processes" of assessment, problem-solving, and treatment plans; and (5) "patterns," referring to patient outcomes related to styles and symbols of leadership, culture, and values of the microsystem (Godfrey, 2010, p. 8).

Workbooks, called *Greenbooks*, were developed for major practice areas, which include (a) inpatient, (b) ED, (c) long-term care, (d) outpatient primary care, (e) outpatient specialty care, and (f) neonatal intensive care. Each *Greenbook* can be downloaded in a Word format and utilized in the appropriate clinical area, and clinicians are encouraged to do so (see Box 9.5).

BOX 9.5 GREENBOOKS

1. Access the Microsystem Academy supported by the Dartmouth Institute for Health Policy and Clinical Practice, at https://clinicalmicrosystem.org/workbooks/. Review the *Microsystems at a Glance* booklet.
2. Choose the *Greenbook* that most closely matches your clinical practice area.
3. Consider areas in your practice environment that could use improvement. For the purposes of this exercise, choose an area that would have an impact on financial well-being. *However, do recall the intertwining of quality measures and cost/finance.* For example, time delays in referrals, transfers, medication administration, laboratory results, and documentation—just to list a few—could affect quality scores as well as efficient use of resources and expanded liability.
4. After creating a clear statement of the area of concern, determine which section of the *Greenbook* you selected would be most helpful to you in understanding the problem. Give your rationale for this selection.
5. Determine the critical information you will need. Note that quantitative measures (referred to as metrics) may not be your only source. Many areas allow for qualitative data, such as interviews. Note the measures that you consider are essential.

(*continued*)

BOX 9.5 GREENBOOKS (*continued*)

6. Develop your team. Such an undertaking can rarely be accomplished by an individual. Who in your work environment (or external, for that matter) could facilitate both the collection and analysis of your data? Whose support do you require?
7. To whom would your present your results? What means would you use to present the analysis (charts, tables, software)?
8. Give some thought to strategies for change. What might be positive outcomes for change in terms of cost management or maximization of revenue?
9. Summarize your experience.

Others have developed and utilized workbooks more closely aligned with a specific clinical practice, and these are available as well. As you will see in your reading, this organization encourages development, feedback, and contributions. Additional resources include descriptions of tools used in microsystem appraisal, problem identification, planning, and evaluation (Dartmouth Institute for Health Care Policy and Clinical Practice, n.d.). Among the *Greenbooks* tools that you could apply are flowcharts, tracking cards, control charts, and Plan-Do-Study-Act (PDSA) templates. Comprehensive exploration of these tools is beyond the scope of this book, but we invite you to review them.

BUSINESS MODELS, PLANS, AND BUDGETS

Expert clinicians are not usually prepared as experts in business or finance. But to make a difference as a leader in any transformational manner, you must know the language, processes, and outcomes related to fiscal matters in healthcare. You must be able to clearly articulate the return on investment of the important work you do, and to interpret the work of promoting health and caring for the sick to professional colleagues whose world centers on providing, developing, or managing resources. Business models are depictions of the business, the theoretical picture, or the conceptual portrayal of the organization from a business or financial perspective. The business plan is the road map used to project the success and contingency plans of the enterprise. And the budget is the operational record of all financial resources and management of the endeavor.

Business Models

Formal and theoretical business models have been developed using a multitude of criteria. Models may be based on relationships with other businesses, type of product or service, physical location of infrastructure, corporate structure, and

TABLE 9.1 Characteristics of Archetypes for Business Models

MIT BUSINESS MODEL ARCHETYPES	CHARACTERISTICS OF ARCHETYPES	EXAMPLE OF HEALTHCARE ORGANIZATION
Creator	• Buys raw materials or components from suppliers and then transforms or assembles them to create a product sold to buyers • Designs products sold • Predominant business model in all manufacturing industries	A company that develops and manufactures health-related products. Could also be the provider of a service product, such as chronic disease management
Distributor	• Buys a product and resells essentially the same product to someone else • May provide additional value by, for example, transporting or repackaging the product, or by providing customer service • Ubiquitous in wholesale and retail trade	A health maintenance organization that sells healthcare products such as vitamins or supplements but also includes teaching and monitoring
Landlord	• Sells right to use, but not own, an asset for a specified period of time • Also includes lenders who provide temporary use of financial assets (e.g., money), and contractors and consultants who provide services produced by temporary use of human assets	Hospitals that allow "customers" to use facilities and receive care on site by use of care providers
Broker	• Facilitates sales by matching potential buyers and sellers	Case management

Source: From Weill, P., Malone, T. W., & Apel, T. G. (2011). New research suggests that the stock market particularly values business models based on innovation and intellectual property. *MIT Sloan Management Review*, para 5. Retrieved from https://sloanreview.mit.edu/article/the-business-models-investors-prefer/

ownership, among other factors. Many models are complicated and seem to have little apparent application to healthcare delivery.

A business model is defined simply as "consisting of two elements: (a) what the business does, and (b) how the business makes money doing these things" (Weill, Malone, & Apel, 2011, p. 6). Generally, healthcare is considered a service model. Using this definition, Weill et al. derived the four basic business model

archetypes—creator, distributor, landlord, and broker—shown in Table 9.1. Under this model, provision of healthcare services would most often be classified as a landlord-type business. It could additionally be subcategorized as "intellectual landlord," that is, the entities do not sell properties or hard goods but rather the use of facilities and the services of caregivers. Some services are provided by contractors, such as physicians. However, "their time (and knowledge) may be 'rented out' for a fee" (Weill et al., 2011).

Weill et al. categorized the 1,000 largest public companies in the United States by archetype and evaluated them for financial performance by analysis of revenue stream. Results demonstrated that selling use of assets to customers (landlord archetype) was more profitable, and more highly valued by the market, than selling ownership of assets. In general, business models based on nonphysical assets were found to be more profitable than those based on physical assets (Weill et al., 2011). The future is likely to bring forth newer, more relevant models as healthcare entities move forward from the traditional models.

Not-for-Profit Status and Making a Profit

Nurses tend to dislike thinking about the probability of payment for care and making a profit from providing healthcare services. However, staff and rent must be paid, supplies purchased, and in many instances, investors repaid. The for-profit, or proprietary model, of conducting business has infused some variety and innovation into the delivery of healthcare in the United States. The number of healthcare facilities and providers who have moved to for-profit status continues to increase. A not-for-profit organization is an organization recognized by both the state and the federal government as not-for-profit and hence exempt from some specific taxes, based on documented return of income to the organization or to the community, or both. This does not mean that the organization does not wish, or need, to make a profit, but rather, on how any profit (if any) is distributed or utilized. Any income after expenses is reinvested by the organization instead of being paid to owners or stockholders. Often, any overage of income beyond expenses is used to provide additional services, to subsidize those who cannot pay, or to fund charitable services.

Business Plans

A business plan is useful as it helps communicate the capital value of the healthcare professional and the services provided to those who may be the gatekeepers to funding. The willingness to support a particular type of venture is generally grounded in the perception that the business will be profitable, or at least an asset to the organization or community rather than a liability. Even charitable donors such as the United Way fund want to see evidence of sustainability. A

significant gap in communication to the gatekeepers may be in creating the vision that the venture will be an asset; this can be articulated most authentically by the expert care providers.

A business plan functions as a developmental road map, integrating goals, resource needs, financial needs and planning, and projected outcomes to begin a business venture, clinical practice initiative, educational project, or some other innovation. It is a document most often prepared as a proposal to obtain funding (Baker & Baker, 2011, p. 271). The doctorally prepared nurse would likely develop a business plan before setting up a new practice, program, or service. This process could also be used to help choose among several competing service or business options or even when considering a new line of services or implementing a new program within the organization. Several factors should be considered before beginning such a venture. Markwich (2016) suggested determining the need for the services in the community; the level of community interest and their willingness to use the services, which is an estimate of potential clients or patients for the service; and reimbursement for services by third-party payers. Other consideration should be the availability of physical sites. Before any movement is made, the practitioner should be aware of any conditions of practice, such as the requirement for collaborative practice.

The business plan for a proposed innovation must include more than money matters. It should include the mission, goals, and vision, which need to be revisited as the plan unfolds to retain focus and connection to key ideas (Markwich, 2016). As a leader, you need to know and articulately communicate whether your plan is budget neutral and why, or why your plan makes business sense. Your projections and subsequent evaluation should quantify cost savings while advancing the mission of the organization. Cost savings may be reflected in the actual budget by costs, charges, or new revenue, or indirectly by reduction in worker turnover or other employee costs such as workers' compensation. Thus, the business plan for a clinical practice initiative should reflect the best information available from those most knowledgeable on the project, good program design, evidence of practice expertise, evidence of expert economic and financial management, and strong evidence of effective leadership (Harris, 2010).

The business plan should be written and should contain many of the following sections. Consider which element is most appropriate and will be most useful and persuasive to launch your enterprise:

> Always include an executive summary. If you cannot make your case clearly on *one* page, no one will want to hear your pitch. An executive summary is a concise summation of the business, inclusive yet brief, that precedes the business plan. It is useful when "seeking new partners, business loans or an early round of funding for a startup venture. It sums up the business plan and opportunity in a tight document. The executive summary should be written in the same order as the full plan." (Cremades, 2018a, 2018b, para. 4)

The visual or graphic approach may be appreciated by some and is the emerging trend replacing the executive summary in some businesses. This is referred to as the pitch deck, consisting of about nine slides or other portrayals of content.The *killer* pitch deck should include the following slides/content in high energy and—again, concise and "tight" manner:

1. Problem
2. Solution
3. Market size
4. Product
5. Traction
6. Team
7. Competition
8. Financials
9. Amount being raised (Cremades, 2018b)

- Your vision or mission statement as well as background information on the initiative that reflects the rationale, need for your initiative, and specific objectives. The background and rationale should reflect a clear definition of your market and analysis of the market, including inputs from stakeholders; analysis of competition, if appropriate; and a profile of the clients or community your project will serve. Objectives should flow from your rationale.
- Plan for specific current products or services and needed research and development, as appropriate. Describe your management teams, your product or service strategies, key factors in delivering your service, and what your project will accomplish, including a timeline. Specifically describe capital requirements; business risks; financial plan, including repayment plans, if appropriate; and your plan to sustain the project.
- Outline a marketing plan for communication, dissemination, advertising, and promotion, and other publicity strategies (Harris, 2010).

BREAK-EVEN ANALYSIS

Simply stated, an organization's break-even point is that point after which revenues exceed costs. Both fixed and variable costs must be considered when projecting the break-even date. Fixed costs are those that can be most easily predicted and tend to be stable; variable costs are those that by their nature can fluctuate. Estimation of the break-even point is especially critical in financial planning for new programs, services, and beginning organizations. Until that point is reached, operations can be thought of as being in the "red"; that is, operations expend more money (such as for salaries, utilities, and supplies) than is received. Funds must be available to meet cost (expenses) until the revenue can at least equal expenses. Even then, it must not be assumed that revenue will enable the meeting of expenses. However, accurate projection of the break-even point can assist in (a) estimating acceptable risk in

beginning a new service, (b) approximating the amount of funds needed for "start up" (i.e., the amount of funding required to maintain operations until a profit is realized), and (c) communicating potential business success to potential funding sources. Projection of the break-even point is also useful in determining charges for units of service, such as the charges for a clinic visit. However, the charge for unit of service is also influenced by market conditions, including competition; by participation in third-party payer programs; conditions set forth by funding organizations or affiliated organizations; and other factors.

Baker and Baker (2011, p. 69) illustrated the break-even point as cost–volume–profit (CVP) analysis. The break-even point is defined as the "point when the contribution margin (i.e., net revenue fewer variable costs) equals fixed cost." Additionally, the break-even point can be expressed in two ways: as an amount per unit of service, or as a percentage of net revenues. CVP projections or portrayals are often displayed in graph form, with the horizontal axis being the volume (e.g., number of visits) and the vertical axis showing cost. Low-cost or free software can assist in plugging in various scenarios of volume, revenue, and fixed and variable costs. Adaptation of electronic spreadsheets can be used to generate graphs showing the intersection between revenue and cost. Changing the variables can illustrate how differences in projections might produce different potential outcomes. Contingency plans can then be made to help minimize risks. For ongoing management, "control charts" can be developed that will provide indications that expenditures are exceeding a set level and also that projected income may be falling below a set level. These reports should be reviewed frequently.

ESTIMATING THE VOLUME

Estimating the projected volume of units, such as clinic visits, is an inexact science. To start, the intended recipients of the service need to be defined in terms of characteristics (e.g., emerging families, the elderly, migrant workers) and by geographical location. These recipients would be the target market. Need and demand for services can then be projected based on demographics of the community, services already in place or gaps in services, client loyalty to and satisfaction with these services, and comparison of charges to existing services. Another potential consideration may be market conditions. Is the service considered a necessity by the potential target market? Is a comparable alternative available to clients? How competitive is the proposed service? Is the service consistent with expectations and community norms, and congruent with the culture of the target market?

The decreasing reliance on fee-for-service options changes the dynamic somewhat, shifting the focus away from the total reliance on unit volume (e.g., patient visits) for estimating revenue. However, this factor remains an important consideration, and analyses must be conducted with a mind not only to payer mix, but also to probable payment programs within payer (e.g., Medicare)

reimbursement models. Additionally, projection of volume is necessary to estimate needs such as facilities, supplies, and staff.

ESTIMATING THE PAYER MIX

The payer mix is the variety of sources that pay, or reimburse, for healthcare services. Information about varied demographic groups, such as the percentage of the population eligible for Medicaid, those older than age 65 who would have Medicare coverage, unemployment rates, and age distribution of the population, help estimate the mix of third-party payers. The type of services provided may also provide insight into the payer mix. Services targeted toward the elderly, for example, would tend to have Medicare as the predominant third-party payer. Generally speaking, those over 65 years of age with Medicare as their primary payer have longer hospital lengths of stay (LOS) and lower payment compared with those under 65 with a managed care insurer (Rundio, 2016). Healthcare organizations located where poverty is prevalent likely would have a higher percentage of Medicaid recipients, and recipients who rely on other sources for subsidized care. These organizations might also have a higher percentage of patients who are not covered by third-party payers and cannot afford to self-pay.

Variations in the mix of payers can have a great impact on the revenue of an organization. Shifts in payer mix or failure to project a near approximation can severely alter income projections, as seen in Tables 9.2 and 9.3. Note that scenarios A and B both show revenue for 100 visits. Reversing the number of visits per payer source in this payer mix results in a difference of revenue of $1,300 for the same number of visits.

TABLE 9.2 Scenario 1 Payer Mix

SCENARIO 1: VOLUME × REIMBURSEMENT RATE = TOTAL REIMBURSEMENT			
THIRD-PARTY PAYER	**VOLUME (NUMBER OF VISITS)**	**PER VISIT**	**TOTAL REIMBURSEMENT**
Payer Uninsured	10	$55.00	$550.00
Payer Medicare	25	$85.00	$2,125.00
Insurance A	30	$95.00	$2,850.00
Insurance B	35	$105.00	$3,675.00
Total	**100**		**$9,200.00**

TABLE 9.3 Scenario 2 Payer Mix

SCENARIO 2: VOLUME × REIMBURSEMENT RATE = TOTAL REIMBURSEMENT			
THIRD-PARTY PAYER	**VOLUME (NUMBER OF VISITS)**	**PER VISIT**	**TOTAL REIMBURSEMENT**
Insurance B	10	$105.00	$1,050.00
Insurance A	25	$95.00	$2,375.00
Payer Medi	30	$85.00	$2,550.00
Payer Uni	35	$55.00	$1,925.00
Total	**100**		**$7,900.00**

CHOOSING TO PARTICIPATE

Some healthcare providers choose to not provide care to individuals whose services are billed to specific payers, due to the potential loss or liability incurred by decreased revenue. Others provide services but limit the percentage of patients whose payment is from a particular source. An example is providers who refuse or limit the number of patients covered by Medicaid. In many states the amount allowed for payment of Medicaid services is lower than payment by other sources. It is not uncommon in a community to find few or no providers for services paid by Medicaid. Whether to accept all payers or restrict those accepted into care based on the payment sources is a decision that encompasses financial, legal, and ethical considerations and the ability to fulfill the mission of the organization.

PROJECTING REVENUE

When calculating projected revenue, the difference between charges and reimbursement, or payment, must be recognized. Only the actual reimbursement amount can be projected as potential revenue. For example, Medicare and Medicaid currently only pay within specific dollar limits. Planning and targeting marketing of services should include defining all potential payers and estimating reimbursement levels. Contracts and agreements, such as care under preferred provider organizations (PPOs), rarely pay at the level of charges, but rather another amount agreed on, or a contractual charge. Some payers use the "customary and usual" guidelines for payment. Customary and usual payments are those that the payer determines by evaluating local or regional markets and assessing the usual charges for like services. Currently, this method is less prevalent than are negotiated contracts, such as those involving PPOs.

REFLECTION QUESTIONS

Among several issues in healthcare finance are cost shifting and "cherry-picking" (e.g., accepting into services those who have the best payers or demographics).

1. What ethical considerations come into play with these issues?
2. Are any principles outlined in the American Nurses Association (ANA) Code of Ethics violated by limiting accepted payers?
3. How are the financial needs of the organization balanced with ethical concerns?

Many contracts state a maximum amount per service that can be billed to the client. Whether or not the client can be billed for any difference between the charges and the designated reimbursement depends on the contract, and this can vary by service from the same provider of services. For example, a payer may not require a client copayment for an annual physical examination but have a set copayment for an illness visit. Expressed deductibles can usually be billed to the client. In addition to set rates, other factors to consider when projecting revenues are discounts, contractual allowances, the likelihood of uncollectable bills, and client copayments.

The time intervals between provision of services and billing, and between billing and payment for services, are significant factors when minimal operating funds are available. Scrutiny of these time intervals will reveal the impact on the organization's ability to meet financial obligations and the level of operating funds needed to meet obligations. Using a device such as the control chart can show patterns indicating the lengths of time from discharges to filing of claims, processing, and to receipt of payment. This will help evaluate the monetary flow of the organization. Any variances between expectations and actual time can be investigated. Lagging payments (i.e., increased time between receipt of claims and payments) are an ongoing concern.

In undertaking a business venture that requires funding, you must consider the level of *personal* financial liability that may be assumed. The structure and legal designation of the organization provides for specific "ownership" of liability. Consultation with legal experts on such issues is imperative. For example, liability, either personal or corporate, must be defined in the event the organization does not generate enough revenue to meet payroll, utilities, rent, and repayment of loans or other obligations.

BUDGETS

Oversimplified, financial management is simply a matter of managing, balancing, and projecting resources. Most simply, a budget is a plan that is a financial representation of an entity's intentions and expectations (Jones,

Finkler, & Kovner, 2013). It is based on expected revenue and expenses. Any difference between the budgeted amount and the amount expended is referred to as a variance. There are several approaches to budgets, such as the *static budget* (rigid, attempts to stay the same even if revenues and expenditures differ from expectations), *flexible budgeting* (allows for adjustments if revenues and expenditures differ from expectations), *zero-based budgets* (developed to achieve specific outcomes), and *rolling budgets* (requires a new budget be developed at the completion of the current budget—e.g., quarterly). Although each model of budgeting has its own advantages and disadvantages, the budget approach selected should support the function of the organization (Bragg, 2017).

A simple traditional budgeting approach (static) calculates annual incremental increases or decreases based on historical information about revenue and expenses. If it is "zero based," it is developed and justified anew (or from zero) each fiscal year. Creating a budget, or a financial road map, for an organization is an ongoing process. Possibly the biggest mistake made in budgeting is to assume that once a budget is constructed and implemented, the work is done until "next year."

Generally, budgets are created at the institutional or organizational level around designated cost centers. A cost center is a unit or department for which a budget is created and to which expenses are charged. A cost center may also be a designated source of revenue; however, depending on how the cost center is defined, revenue may be difficult to define. An example of this is a centralized cost center for nursing services in a hospital. The revenue for nursing services is often not detectable but rather embedded with other services or charges. Thus, expenses can be clearly defined but not the contribution to revenue.

Approaches to Budgeting

Budgets most often span a fiscal year. The fiscal year for a private organization is self-defined; for example, it could be from January 1 to December 31 or from July 1 to June 30. The choice of inclusive dates is influenced by the fiscal year of funding sources and reporting requirements of associated or governmental agencies. Public organizations would most often follow the appropriate government fiscal year.

There are two basic approaches to budgeting, as well as variations and combinations of the two. They are the historical or incremental approach and the zero-based budgeting or budgeting-by-objectives approach.

THE HISTORICAL OR INCREMENTAL APPROACH

The simplest and most commonly used approach is to base the following year's budget on budgets of the past, usually that of the previous year, assisted by data from the current year. A certain percentage is added or subtracted

based on increases or decreases in projected expenses. Investigations are conducted on more or less predictable changes, such as employee salaries, benefits, and costs for energy, supplies, and equipment. Actual expenditures of the preceding year are also considered. This expected increment or decrease (the difference between last year's budget and the expected expenses for the coming year) is added to the current year's budget, producing the new proposed budget.

The historical approach to budgeting is attractive because it requires less time commitment and expertise for those preparing the budget. The assumption of this approach is that business will continue into the future relatively unchanged. Therefore, it is especially useful in an organization with intentionally enduring services or programs and in a stable economy.

The downside of historical or incremental budgeting is that it tends to sustain existing departments, programs, or activities for better or worse. While change is not incompatible with this approach to budgeting, neither is it fostered by this process. A tendency toward maintaining the status quo may make it difficult to align organizational objectives with the needs of the community or with changes in the economy, reimbursement practices, or healthcare delivery. This could stem from a tendency to look within the organization rather than considering the external environment.

THE ZERO-BASED OR BUDGETING-BY-OBJECTIVES APPROACH

In contrast to the historical approach, the zero-based or budgeting-by-objectives approach makes no assumptions regarding the continuation of specific programs of the organization or of services provided. The budget is presented as a package that includes objectives, projected outcomes, and cost and revenue. Each budget unit must be justified and have definite objectives in line with the mission of the organization. Priorities are assigned to each of the unit budget proposals related to the mission and needs of the organization.

One of the strengths of zero-based budgeting is that a mechanism for discontinuing ineffective or inefficient departments or programs is inherent to the process, whereas historical budgeting tends to perpetuate the status quo. If the costs of a program or department cannot be justified in terms of intended outcomes or ratio of cost to benefits, then deletion must be considered. The danger of this approach is that financial benefit to the organization may be the sole factor used for this determination. Care should be taken to ensure that intangible benefits are considered. Public expectations, goodwill, mission, and community needs must be considered.

An additional strength of zero-based budgeting is that new and creative programs have an equal footing in terms of possible funding as do established programs. The organization can be more responsive to changes in the social, economic, and health delivery environments. Rather than being grounded in established traditions, new creative and innovative approaches to healthcare delivery

can be grounded in community needs, results of evidence-based practice (EBP), trials of community interventions, and opportunities for collaborative ventures.

Zero-based budgeting does have potential drawbacks. It is more time-consuming than the historical approach and requires a higher level of budgetary expertise. Employees may feel threatened by a perceived lack of long-term stability and viability of their work environment, because continued funding will be questioned and may suffer in competition with other programs. In this same vein, a sense of negative competition may exist among departments and programs. A department or program's continued existence may be seen to depend on the manager's ability to develop unit objectives, assign cost to achieving defined outcomes, and analyze the impact on the overall organization. The leader has an obligation to assist the units in best presenting their budgetary package.

Several conditions may influence the manner in which budgets are framed. Budgets are framed within a specific time period in each organization, which may include a set fiscal year or a continual rolling process over time. Budgets may be relatively fixed or flexible.

ROLLING BUDGET

A rolling budget is projected for a selected time frame in the future, for example, 3 or 6 months. While that budget is in effect, a new budget to follow that time period is developed. Thus, a budget is always in use and a new budget is always in development. Although this approach appears to be time-consuming (and it is), it is not as great a variation from the yearly budget as it may appear. In actuality, organizations are engaged in developing future budgets on an ongoing basis, even when employing yearly budgets. The advantage of the rolling budget is that it allows for shifts in needs and proprieties that become apparent during the current budget span, allowing for adaptation to changes in priorities and needs without having to restructure a budget or miss an opportunity due to budget constraints.

TRENDED BUDGET

A trended budget is useful when there is a predictable unevenness in services over the budget year. If 20% more services are provided in September, October, and November than in June, July, and August, budget appropriation for those time periods differ by that same percentage difference. This prevents unnecessary budget variances in these months, as well as a surplus of funds in one period that might have been better utilized in a different period.

FIXED VERSUS FLEXIBLE BUDGET

A fixed budget assumes that both revenue and expenses will be essentially the same from month to month. The total amount allotted to an expense for

the year is divided by 12 to determine the allotment for each month. A flexible budget, in contrast, is a budget that can be adjusted to reflect changes such as volume, labor costs, and capital expenditures (Johnston, 2017). The advantages of a flexible budget also apply to a trended budget but are enhanced. The ability to respond to changes in economics, patient care delivery, personnel needs, and emergencies is inherent in the flexible budgeting approach. What could be thought of as a disadvantage of flexible budgeting techniques—that is, the requirement for constant surveillance and synchronicity with both internal and external environments—is actually a business advantage. The biggest advantage of a flexible budget is the ability to make timely operational adjustments, if necessary (Johnston, 2017). For example, a home health agency may recognize that the cost of gasoline has increased and that travel expenditures are running over budget. Using a flexible approach, alternatives could be identified immediately and set in place to mitigate the cost increases. Collaboration with those at the point of care might provide assistance in defining alternatives without diminishing quality of care. In the previous example, it might be possible to sequence home visits more efficiently without diminishing quality.

In the past, the ability to access the data needed for successful flexible budgeting would have been impossible. Today, electronic processes and sources of information make it relatively easy. The first challenge to implementing a flexible budget is to ensure that a system is in place to collect the needed data (Johnston, 2017). Johnston, in relaying the experience of a large Midwestern organization, explained that organizations have less control over factors such as volume, case mix, and expenses than in the past.

Also noted are the difficult-to-predict and complex pay-for-performance penalties incurred due to readmissions and HAC, making the need for flexible budgeting approaches even more critical. These complicated conditions make the ability to adapt the budget to changes and challenges, allowing adjustments to occur during the year and informing the upcoming budget even more important.

Components of the Budget

Organizations often have a format for creating the budget that includes several components. The most common components are outlined here. The operating budget, mentioned earlier in this discussion, is the expenditure plan for daily operating activities of the organization. It includes budgets for each cost center and all expense units in the organization, as well as a projection of revenue (Yoder-Wise, 2011). The personnel budget is usually the largest portion of an operating budget. Personnel costs include wage and salary for each position and for each person, anticipated compensation raises, adjustments resulting in changes in personnel status, vacation relief, overtime pay, and temporary or seasonal help (Talley & Thorgrimson, 2018). Of this expenditure, 37.6% is currently

BOX 9.6 MAJOR COMPONENTS OF AN ORGANIZATIONAL OPERATING BUDGET

- Personnel
  - Salary and Wages
  - Anticipated Compensation Adjustments
  - Benefits
  - Recruitment and Orientation
- Capital Items
  - Facilities: Land, Buildings, Lease Agreements
  - High-Cost Equipment
  - Appreciation/Depreciation
- Supplies
  - Necessary Dispensable Items
- Travel
  - Local Travel Costs for Personnel
  - Out-of-Town Travel Costs for Personnel

required for employee benefits (U.S. Department of Labor, 2018). Consideration is also given to the cost of recruiting and orienting new personnel. Most organizations include a separate section on the cost of benefits, such as any health insurance and life insurance premiums that the employer pays, or payments made into retirement benefits by the employer on behalf of the employee. Both time worked and time paid but not worked must be included in the budget (see Box 9.6).

Personnel needs are usually calculated by full-time equivalents (FTEs), which, in turn, are calculated using projections of units of service or volume of services. Usually, an FTE is equated to working 40 hours per week for each week of a year, or 2,080 hours yearly (Yoder-Wise, 2011). The unit of service is defined by the organization (though influenced strongly by payers' definitions) and may be the number of clinic visits, admissions to service, treatments, and so on. For a continuing budget, past volume and productivity can be used to estimate future needs. For new services, descriptions of expected services, examination of similar services, and expert opinion of providers are useful in projecting personnel needs. For added or new services, orientation time for employees is a special consideration, and there is an expense any time there is turnover in staff.

The capital budget items are facilities and other nondisposable or high-end purchases such as land and buildings, machinery, and equipment. Each organization has its own guidelines regarding what constitutes a capital expenditure. For example, criteria may dictate that to be included in the capital budget, equipment and machinery items must cost at least $1,000 and have a life expectancy of

more than 5 years. Acquisition costs of equipment are calculated and prorated over the expected life of the equipment. Operating and depreciation costs are also calculated (Jones et al., 2013). Choices in equipment should be grounded in many factors, including the overall operating and maintenance expenses, human resource costs in educating staff to use the equipment, and clinical usefulness and ease of use.

Capital budget items may originate as a part of a cost center or work unit or be a part of the organization's strategic plan. In some instances, depending on the organization's policies, lease agreements may be subjected to the same type of budget proposals. A separate budget may be developed for future planned construction and may be referred to as the building or construction budget.

The supply budget ranges from disposable office materials such as pens and paper clips to clinical supplies, and it is usually the most flexible component of the overall budget. Some materials may require requisition forms; others must be immediately available. Some supply charges are considered a part of "doing business"; others may be billable patient supplies. Some supplies are stable in price; others vary over time. Tracking systems must be able to capture and match the classification of supplies and their accounting to a unit budget.

Budgeting Process

Regardless of the approach or technique used in budgeting, budget items or components must be justified. That is, it should be clear to decision-makers why each proposed expenditure is necessary. All expenditures should be tied to the mission, goals, objectives, and strategic plan of the organization.

As participation of stakeholders in the budgeting process increases, commitment to the budget priorities and outcomes also increases. An inclusive approach is especially important when resources may be limited. The leader can bring into the process midlevel managers and providers of care across disciplines in a workshop environment. Working collaboratively to complete a budget is not only fruitful, but it also establishes a forum for educating staff about the budget process, discussing mission and goals of the organization, and addressing concerns.

Managing the Budget

FLEXIBILITY

The degree of flexibility of budget parameters is affected by the type of budget, the seat of power and decision-making, and policies of the organization. Decisions can be swayed by perceived inflexibility of the budget, expressed as "The budget won't let us do it!" Rigid adherence to a budget may dampen creativity and squelch innovation, or even avert disasters, but choices about how to expend money are human choices. The budget is a management tool; it is

not a management entity in and of itself. Although resources must always be considered when making choices, accountability and responsibility for making a particular choice do not lie with "the budget"; they lie with leadership.

OVERSIGHT AND UNDERSTANDING BUDGET VARIANCES

One of the most useful tools for determining if a budget is on course is the variance report. The "variance" in this context means that the funds expended on certain budgetary items (e.g., salaries or supplies) are over or under the amount allotted. At first glance, you may think that being over budget is inherently a negative occurrence, while being under is a desired one. Although this is true, in general, it is critical to evaluate each occurrence. Being over budget on supply items may be detrimental to the organization if services provided are constant, but not if that overage is offset by an increase in revenue. Accordingly, revenue should also be monitored for consistency with budget expenditures. For example, an organization that provided services at the same level while revenue for units of services remains steady might still see total reimbursement decrease because supplies that could once be billed now must be absorbed into the organization. Due to efficient electronic data retrieval and management, reports can be generated in nearly "real time," providing an opportunity to correct any deficiencies.

Control charts are useful tools in determining patterns of variances, both for financial performance and the related quality indicators. They are essential for budgetary management. Control charts are graphically displayed measurements, presented over time, that help in determining variations, possible causes, and meaning of changes in metrics. Often, benchmarks are used so that variances outside desired ranges can be immediately noted. Specialized computer programs allow for easy creation of such charts, but office-based software that is probably accessible to you can be adapted for this purpose. Most large organizations employ their own charts or contract with providers of such programs. An example of a commonly used, ubiquitous program is Microsoft Excel, which provides templates and tutorials. However, these charts alone are not sufficient to perform the analysis. Connections must be made to real-world occurrences. For example, if overtime spiked over a period of time, it would be important to know whether patient visits were also higher due to seasonal illness as this might have caused staff members to become ill, leading to absences.

In considering the etiology of a budget overage, several questions could be asked:

Was it within your control? If so, was it something that could have been—or should have been avoided. Sometimes opportunities arise that just need to be taken and priorities revisited. Did it occur due to waste or lack of attention? If it was not within your control, you may still want to consider if any of your decisions or actions impinged on the matter, or if your actions might mitigate the effect of the overage (Jones et al., 2013).

REFLECTION QUESTIONS

Recall your experiences with budgeting.

1. Have you been involved in creating a budget or in managing one?
2. What is your comfort level in budgeting?
3. What issues might concern you?
4. What approach to budgeting is used at your workplace (or former workplace)?
5. Is it a "good fit"? Why, or why not?
6. What would you recommend as positive changes to improve the budgetary process?
7. What approach to budgeting do you find most attractive? Why?

EMERGING MODELS OF CARE DELIVERY: A GLIMPSE INTO THE FUTURE OF FINANCING

One of the criticisms of healthcare reform legislation is that it seeks to create a free marketplace atmosphere for the procurement of healthcare commodities in much the same fashion that other consumer goods are marketed and sold (Nix, 2013). Most might agree that the purchase of healthcare often carries with it emotional aspects and, not infrequently, emergent needs. Still, terms such as *value-based purchasing* and *reward value*—reimbursements linked to quality indicators—have invaded the literature and are our current practice reality. Finance and quality *are* linked. *Fee for service* is becoming an obsolete term. While these changes may be fast moving, confusing, and consumptive of energy and resources, they also present an excellent atmosphere for innovative change. This is the perfect time to be a DNP student!

Many of the obvious and most often discussed changes in finance have been present in the models of hospital payment by Medicare, and we know that other payers often follow suit. Aetna Insurance Company paid more than one quarter of reimbursements for healthcare in 2014 through value-based contracts with plans to increase this figure to three quarters by 2020. Blue Cross/Blue Shield paid 20% of claims in 2012 as value-based care, an amount that exceeded $65 billion. In addition, that insurer reported saving $500 million in 2012 as a result of fewer ED visits and admissions, and improved access to preventive care, attributed to value-based contracts (Bryant, 2015).

Changes in payment models continue in the provision of primary care. In a survey of 1,624 primary care physicians and 525 nurse practitioners and physician assistants, more than half reported receiving financial incentives based on quality or efficiency. Only one third of the physicians were being paid exclusively on a fee-for-service basis, and the percentage of nurse practitioners and physician

assistants was even lower (13%). One third of the physicians acknowledged that their practice qualified as a patient-centered medical home (Ryan et al., 2015).

Presently, Medicare has a multipronged effort under way to enact value-based payment, comprising patient-centered medical homes (PCMHs), the Transitions Programs, and emerging Chronic Care Management Programs and population-focused initiatives. A PCMH is a primary care model that provides accessible, comprehensive care to patients using a team approach. Patients and families are key members of the team. Other approaches to care are being tested through demonstration projects under the Comprehensive Primary Care Initiatives (CMS, 2015a). Details about this program and others are beyond the scope of this chapter, but they illustrate the opportunity to create new approaches to practice in your care environment.

NURSES AS INNOVATORS TO INCREASE ACCESS AND DECREASE COST

Nurses have a long history in innovations and inventions. The year 1911 brought Mrs. Sally Chase, a life size doll used in nursing education and developed by nurse educator Miss A. Lauder Sutherland. Mrs. Chase was followed by Arabella who was able to accept injections. In the 1960s, Nurse Ann Moore developed the Snugil, a carrier for an infant that can be used to carry the baby closely and with hands free, such as the way she observed women in Africa using shawls. After she patented this idea, she went on to introduce other inventions. Do not think that great ideas have waned. Only recently, the "GoGown" was invented by nurse Ginny Porowski. The GoGown reduces the chance for contamination after use by having a disposable sack inside the gown (Stokowski, 2014).

Did you know that a nurse invented the crash cart? In the 1960s, when the area of acute cardiology was emerging, Anita Dorr, a nurse in an ED, had an idea for a rolling cart designed to facilitate quick responses to cardiac events. It was designed for immediate access to supplies, materials, and tools according to the relationship to the patient's body and thus the use. She had her husband build a prototype but was not able to acquire a patent (Stokowski, 2014). About the same timeline but on the opposite side of the country, Joel J. Nobel, MD, had a similar idea. He was able to get funding for the development of a prototype and to obtain a patent (Life, 1966). Nobel's original crash cart protype, named "MAX," was donated to the Smithsonian Institute (Smithsonian, 2010).

Great ideas are not all about inventions; sometimes they are about making a product more usable for specific needs. An example would be "snugglers," a disposable diaper sized and designed for the tiniest babies, a product of collaboration between NICU nurses and Kimberly Clark. These diapers, developed for infants less than 2 pounds, required not only an adaptation in size but also material that would accommodate the especially sensitive skin (Cision Communications, 2017).

Emerging technology provides additional opportunities for innovations. An interdisciplinary team including nurse Dr. Sarah Rhoads developed the Angel Eye Web-Camera System at the University of Arkansas for Medical Sciences for the NICU. Although the idea was received positively by parents as a means of seeing their children, who could be in the hospital for months, the usability was hampered by both the complexity of the equipment the parents had to set up and by limits on the time frames for access. Continued research and development allowed these issues to be worked out. This project won the Raise the Voice Edge Runner award bestowed by the American Academy of Nursing (AAN). The award program is designed "to recognize nurse-designed innovations which improve care and reduce cost" (Rhoads, 2017).

The changes in healthcare payment in recent years, albeit at times confusing and even confounding, do provide opportunities (and demand) for innovations. The CMS sponsored 18 Community-Based Care Transitions Programs across the United States funded by Section 3026 of the ACA. The programs, operational between 2011 and 2017, focused on identifying Medicare beneficiaries who were at high-risk readmissions to hospitals and providing support at the discharge setting (CMS, 2017a). It is incumbent on nursing leaders and innovators to be aware of current needs, trends, and possibilities.

In a truly landmark initiative, the Robert Wood Johnson Foundation commissioned a study to analyze 24 nurse-driven projects that the Foundation had funded in recent years. Themes emerged from the study of the project to include programs designed to improve: (a) interdisciplinary collaboration, (b) the continuum of care, (c) the setting for care delivery, such as the home, (d) the needs of "high users," as an example, the geriatric population, and (e) the results, such as patient perceptions of outcomes or quality metrics (Robert Wood Johnson Foundation, 2009). It should be noted that 23 of the 24 projects created a new role for nursing. In the analysis of these applications, the characters of these 24 funded projects included the following four elements in final ranking criteria:

- Replicability, the ability to replicate the model widely in healthcare organizations throughout the country.
- Innovation, as exemplified by redesigned provider roles and teams, greater reliance on interdisciplinary teams, introduction of new technology, increased responsiveness to patients, and/or the redesign of the physical care environment.
- Sustainability of the model at the original organization and likely sustainability at replication sites.
- Demonstrated effect in terms of reduced cost or use, improved patient safety and quality, improved patient and provider satisfaction, and ultimately the ability to reduce the long-term demand for acute care nurses. (Robert Wood Johnson Foundation, 2009, p. 13)

TRANSFORMATIONS: A PROCESS AND AN EXPERIENCE

Transforming an idea or need into a sustainable (and possibly an income-producing) product or program takes careful planning. As a nurse leader, you may be in the position of not only promoting your own innovations, but also in the support of others. Evidence supports a positive relationship between nursing staff's innovative behavior with entrepreneurial leadership. A study involving 273 participants found that this approach to leadership stimulates and sustains idea generation, implementation, and support for new ideas (Bagheri & Akbari, 2018).

Although the full details of product development or program planning and development are beyond the scope of this chapter, the idea of protecting the nurse innovator's financial interest is not. For instance, many times it is prudent to obtain a copyright or patent. One definition of copyright is the following:

> … a form of protection provided by the laws of the United States for "original works of authorship," including literary, dramatic, musical, architectural, cartographic, choreographic, pantomimic, pictorial, graphic, sculptural, and audiovisual creations. "Copyright" … has come to mean that exclusive rights (are) granted by law to copyright owners for protection of their work. Copyright protection does not extend to any idea, procedure, process, system, title, principle, or discovery. Similarly, names, titles, short phrases, slogans, familiar symbols, mere variations of typographic ornamentation, lettering, coloring, and listings of contents or ingredients are not subject to copyright. (Copyright.gov, n.d.)

Publishers who would wish to publish a manuscript submitted by an individual or group would require ownership of the copyright; however, individuals can also copyright materials.

A trademark protects words, phrases, symbols, or designs identifying the source of the goods or services of one party and distinguishing them from those of others (Copyright.gov, n.d.). Most of the images you see representing products are registered trademarks.

A patent, however, protects inventions or discoveries. Ideas and discoveries are not protected by the copyright law, although the way in which they are expressed may be (Copyright.gov, n.d.). A patent grants the property right to the inventor and is issued by the U.S. Patent and Trademark Office (USPTO). Generally, a new patent provides these rights for 20 years from the date of application (U.S. Patent & Trademark Office, 2015).

There are three types of patents: (a) utility—a new and useful process, machine, that is original or a significant improvement; (b) design—a new, original, and ornamental design for an article of manufacture; and (c) plant patents (U.S. Patent & Trademark Office, 2015).

Fees for patent applications can be considerable. To determine if someone may already have a patent on your idea of invention can be challenging. While the final search is conducted by the patent office, you may conduct your own search. The Public Search Facility of the USPTO can be found in libraries located throughout the United States that have been designated as Patent and Trademark Resource Centers (U.S. Patent & Trademark Office, 2015). Very often, applications are made with the assistance of a patent expert or patent lawyer.

However, much work would need to be accomplished before a patent or other application is made, if needed and even before the idea is presented to others. Rhoads (2017), reflecting on the Angel Eye project, derived questions to aid in determining a focus for interventions:

TABLE 9.4 Transforming the Idea into an Innovation

Research	Find out if others have begun on this path. Do they already have clear "ownership"? Even if the process, invention, or idea is not unique to your idea, replication is an option not chosen often enough! How does the literature inform your idea? Do not limit yourself to nursing literature.
Vision	Given your own thoughts and what you have learned from others and from the literature, reflect on what you want to occur or create. Nurses will focus on the effect on patient care, but also consider the effect that implementation could have on your career development and opportunities and for the potential of financial advantages.
Collaborate and consult	Give this careful thought but connect with others who have similar interests and those you trust. You may also want to consult professionals. (Will you require a patent?)
Begin planning	Give flesh to your vision. Consider the input of others. Consider financial and resource requirements.
Develop a preliminary presentation	Although you need to create a clear story of your vision with the "nuts and bolts" related to critical components, be protective of your information before sharing it in any public forum. You should protect your priority and financial interests.
Make the decision	Decide if you want to commit to this idea. If so, then begin with management tools and processes to develop your idea.

- What makes my program innovative?
- What healthcare challenge am I addressing?
- How does my innovation reflect the nursing perspective?
- How do I measure the success of the innovation—clinical outcomes, financial outcomes, and dissemination of the innovation? (Rhoads, 2017, p. 44)

Once these areas of clarity are addressed, a process can be begun (Table 9.4).

RATIONAL RISK-TAKING

When resources are designated to produce a specific outcome, there is always a certain amount of inherent risk in reaching for that outcome. Although you can develop skills to forecast changes affecting organizational, economic, and social environments, exact outcomes always remain certain.

> Rational risk-taking is about taking risks for all the right reasons. It is more than thrill seeking and experience enhancing; it is focused on and consistent with the organization's goals, values, and resources, as well as consideration of others involved. This kind of risk-taking can be organized into four categories: advancing the organization, developing skills, mandatory reporting, and whistle blowing. (Porter-O'Grady & Malloch, 2016, p. 20)

Fear of risk taking can paralyze decision-making and deter organizational success. Porter-O'Grady and Malloch (2016) suggested that rational risk-taking is a leadership skill that can be learned and practiced. Rational risk-taking requires shifting from the notion that risk-taking is negative to developing the skills to promote success of a complex and evolving organization.

It is worth saying again that opportunities abound. The current healthcare environment is in acute need of the skills of the DNP. Clinical redesign is a financial imperative that must be accomplished by a partnering of financial and clinical experts. Collaboration and valuing of each team member's contributions are necessary to achieve the difficult balance of cost containment and revenue maximization; of sustainability or stability and responses to change; and of the continuing need of "traditional" care and the movement toward population-focused preventive care. The dynamics of care must be explored by the expert clinician (i.e., you) to ensure not only the best in care to individuals, but also the restructuring of care delivery from an improved systems perspective.

CONCLUSION

Any words on the rapidly changing environment of healthcare finance would likely be taken as an understatement. Yet, as complexities increase in both payment and care delivery models, foci on outcomes and on patient-centered care,

and on the roles of healthcare providers, there are those who call for even more transformation. Indeed, many welcome and support it. It should be remembered that the roles of nursing are a function of the needs of those in our care. Recall that in the aforementioned projects funded by the Robert Wood Johnson Family Foundation and analyses, 23 of the 24 provided for new roles for nurses. This responsiveness of nursing to the emerging needs of the population aligns with the values and priorities of the nursing profession.

In chaos theory, the "edge of chaos" is a conceptual term that denotes the space between chaos and order and is a place of transition. It involves the tension between being not quite stable and dissolving into turbulence. As healthcare economics continue to change—and they surely will—in the courts, the legislation, and consumer expectations—as movement continues from a service model to a market model, the edge of chaos will support cognition and creativity, in the understating of societal needs and will be manifested as evolutionary. These changes in financial rules, regulations, models, and even available resources will likely result in the discarding of what has become familiar and embracing new innovations in healthcare finance. It has been posited that creative destruction is the driving force within a market economy with new innovations is constantly generated by entrepreneurs by displacing older ones in continuous cyclical dynamic change (Bloch, 2018). It could be surmised, then, that the greatest potential for energy and momentum for change from a financial perspective lies when the tension between order and chaos are most dynamic. An awareness of these potentials is essential for the nurse leader.

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CHAPTER 10

Leading Across Systems of Care and in the Larger Community

Marion E. Broome and Elaine Sorensen Marshall

You are not here merely to make a living. You are here in order to enable the world to live more amply, with greater vision, and finer spirit of hope and achievement. You are here to enrich the world, and you impoverish yourself if you forget the errand.

—Woodrow Wilson

OBJECTIVES

- *To understand the importance of the ability to take the perspective of other leaders when working on common goals and organizational initiatives*
- *To describe how education and training influences perspective and collaborative behaviors*
- *To identify how differences in generational cohorts influence a leader's approach to planning and execution of ideas*
- *To identify various regulatory and political arenas in which leaders of nursing operate and to recognize strategies to improve the viability of nursing expertise*
- *To describe actions of a nurse leader to widen a sphere of influence in the larger community*

INTRODUCTION

Current healthcare environments are complex, uncertain, and changing in ways we never imagined. Important changes in American demographics that will ensure change in healthcare are: (a) sheer growth in population and migration patterns from one part of the country to others, (b) increasing racial and ethnic diversity, (c) dramatic aging of the population, (d) prevalence of overweight and obesity among younger generations with concomitant increase in chronic

conditions, and (e) the epidemiology of illness and care moving from acute to chronic, and from hospital to community. These changes will require strategic thinkers and leaders across health professions, finance, and information technology who can work together to address the myriad of challenges in healthcare.

Healthcare institutions are confronting the need to consider business decisions they have rarely faced before. Mergers of hospitals and ambulatory and surgical care centers into larger systems have increasingly changed the landscape of healthcare and require leaders to think and act across systems of care (Burnes-Bolton, 2018). For example, how many primary care practices can one system support to provide a "customer base" from which to refer patients to specialists within the system? How many nurses are needed in primary care settings to manage the chronic care needs of patients (Bodenheimer & Mason, 2016)? Must a system maintain all patient care services within its network (e.g., rehabilitation)? How many primary care providers (APRNs, physician assistants, and primary care physicians) are needed to manage the number of individuals within a network? Hundreds of other such questions challenge leaders within healthcare systems at all levels. As accountable care models change the emphasis to one of securing cost-effective, high-quality outcomes within a fully integrated system, leaders of all professions and disciplines will be asked to think of new ways to work together to generate solutions to system problems and to support their workforce to enact shared decisions. Such bold, creative moves will surely change how we think about healthcare financing, coverage, services, and systems (Schur & Sutton, 2017). How we predict and prepare for a better future depends on how we as leaders understand each other and how we all work together.

Never has the need been greater for an army of visionary leaders to join in the transformation of healthcare to meet the challenges of the next generation. Supreme among the challenges is the requirement to work together and to understand each other. Leaders are serving in a time of challenge when simply understanding the language, practice, and culture of other disciplines is not enough. We must come to the table, understand each other's perspectives, and work together to seek common solutions to challenges facing healthcare.

KNOWING THE OTHER LEADERS AND TAKING THEIR PERSPECTIVE

The enterprise of healthcare comprises dozens of different highly trained clinical and management experts representing a broad range of preparation, theoretical perspectives, disciplinary bodies of knowledge, practice experience, and viewpoints. Given the number and complexity of issues that nurses, physicians, and other healthcare leaders deal with within their own sphere of responsibility, it is easy to understand their siloed approach to an average workday. Although we interact cordially with professionals from other disciplines, we often approach our work in parallel without meaningful attention to the perspective of our colleagues. Yet, patients, families, and all providers in the system rightfully expect that we truly understand each other as we work together.

Throughout the history of healthcare, members of various disciplines have been educated, trained, and set out to engage in practice almost solely from within the narrow perspective and traditions of a single discipline. On occasions, once we enter the real world of practice, we run into each other in areas where the disparities in power and influence erupt. This sometimes happens when we notice that "someone else" is doing the tasks to which we have become accustomed as our territory. Physicians can become distressed when nurse practitioners write prescriptions; nurses resist registered care technicians at the bedside; radiological technicians are upset when dental assistants take x-rays. Even within disciplines, RNs complained when licensed practical nurses first inserted IV needles, and radiologists complained when the obstetricians first used the ultrasound machine. We have fought disciplinary battles over obstetrical forceps, venipuncture, ownership of the button on the x-ray machine, and, most recently, who can be addressed as "doctor." We assert authority over the skills and tools we were taught to use. For example, policy statements from medicine continue to set barriers for advanced practice nursing (Hain & Fleck, 2014). Such actions are unbecoming to professions that profess healing and altruism at their core.

And the current system is not a sustainable model in terms of efficiency and cost-effectiveness of care models. In fact, in a recent study of the percent of time RNs spent practicing to the full extent of their license activities, the average was less than 10% (DeGroot & McIntosh, 2018). This is just one example of how one professional group is not using skills and education to function at the highest level. The redundancies in our healthcare systems in terms of overlap of responsibilities and gaps in the care delivered demand new interprofessional models of care that save money and increase access and quality (Dy, Major-Joynes, Pegues, & Bradway, 2016; Ireland, 2016). Patients, families, and the communities we serve deserve better. This means the next generation of leaders must respond with authentic understanding and interprofessional collaboration. Excellence in healthcare demands our ability to understand and work together at the most basic levels.

It is important to understand the context out of which the present situation evolved. Disciplinary boundaries for preparation, expertise, and scope of practice are important to confirm order, develop expertise, and provide clear public information about professionalan accountability. But the public needs to be informed by wisdom and not by squabbles over tools, procedures, and titles. We must work together for the good of our communities, and begin to do that by cultivating the basic skill of professional perspective-taking.

Perspective-taking is the empathetic understanding of another's viewpoint, way of thinking, motivation, or feelings (Dugan, Bohle, Woelker, & Cooney, 2014). It goes beyond simple understanding of the "other" to include the ability to interpret back the other's viewpoint from his or her frame of reference as well as to convey empathy. It requires that we reflect on our own viewpoint, and practice seeing the world through the prism of the other. From an interprofessional

viewpoint, we can begin to build authentic working relationships by learning each other's history and traditions; by reflecting on our similarities, differences, and mutual priorities; by reading each other's literature and policies; and by basic respect for and recognition of our need for each other as we work together (Burnes-Bolton, 2018).

It is simplistic and commonplace to point to "the other" discipline as the problem. First, the unbecoming behaviors of physicians and nurses who continue to point to each other as uncivil and to be blamed for lapses in care delivery have become old and tired and, in many cases, can place patients at risk when communication links are broken. Second, we need to move beyond attempts to highlight the virtues of our own discipline over how we work together. For example, often, nurse leaders emphasize the contribution of nursing or herald the "voice of nursing." Often, what is needed is to take the perspective of other healthcare disciplines to move the agenda forward for improved healthcare. Taking the broader perspective enhances understanding of the "whys" of intention and behavior, while not requiring that one agree with that line of reasoning or behavior. Of course, nursing and medicine are not the only disciplines that confront these kinds of tensions; a kind of egocentrism is present to some degree in all professions. The wise leader is at least aware of this tendency and is willing to look at the horizon through a different frame of reference.

How does one begin to take the perspective of another discipline? The first step is to understand the education and training used in that discipline. Times have changed a great deal in the last 5 years within disciplines. For example, pharmacy schools teach injection skills, schools of medicine have moved clinical experiences with patients to the first year, and nursing schools have added a significant number of community health experiences as well as increasing preparation in chronic care management. Another simple strategy is to ask questions of the next physician or physical therapist you meet. You might ask, "What was your favorite experience in caring for patients?" "Which part of your education did you find the most challenging?" "Why did you decide to become a physician, or pharmacist, or physical therapist?" Their answers will tell you a lot about your colleagues in other healthcare professions. And be sure to share your stories as well.

Another common problem in professional disciplines is to focus on the time-valued activities within the profession without considering resources or the bottom line for the whole. The worn phrase "Follow the money" is a truism (Steinbrook, 2009). Clearly, we need another phrase, such as "Follow the care to the patient" (Cassell & Guest, 2012). Patient-centered care is a core value on the website of many health systems. How we act out that core value is what really counts. Far too many systems, policies, and procedures in healthcare are provider-focused (and not just other professions but nursing as well).

We cannot adequately take the perspective of the other if we do not know about our colleagues in other disciplines. We need to understand the basic

philosophies that underpin the knowledge and practices of each discipline, how and why we prepare our clinicians in the way we do, and what are our values are. We need to understand each other's fears, hopes, and aspirations. We believe you will find that as nurses we have much in common with other health professionals.

Working Across Disciplines, Styles, and Models

There is hope on the horizon. In the United States, we are beginning to foster collaborative ventures between medicine and nursing—especially in professional education—in learning didactic, clinical and evidence-based practice (EBP) skills (Albarqouni, Glasziou, & Hoffman, 2018; Melnyk, Gallagher-Ford, Long, & Fineout-Overholt, 2014). Globally, new nurse-led models of care are becoming more prevalent, and the evidence supports their effectiveness in reducing readmissions (Ireland, 2016; Lambrinou, Kalogirou, Lamnisos, & Sourtzi, 2012), as well as improved health outcomes and cost reductions in all settings (Oliver, Pennington, Revelle, & Rantz, 2014).

"Working across styles" refers not only to different characteristics among disciplines or personalities but also to actual styles of practice or practice model designs. Leaders who are multilingual across disciplines are needed to develop and implement such organizing principles. Systems that integrate across disciplines are better able to meet population healthcare needs, link information systems between providers and patients, and coordinate care across settings. Models that build "integrated practice units" not only treat disease but engage individuals in care, encourage adherence, provide health education, and support needed behavioral change. However, these processes demand a "village" approach to care delivery. Teams will have one primary goal: Improve outcomes through review of data on performance, develop and test new protocols, collect data to personalize care, and assess changes in both patient and provider performance (Porter & Lee, 2013). Disciplinary squabbles about who does what will detract from optimal performance and affect access, quality, and cost of care.

Primary care is an important example in current healthcare debates. To meet the needs for primary care, it will be especially important for physicians, physician assistants, and APRNs to work together to understand the perspective of the other to best serve the public. This will affect practice, business affairs, educational preparation of practitioners, and licensing regulations. For example, a growing trend in primary care is the retail clinic. Clinics inside large big box stores or pharmacies, such as CVS or Walmart, have attracted controversy and debate, largely because they are "different," but are gaining increasing traffic from consumers who find their approach and convenience attractive. The nearly 3,000 such clinics across the United States (a threefold increase since 2010) provide an opportunity for transformational leaders to

collaborate not only across disciplines but also across new approaches to care. But the cost-effectiveness of these clinics is influenced by state regulations about scope of practice, which are slow to change (Robert Wood Johnson Foundation, 2016). And now that Amazon has entered the market it is hard to tell what this landscape will look like in the future. Many of these models use APRNs to deliver high-quality, cost-effective care for common health conditions and there is no reason to think this trend will decrease. So, nurse leaders need to understand these new models and how they provide care for the same individuals as those in their health system and think about developing new interprofessional models of care that can also provide cost-effective, high-quality, and accessible care.

Another interprofessional model is the "medical home," a concept advocated in 2007 by a consortium representing the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association. It is officially named the *patient-centered medical home* (Kellerman & Kirk, 2007). Early principles of the medical home included the provision of a personal physician for each patient, a focus on primary care, a physician-directed medical practice, whole person orientation, coordinated or integrated care, quality and safety, enhanced access to care, and payment structures that "recognize the added value provided" (Kellerman & Kirk, 2007, pp. 774–775). The current iteration reflects the team-based model (physician, APRNs, physician assistants, and medical assistants) that has expanded to provide chronic illness management in ambulatory care (Bodenheimer, 2011; Washington, Coye, & Boulware, 2016), as well as care delivery models for entire communities. The medical home has increasingly included nurses at the heart of the model (see Aktan, 2016; Corso & Gage, 2016).

Despite its initial flaws, a model that values a healthcare "home" for primary care and care coordination for patients and families is highly needed and becoming a reality for progressive health systems that recognize the advantages of value-based care. Our challenge now is to secure the broadest perspective of patients, communities, and healthcare disciplines in the construction of care models that enhance the patient experience and provider satisfaction (Buerhaus, 2018).

Working Across Generations: Every Leader's Challenge and Opportunity

As the healthcare workforce becomes more diverse, leaders will have opportunities to work with people not only from a greater variety of disciplinary backgrounds, but also across the range of generations. We now recognize some general common characteristics in various generational groups. Of course, those commonalities do not represent specific individuals, but they do provide a general guide to understand generational perspectives.

Current popular culture recognizes traditionalists (Silent Generation), born between 1925 and 1945, who have been socialized to stay in a specific workplace, or even the same position, over an entire career and thus may be resistant to change. Baby boomers (Boomers), born between 1946 and 1964, are also generally loyal to their work and to their employer. However, members of Generation X (Gen X), born between 1965 and 1980, show no such loyalty but may rather seek immediate rewards, advances, recognitions, and benefits. Gen Xers are individualists who search for career meaning and purpose. They are not impressed by authority or traditional hierarchical organizations. If they do not get what they seek, they will go somewhere else. We are now also working with Generation Y (Gen Y or Millennials), who were born pre-wired for electronic technology (Chou, 2012). They seek the immediate and customized service that technology has always provided them, and they are less willing to see the value of personal sacrifice for an employer (Malleo, 2019). A new generation, called the New Silent Generation (Gen Z), born between 2000 and the present is on the horizon.

Nurses who have been surveyed follow some of the same patterns of beliefs and work–life behaviors. Keepnews, Brewer, Kovener, and Shin (2010) studied 2,369 newly licensed nurses and found significant differences among Boomers, Gen X, and Millennials on 12 different dimensions of work-life, including job satisfaction, supervisory support, work-to-family conflict, and organizational commitment. For instance, job satisfaction, work-to-family conflict and group cohesion were highest for Millennials, with no differences reported on autonomy, organizational commitment, and collegial relations with physicians. A more recent survey (Faller, 2018) among 3,347 nurses revealed that, compared with nurses from other generations, Millennials are more interested into moving into leadership positions, have more concerns about their work environment affecting their health, and are less loyal to a specific employer. At least 35% of all workers in the United States are now Millennials.

The informed leader cultivates a background in such sociological and cultural information. Keepnews et al. reminded us that differences must be recognized in all aspects of the professional nurse's work climate, from orientation through evaluation. To develop and support the next generation of leaders, doctorally prepared nurse leaders must recognize how younger nurse professionals view their work as well as sources of satisfaction, and then leverage opportunities to maximize productivity. For instance, work–life balance is clearly more important to younger professionals, which lends another dimension to shaping care delivery. A particular difference that leaders may want to think more about while working with Millennials is the need to provide consistent feedback about their performance. Generally, they learn from others and tend to shape their performance based on constructive, specific feedback (Stewart, Oliver, Cravens, & Oishi, 2017).

REFLECTION QUESTIONS

1. What age group are you in? How do the values and traditions and perspectives of that generation and their experiences influence your approach to leadership?
2. Over 40% of the nurses who work for you are from the Millennial generation. Last year the attrition rate for this age group was 50% higher than other age groups. A group comes to you and says they need to "grow more," "learn more," and "hear more" about how they are performing. How would you approach engaging them in activities that would address their concerns and improve retention?
3. The younger, new graduates hired into your clinic or unit have been asking for mentors. You decide to ask administration for an altered staffing model so you can include one of the highly respected, knowledgeable seasoned nurses in the indirect-care schedule for half the work week to serve as a mentor and resource for these nurses. How would you craft your request to administration to justify that change? How would you advise this nurse to spend his time with the five new hires for the next year?

SUCCEEDING WITH REGULATORY ORGANIZATIONS

Within the culture of professional healthcare is the ever-present heavy hand of regulation. Indeed, healthcare has become one of the most regulated industries in modern society. Ginter, Duncan, and Swayne (2013) described numerous external organizations that regulate healthcare, which include the following:

- Government agencies such as Centers for Medicare & Medicaid Services (CMS), Centers for Disease Control and Prevention (CDC), and the Food and Drug Administration (FDA), the Occupational Safety and Health Administration (OSHA)
- Business organizations that provide accreditation or regulate healthcare practices such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Committee on Quality Assurance, and Magnet™ in the American Nurses Association (ANA)

In addition, there are other specific compliance requirements, such as privacy protections from the Health Insurance Portability and Accountability Act (HIPAA), protection of human subjects in research, health information technology standards, nondiscrimination regulations. Employees in most healthcare organizations and university health professions schools are required to complete training (sometimes online, sometimes in person) in as many as five to seven of these various compliance policies and regulations. To the leader at any

level, enforcing the vast array of external regulations can be daunting, but they cannot be ignored. Most importantly, it is crucial that the leader set the pace in this area through his or her on-time completion of requirements as well as by providing for the success of others.

Although these responsibilities may appear overwhelming, most accredited healthcare institutions have processes and personnel in place to help the organization sustain compliance with myriad regulations. Your job as a leader is to ensure that such offices and people perform to their fullest, support their work, champion compliance, and integrate compliance with your own vision, as well as integrating quality and performance within your organization.

Beyond the employer, the first-level regulatory body for professional nursing practice in the United States is the state board of nursing, which takes its authority from the state legislature. Each U.S. state has its own practice act that governs the scope of nursing practice and its own regulatory body, usually called the board of nursing. Practice acts outline the authority, scope, and criteria for licensure. State regulatory boards differ considerably, especially in their requirements related to advanced practice nursing and the scope of practice for nurses in each state.

As a leader, it is important to know and understand your local and state regulations. Critical issues related to autonomy and practice authority, particularly for APRNs, are yet to be resolved. For example, there remains a vast range of state regulations regarding prescriptive authority. As of 2019, there are 23 states where nurse practitioners are allowed "full practice," defined as the authority to "evaluate patients; diagnose, order and interpret diagnostic tests; and initiate and manage treatments, including prescribing medications and controlled substances, under the exclusive licensure authority of the state board of nursing" (American Association of Nurse Practitioners, 2019; Campaign for Action, 2019). These states are largely in the West and Midwest regions of the country. More states with restricted practice are located in the Southeast region with some of the poorest health outcomes in the country. Advanced nursing practice has evolved in response to consumer demand and financial issues, yet the role remains constrained in some areas due to public policy challenges at the state level, although some areas of the federal government have changed reimbursement patterns in substantial ways and these are expected to change even more (Iglehart, 2013).

As a leader, you must be visible and build relationships with the regulators, including members of boards of nursing, legislators, and other civic leaders who have influence on healthcare. Regarding scope of practice, legislators are often heavily influenced by professional organizations, such as the state medical association. Be an active part of your state nurses association and be available to provide testimony to support expansion of APRN roles so that patient access can be improved, and costs of healthcare reduced. It is critical as a transformational leader to be an integral member of the professional community at large.

Personal relationships have been instrumental in legislative changes more often than well-written, well-reasoned proposals.

Although unions may not be considered regulatory organizations, they can exert considerable influence on regulations and practices within your organization. In 2019, unions represented 10.5% of all workers in the United States and in 2019, 20.4% of all RNs were represented by unions (RegisteredNursing.org, 2019). The best-known union is probably the United American Nurses, formed in 1999 as an independent affiliate of the ANA. Laws related to labor relations in public healthcare facilities vary across states. As a leader you need to be aware of how these rules influence your ability to speak with legislators, nurses in the union, and so on. Generally, employees have the right to organize and bargain collectively, strike, grieve, and arbitrate issues. Many unions speak for issues that directly affect not only nurses but care delivery (Turner, 2018).

Regardless of the regulation load, keep your perspective as the leader. Remember that such regulations and programs are designed to make your work better. Do not allow yourself to become either buried in overwhelming "stuff" or beguiled by illusions that compliance or guarantee human caring. Remember your vision and purpose to help others to promote health and care for the sick and suffering. You are the guardian of the human processes and the humanity in your organization.

WORKING WITH THE GOVERNING BOARD

Working with the board of trustees of your organization can be one of the most unique and rewarding aspects of your life as a leader. Boards usually include selected members of the community, representing a broad range of experience in healthcare from none to considerable. Since boards have a fiduciary responsibility to represent the community, there is increasing expectation of responsibility in financial oversight. This requires considerable orientation, training, and preparation for effective service (Walton, Lake, Mullinix, Allen, & Mooney, 2015). That is usually the job of the leader of the organization, working with the director or president of the board.

During your career as a leader, you may be responsible for recruiting, working directly and collaborating with, or actually serving on a board. If you work for a hospital or nonprofit organization, you may work directly with your board of trustees. In 2014, the American Academy of Nursing (AAN) joined 34 other organizations, founding strategic partners and sponsors including AARP, ANA, Sigma Theta Tau International, and the American Organization of Nurse Executives (AONE), to promote the appointment of 10,000 nurses to boards by 2020. This national coalition will implement a strategy designed to bring nurses with their expertise to governing boards in health-related sectors (Campaign for

Action, 2014). As of 2019, over 10,000 nurses are registered and over 6,000 board seats filled.

The board of trustees is the governing body of the hospital. The board can vary in size from 10 to 20 members—usually from industry and business, nonprofit organizations, clinician leaders with experience in business, and community members. The board members are responsible for developing and reviewing the hospital's overall strategic plan, mission, and finances. The board guides the long-term goals and policies for the hospital by making strategic plans and decisions. Members of the board of trustees are not involved in management; rather, they set the vision and assess its implementation through careful oversight As part of their oversight duties, the board of trustees sets the job description for the chief executive officer (CEO) and is responsible for hiring, firing, and monitoring of the CEO. The board typically sets clear goals and expectations for the CEO in keeping with the strategic plan. The board's trustees oversee the employee credentialing process, making sure healthcare professionals have proper training, licensing, and accreditation (Boardeffect, 2018). Each board, and each situation, is unique. If you have the opportunity to recruit members to your own advisory or governing board, think strategically. Consider needs for the makeup of the board itself, but especially for your organization. All members of the board must care deeply about your organization; loyalty is the prime qualification. If you need fundraising, identify people who will either make significant donations or have connections with those who may. Be prepared to accommodate a range of types of participation. I (Marshall) served on a board where one member seldom engaged directly in board activities, but had a key legislative connection. Be creative in including such board members in activities outside the board meetings, in committee subcommittees, and as well-informed advocates or representatives of your organization to the community at large. Make sure that all board members understand the mission of the organization and tell the same story—your story!

As a leader with stature, you will likely be invited to serve on the board of another agency in your community. Some board members are compensated; others are expected to provide voluntary service. If you serve on a board, you can benefit from positive personal relationships with other board members to influence decision-making, resource allocation, and the strategic direction of the organization (DiMattio, 2015). This raises a broader concern. Especially in board service, the possibility of conflicts of interest must be considered.

A conflict of interest occurs when personal or private interests exist that may interfere with professional or public responsibilities or interests. As a leader, at some point, you will be confronted with a potential conflict of interest. It may be the offer of an inappropriate personal gift or the opportunity to gain personally from a professional or public endeavor. Conflicts of interest involve the use of position, power, or influence to gain advantage for self or others, and seldom occur because of actual malicious intent. Such advantages may be large

or small; personal, political, or financial. A conflict of interest may be actual, perceived, or potential.

It may not always be easy to recognize a conflict of interest. It helps to ask the question, "If this worked for me, would I think this was appropriate?" Or, "If this appeared in the newspaper, would it be something I would be proud of?" Then trust your inner voice. Confer with a wise mentor or leader. Sometimes, it is enough to simply disclose the potential conflict of interest publicly so that everyone involved is aware that you have some personal involvement in the issue. Other times, you must remove yourself from the situation, refuse the offer, or decline the opportunity. It may be helpful to consult the legal counsel within your organization if the potential conflict is significant or even just ambiguous. If the conflict precludes your service on one board, be assured that other opportunities will come. Whatever your action, the ethical response always offers personal peace and potential future opportunities. In many institutions one is asked to annually disclose any conflicts of interest once a year. The conflicts could include things normally viewed by professors as part of their service to the profession. I (Broome) am the editor of *Nursing Outlook, The Official Journal of the Academy of Nursing*. In that role, which consumes about 10

BOX 10.1 NEW MEDIA: NURSE LEADERS AND THE GOVERNING BOARD

TED Talks

Drew Dudley: "Everyday Leadership" 2010 (6 minutes)

Stanley McChrystal (Gen. retired): Listen, learn…then lead 2011 (16 minutes)

Susan Carter: "What's love got to do with it?" (6 minutes)

Videos

Bob Dent. "2018 AONE Year-End Address." January 2, 2019. YouTube: AONL Nurse Leaders.

Terence Mason, RN, BSN. (2017). "The reason I serve." Nurses on Boards Coalition (www.nursesonboard.org)

Transforming Health Care Through Nurse Leadership: Campaign for Action. (2015)

2019 Nurse Day at the Capitol. Texas Nurses Association. www.texasnurses.org. Andrew Cates' interview

Blogs

Blog.modernhealthcare.com

Blog.Tedmed.com

Thehealthcareblog.com

to 12 hours a week of my time, I receive a modest stipend from the publisher. In my annual conflict of interest (COI) disclosure I share that role and the amount I am paid. That form goes to the university's compliance office for review and I am expected to develop a COI plan that will remove even the hint of COI on my part, for instance, I would not participate on the library committee deciding what journals to order.

Finally, be aware that on occasions, decisions you make as a board member will not be popular with other nurses (DiMattio, 2015). As a board member you are not there to represent nursing alone, but rather the interests of the system as a whole. That is not to say your perspective as an experienced nurse working with patients, families, and care systems will not be valued; it will be. But it will not be your role to advocate for nurses or the department of nursing. This may place you in a difficult position, but if you support decisions for the right reasons you will sleep better at night. People notice and respect the ethical leader.

See Box 10.1 for resources focused on nursing leaders and their role as members of governing boards.

WORKING WITH LAWYERS, LEGISLATORS, AND POLICY MAKERS

The practice and leadership of nursing are integrally related to decisions of law, government, public and private payment organizations, and a variety of other legal entities. Such groups affect standards, practices, and payment for care.

If you serve any time as a leader, you may at some point be involved directly or indirectly in litigation. Most often lawsuits involving nurse executives are related to patient safety or breaches in duties performed by subordinates who report directly or indirectly to the executive. The leader facing litigation for the first time quickly realizes that he or she did not learn about this in school. And, since no one talks about it at work, you may feel unprepared and alone. In this situation, it is easy to think, "I must be the only one this has ever happened to." That is not true. Because of the discreet, confidential, and often distressing nature of most issues of litigation, few people talk about them. Usually, these issues have little or nothing to do with you as the nurse executive personally; rather, you are named because of the specific leadership position held. Regardless of the situation, the adversarial nature of such events can be overwhelming and sometimes devastating.

If you find yourself in this situation, seek legal help immediately. Begin by contacting legal counsel within your organization, if such exists. In any position of leadership, you should have already cultivated a positive relationship with your institutional general counsel (i.e., attorney). If you have a personal issue in the case, seek your own attorney. Remember that the organizational counsel's priority is to protect the corporation, not you personally. If you are called to give a deposition or to testify in a case not related to you, still seek counsel. You need

a lawyer to help you prepare. Usually the institution's counsel will help prepare you for such testimony—whether in a deposition or in court. Do not forget the following three simple rules when you are deposed or testifying under oath in court:

1. Listen to the question.
2. Answer the question (and *only* the question).
3. Then stop talking.

Also remember that most legal cases go on for what seems like forever. You must find a way to live your life alongside the case. Let it unfold, attend to it when required, and continue your best performance as the leader you are. In the meantime, while the case unfolds you are expected to keep all the case details confidential. For any leader this can be difficult as the person who brings the suit may share his or her side of the story with many in your workplace. That may be the only side others will hear and may, in some cases, believe that side. Just stay on the course and be patient. If asked about the case, simply state that you cannot provide any information as the case is under litigation.

Most activities in the public arena will not have direct legal implications but rather be related to influencing public policy. Public policy refers specifically to sources of such rules, actions, and decisions specifically from government agencies. Simply stated, policy comprises the official plan, rules, and decisions regarding how resources are allocated to a specific purpose. Health policy includes the "rules, actions, and decisions by government and private bodies—which affect the delivery of healthcare and the processes by which health care takes place" (Keepnews, 2008, p. 270).

The transformational leader in healthcare must be fluent in current issues and activities related to health policy. Resources, regulations, and decision-making in healthcare are increasingly influenced by legislative and professional policy. Policy fluency affords the leader the opportunity to provide input and be proactive rather than reactive to measures that affect healthcare organizations. A significant number of Doctor of Nursing (DNP) practice programs include offerings on health policy to improve understanding and skills in negotiating policy issues, such as scope of practice, healthcare compensation, the effect of care delivery models, and related issues. To improve policy literacy, nurse leaders may participate in policy training programs, graduate courses, or studies of information, which are provided by nearly every major healthcare organization.

In 2019, there were two nurses serving in the United States Congress and many more in the state legislatures (ANA, 2019). Many of them have shared that their nursing background provided them with interpersonal, analytical, and advocacy skills to represent their constituencies. The Congressional Nursing Caucus is a group of members from both parties whose backgrounds help them provide a voice in Congress for the healthcare needs and professional values of

nursing. These members can be especially helpful to the profession in addressing nursing issues.

In an interview in 2014, two nurse congresswomen, Lois Capps (D-CA) and Diane Black (R-TN), emphasized the critical importance of nurse leaders who can lend voice and skill to the national healthcare policy agenda (Robert Wood Johnson Foundation, 2014). The American Association for Colleges of Nursing (AACN) prepares valuable tool kits each year outlining the issues and talking points for those visiting with their legislators (AACN, 2015). It is an important opportunity to speak with your own legislator in the state or Congress.

Key points for interacting with your legislator include the following:

- Be prepared for a 15-minute maximum visit.
- Prepare your elevator speech, which should include only a few powerful salient points.
- Include short data points that support your premise.
- Use stories or examples of nurses who make a difference.

These stories are especially helpful to legislative aides who prepare briefs for the legislators. Many of these are the same skills you use daily as you prepare to have a conversation with a patient or family member.

To convert your practice, research, or project to policy, observe what kinds of evidence are best accepted by legislators and policy makers and what kinds of projects are funded. Identify networks within your community and become part of them. Lewis (2009, p. 125) called these "networks of influence." They use knowledge and practices from frontline caregivers on interdisciplinary teams, and contribute real stories to policy makers, with images that make policy needs real.

Always have your 30-second elevator conversation ready. Practice it to yourself, emphasizing no more than three major points of your issue. Prepare an internal script that you can recite, with passion, in any situation. Keep it short, clear, and compelling. Then watch and wait for the perfect opportunity. I (Marshall) knew of an influential leader who was prepared. She needed support for a major change initiative from the highest level—the president of the corporation. Without regular access or optimal timing, she simply prepared and waited. She practiced her 30-second approach. She watched and waited. Finally, she coincidentally met the president in an airport security line. When he asked the generic innocuous question, "How is it going?" She was ready. She knew she had only about 30 seconds. She did not hesitate; she did not force, mumble, fumble, or whine. She simply repeated the main points she had rehearsed for weeks. She took advantage of the "luck" of the circumstance through supreme preparation. The president responded with interest and intrigue. Soon, she was *invited* to the president's office to share her idea, which eventually culminated

in full support for her plan and her inclusion as a trusted professional colleague at the highest level of the institution.

HAVING INFLUENCE IN THE POLITICAL ARENA

Influence is power. And so is knowledge, so use your knowledge and expertise to shape the story you want to tell when working with other leaders. Influence is the capacity to compel change in ideas, action, and results. Having influence is one of the most important and fulfilling gifts of being a leader. It is also a gift any leader must be careful to use judiciously.

Just as policy is ultimately a decision about how resources are allocated, politics is largely the distribution of power. Power involves making decisions to use the resources where one thinks the most benefits will be accrued for the organization's mission, and political power resides in who gets to make the decision (Gebbie, 2010). Resources can be time, people, or money. Leadership includes elements of policy and politics. In the larger arena, healthcare leadership may include effective *response* to policy and politics but must also include effective *influence on* policy and politics. Lewis (2006) analyzed the history of the influence and power of medicine on policy. All healthcare disciplines can learn from medicine's example to use ties of association and effective use of positional and personal influence. To be effective as a leader, you should engage in the policy arena and network with other people of influence. The report, *The Future of Nursing,* from the Institute of Medicine (2010) reminded us that nursing has not maximized its political power and to create long-lasting change we must learn to do so. Education alone will not be sufficient unless we use our political power and influence.

It is well recognized that influence on policy requires collaboration and networking across a variety of interests. "Strategic alliances" are described as a way to promote collaboration across organizations working toward policy-related solutions to common problems. One contemporary example of a constructive alliance is between nursing and the AARP. In this partnership, both groups come together to influence policy related to the health and well-being of aging individuals in the community. As nurses test innovative models of care to improve health of the elderly (Popejoy et al., 2015), the AARP works to disseminate information about the new innovation as well as influence policy makers to think of new ways to care for frail elders.

So how does all this relate to you now? You are likely leading, planning, or even contemplating some extraordinary or innovative project that might be expanded beyond your organization to make a difference in the larger community. At the outset, think larger. Include policy makers on your team. Invite your local government official, state legislator, or even your congressional representative. Become active in understanding and participating in regulatory initiatives. Regulations are most often developed as a result of bad care rather than

promotion of good works (Mason, 2010). The only way to influence a change is to become involved and to involve policy makers directly in your good work.

Mason (2010) outlined barriers related to policy that restrain the advancement of innovative models of care. They include national position statements and state regulations that limit the scope of practice of nonphysician providers (Buerhaus, 2018). Other barriers include limitations on reimbursement by insurers and payers to nonphysician providers. These barriers are further extended to definitions and credentialing of the medical or health home. In many cases, such restrictions are not necessary for quality and may interfere with access. Mason (2010) also pointed to a list of nurse-related barriers to policy that supports innovative programs. The list includes "lack of clinical and financial outcome data," limiting reports to descriptions of programs and recipients served, and "failure to recognize the mandate to translate research into practice and policy." Another key barrier is the inability to translate or "scale up" creative interventions beyond a local use to larger applications (Mason, 2010).

The United States continues to be embroiled in debate regarding the national healthcare policy (Auerbach, Buerhaus, & Staiger, 2018). The issues are highly entangled regarding health insurance reform, mandated health insurance coverage; healthcare structures and paradigms such as the medical or health home; education for health professionals; scope of practice and roles of various health professionals; and ongoing issues of cost, access, and quality of healthcare. Among the most difficult questions are how to support health promotion and disease prevention initiatives, promote innovation, manage chronic conditions, and reach rural and underserved populations (Auerbach et al., 2013). All these areas are crying most for creative leadership from nurses and health professionals.

Yet, too many nurses opt out of policy discussions. Coming from educational preparation that provided little or no training in policy, and heavily involved in patient care inside the clinical setting, nurses often do not see policy involvement as a priority. Demands of healthcare now require that nurse leaders join other professional leaders to influence and implement policy. As an expert clinician moving to the role of transformational leader, you have the preparation and tools to lead, and have the social responsibility to influence policy. Mason (2010) reminded, "Society, and nurses themselves, should have higher expectations for what nurses can achieve, and… nurses should be held accountable for not only providing quality direct patient care, but also for health care leadership [in policy]."

Opportunities to become involved in making a difference in policy and politics abound. Speak up and speak out on institutional and public policies. In your role as expert, communicate on specific issues with policy makers; communicate in public forums through both traditional media and emerging social media; and connect and partner with other healthcare leaders. Think creatively about influencing policy from a new perspective. For example, every state land-grant institution has an agricultural extension service that provides valuable

public information. What would happen if we had a health information extension service? Just a thought—what would be the policy implications? Finally, seek and take opportunities to serve on corporate boards, hospital boards, boards of health, and nonprofit organizational boards at the local, state, and national levels. If your professional association is part of the Nurses on Boards Coalition (2016), work through their offices and let them know who you are, what your experience is, and your interest in serving on boards. Think about running for office in your local area, including boards of health, city council, or state legislature. Who knows where it will lead you, and where you will lead? Get your message to the public.

Throughout these experiences take the opportunity to learn from others, read widely, and study the biographies of great public leaders. Join and participate actively in national professional organizations. Collaborate broadly at every opportunity. Mentor, sponsor, and empower others to expand the influence of your own leadership. Think of yourself operating in different spheres: locally, nationally, and globally. Transformational leaders recognize and promote the talent of others. They transcend the bureaucracy of their environments to raise all workers to higher levels.

TRANSFORMING PRACTICE AND POLICY IN THE LARGER COMMUNITY

Regardless of your practice or leadership role, your work environment includes the community beyond your institution. Just as individuals must lead from a collaborative interprofessional perspective, organizations within communities are interdependent and function best within the larger community perspective. There are various stimulating ways to serve.

As you continue your journey as a transformational leader, you will have opportunities to work with a variety of community agencies, including nonprofit organizations. In these times of cross-setting collaborations, partnerships, and mergers, the skill of showing authentic interest in working with others for the benefit of all is an art in and of itself. As a respected community leader, you may be invited to serve on the board of directors of a nonprofit organization. It is important to understand the general characteristics of nonprofit organizations. Although hospitals are usually considered nonprofit—especially those associated with academic health centers—here we are talking about nonprofit community agencies.

Most nonprofit organizations function with a specific mission. "They rally under the banner of a particular cause" (Rangan, 2004, p. 112) such as homelessness or other underserved populations. Nonprofit organizations are particularly mission driven. Rangan (2004, p. 114) explained, "After all, the mission is what inspires founders to create the organization, and it draws board members, staff, donors, and volunteers to become involved. What's more, the founders often deliberately try to assure that their original vision is embraced by the next

generation of leaders." Nonprofit organizations usually depend heavily on a financial base laid by private donations and grants. Thus, nonprofit organizations are closely tied to the community in which they reside, and the contribution of board members usually focuses on helping to secure donors.

Your experience with strategic planning and outcomes evaluation can be especially helpful if you serve with a nonprofit organization or any other community agency. Although most nonprofit organizations are strong on mission, they are less able in translating the mission statement to an operational mission and strategy process. Because they are usually single-mission focused, there is little need to identify integration of specific programs. An operational mission can bring quantitative measurement and evaluation to the "lofty" inspiring mission. Then, specific objectives and strategies can be implemented. As a leader in healthcare this is certainly an area in which you could put your skills to use (National Council of Nonprofit Boards, 2019).

REFLECTION QUESTIONS

1. Have you ever written an opinion paper (Op-ed) on a topic you are an expert in, and others want to know more about? If not, do so and send it to your local newspaper.
2. Do you know the names of your state legislators? U.S. Congressmen and women? Go to the website of your professional organization or ANA and look that up—it is easy. Send your Op-ed to them!
3. Run for one of the committees in your professional association, local chapter, or state nurses association. Then work your way up to the board of directors for that organization. You will learn so much, get to know other nurse leaders and have an opportunity to make a difference in the lives of other nurses.

Preparing to Influence

The messages of this book have been directed to expert clinicians who are launching their careers as leaders. As you think about your own preparation to influence, consider advanced leadership preparation beyond the terminal degree. The Sigma Theta Tau International (2019) and the American Organization of Nurse Leaders (note that in 2019, the AONE changed its name) both offer leadership training experiences ranging from short-term conferences to 18-month leadership academies. And today most healthcare systems are very concerned about the resilience of its employees, about retaining them long term and about promoting their careers and building leadership programs you may be able to take advantage of. Take advantage of the opportunity to engage in larger arenas

where you might interact with leaders from all disciplines. Make a commitment to never stop learning or growing.

Several formal leadership development programs are designed to help you build on your current preparation and experience to enhance your influence. A few others are described briefly here as examples. The Wharton Nursing Leaders Program (Wharton Executive Education, 2019) is directed toward high-level nursing leaders preparing for the role of chief nursing officer of a healthcare organization or a deanship. The program addresses the complexity of leadership in healthcare, strategic planning, resource management, decision-making, and team building. The Harvard Business School (2015) offers several short- and long-term programs in leadership development, including programs in managing healthcare delivery and higher education.

If you aspire to leadership in higher education, many programs and fellowships are offered by the AACN (2019) and the American Council on Education (2019). The Higher Education Resource Services (2019) provides short-term residence programs specifically for women aspiring for higher education leadership. The Center for Creative Leadership (2019) also offers a range of programs for women and members of racial minorities in management positions. Several other creative endeavors to promote leadership development in specific areas offer programs, consulting, or information. For example, the Robert Wood Johnson Foundation combined with the Kellogg Foundation to support the National Center for Healthcare Leadership (2019), which has created Leadership Excellence Networks as a platform for healthcare systems to share best practices in leadership development. Many highly reputable university business schools offer executive development programs. Seek out and participate in programs that may be offered at your own institution. A simple search and talking with other leaders produces a large variety of programs and opportunities. The cost of such programs varies widely, from $1,000 to $10,000. Choose the best and make the case at your organization for the return on their investment in your preparation and networking as a leader. Negotiation for your preparation is instructive in itself to refine skills to negotiate ideas, projects, and changes related to your larger stewardship as a leader.

By the same token, generativity is an important part of your stewardship as a leader. “Paying it forward” includes the development of others and the creation of a learning organization for those within your institution (see Box 10.2). Supporting people in formal leadership development programs is not only helpful to the individual, but also powerful in the message of support for advancement and excellence in your organization, and it attracts useful networks to your work. Your influence is also critical to the next generation of leaders. Wise influence from a perspective of generativity includes succession planning at all levels. Healthcare has been behind other industries in succession planning in leadership (Carriere, Muise, Cummings, & Newburn-Cook, 2009; Titzer, Phillips, Tooley, Hall, & Shirey, 2013). Succession planning for positions throughout the nursing organization requires that time be spent identifying

BOX 10.2 LEADERSHIP IN ACTION: DEVELOPING EMERGING LEADERS

As a nurse leader you have been asked to develop a leadership program for emerging leaders from medicine, pharmacy, nursing, and social work in your health center. You are asked to present your proposal to the System Executive Leadership team, which includes the CEO, CMO, CNO, Human Resources VP, and CFO. Develop a 15-slide PowerPoint and address each of the following points:

- The need for the program
- Duration and time required outside of learning sessions
- Topics and learning activities
- Timeline
- Cost to the organization, including direct and indirect time away from patient care activities
- Expected return on investment (ROI)
- Evaluation strategies
- Anything else you think would be useful to justifying the use of organizational resources to develop next generation of leaders.

Source: Hagemann, B.: *Creating a leadership development program* (1 hour). Lynda.com (This incredibly useful resource is accessible through most universities)

potential leaders and providing them with development opportunities outside the organization, feedback on their performance, and regular assessments of their learning.

Leading to Transform

It is important to understand various levels of influence in leadership. Within your healthcare organization, the primary goal is to support those who deliver direct care for the people or populations served by the agency. At this level nurse managers, directors, and executives now have budgets they must monitor and stay within. They make decisions about resource allocation and management. At higher levels of state, regional, or national service, you have the power to influence regulations, policy, and resources. You and your nurse colleagues at this level will be asked to make decisions regarding how money is allocated and for what services. At the international level, you have the influence to make recommendations for healthcare policy across nations.

Opportunities to advance your influence abound throughout the world. Do not limit yourself. At the international level, you can influence policy for improved healthcare across the world. Global issues call for leadership to solve issues of worldwide shortages of healthcare professionals, especially nurses, and other important issues of international disaster and humanitarian services

(Negus, Brown, & Konoske, 2010). Become acquainted with and involved in international efforts. The International Council of Nurses (ICN) is a federation of national nursing organizations from 130 countries, representing over 13 million nurses throughout the world. ICN's current initiatives include championing the contribution and image of nurses worldwide, advocating for all nurses, advancing the nursing profession, and influencing health, social, educational, and economic policies (ICN, 2020). Think global: How might you become involved? What knowledge, skills, and insights as an American nurse might you bring to that arena? What could you learn from international colleagues about healthcare leadership?

International or global influence may take the form of involvement at the global level, as with the International Council of Nurses (ICN) or the World Health Organization (WHO), or a more local foreign partnership perspective by collaborating on specific issues with international partners, such as capacity building of nurses in direct care in developing countries, or participating in one of many international nursing mission opportunities. It is challenging, and well worth it, to work with partners in another country. It opens your vision and your view to new perspectives on old problems. You gain insights into cultural influences. You learn new perspectives of time. You discover different priorities. When the needs of your partner in a developing country may be as basic as water sanitation, you learn about different resources. And you share work across different technologies (Riner & Broome, 2014). The WHO has recently declared 2020 as the "Year of the Nurse and Midwife" to identify, recognize and celebrate all the contributions of nurses to peoples' health around the world. Find ways in your organization to celebrate this as well!

You have prepared and cultivated the characteristics and habits of a transformational leader. You are able to function as a leader in a broad range of contexts, and you understand the power of culture. You embrace challenge. You know when to sustain tradition and when to be bold with innovation. You build and nurture your team. You understand economics and finance. You have prepared to become the leader the world needs.

You will have the greatest positive influence as a transformational leader if you are authentic and speak the truth. Authenticity means that you know and understand yourself. You are aware of your influence and effects on others. You can take the perspective of another. You are aware of your own values and strengths, and you can recognize the values and strengths of others. You are sensitive to the context in which you work, and you are "confident, hopeful, optimistic, resilient, and of high moral character" (Avolio, Gardner, Walumbwa, Luthans, & May, 2004, p. 804). People can believe you and count on you, and they want to work with you and for you. You live your values.

If you feel like you are not the person described, you can be. You can practice every day. Reflect on your progress at the end of the day, identifying what was the best part of each day. You bring the credibility of experience

in expert clinical practice to the joyful places you create as environments for healing.

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