Linda Roussel • Patricia L. Thomas • James L. Harris

EIGHTH EDITION

Management and Leadership

FOR NURSE ADMINISTRATORS

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The Pedagogy

Management and Leadership for Nurse Administrators, Eighth Edition increases comprehension through various strategies that meet the learning needs of students while also generating enthusiasm about the topic. This interactive approach addresses different learning styles, making this text ideal for ensuring mastery of key concepts. The pedagogical aids that appear in most chapters include the following:

CHAPTER 1

Forces Influencing Nursing Leadership

Linda Roussel

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LEARNING OBJECTIVES

1. Discuss current trends in healthcare management and their impact on quality, safety, and value-added care (care delivery).
2. Envision care delivery systems for the future.
3. Discuss major influences—specifically, Institute of Medicine (IOM), Agency for Healthcare Research and Quality (AHRQ), Institute for Healthcare Improvement (IHI), Magnet, Baldrige, and other major stakeholders—in healthcare systems.
4. Identify how ethics relates to managing healthcare services.

AONE KEY COMPETENCIES

I. Communication and relationship building
II. Knowledge of the healthcare environment
III. Leadership
IV. Professionalism
V. Business skills

AONE KEY COMPETENCIES DISCUSSED IN THIS CHAPTER

II. Knowledge of the healthcare environment
III. Leadership
IV. Professionalism

II. Knowledge of the healthcare environment

- Clinical practice knowledge
- Patient care delivery models and work design knowledge
- Healthcare economics knowledge
- Healthcare policy knowledge
- Understanding of governance
- Understanding of evidence-based practice
- Outcomes measurement
- Knowledge of, and dedication to, patient safety
- Understanding of utilization and case management
- Knowledge of quality improvement and metrics
- Knowledge of risk management

Learning Objectives Each chapter includes learning objectives that help readers identify and discuss important concepts from the text.

American Organization of Nurse Executives (AONE) Key Competencies AONE Key Competencies are outlined at the start of each chapter, focusing student attention on important concepts in the material.

III. Leadership
- Foundational thinking skills
- Personal journey disciplines
- Ability to use systems thinking
- Succession planning
- Change management

IV. Professionalism
- Personal and professional accountability
- Career planning
- Ethics
- Evidence-based clinical and management practices
- Advocacy for the clinical enterprise and for nursing practice
- Active membership in professional organizations

FUTURE OF NURSING: FOUR KEY MESSAGES

1. Nurses should practice to the full extent of their education and training.
2. Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
3. Nurses should be full partners with physicians and other health professionals in redesigning health care in the United States.
4. Effective workforce planning and policy making require better data collection and information infrastructure.

Introduction

According to GOV2020 (n.d.), we can expect a number of changes with the dominant 2020 healthcare trend: health care everywhere. Noteworthy are trends in mobile health applications, telemedicine, mhealth, remote monitoring, and ingestible sensors generating robust streams of data. This data allows providers and patients themselves to track sleep patterns, heart rates, activity levels, and caloric output in real time. GOV2020 identify categories for healthcare leaders to be on the alert for: health care in developing countries, healthcare systems, next-generation care, patient-powered health care, and the data revolution. For example, when considering health care in developing countries, frugal health care is a dominant theme. Specifically, universities, medical technology giants, and even mobile phone companies are developing portable diagnostic tools that can created for just 1% of the cost of traditional medical devices. Good examples include developing countries pursuing a back-to-basics approach to prevent disease, such as washing umbilical cords with antiseptic to reduce infections among newborns. No-nonsense models such as Aravind Eye clinic and Narayana Hrudalaya in India, and franchise "clinic-in-a-box" models such as Unjani in South Africa, provide affordable care augmenting overstretched public healthcare systems (GOV2020, n.d.). Health systems are changing with such examples as communities as healthcare providers and expanded definitions of health. Skilled healthcare professionals are experiencing shortages (around the globe) particularly with an aging population and expanding disease burden. To address these issues, the community is stepping up and increasingly providing community outreach, peer-support initiatives, and greater partnering with patients and families to expand care options. Notable are developing nations who are using community healthcare workers (with minimal training) to provide education and supportive treatments using diagnostic

Future of Nursing: Four Key Messages Four key messages focused on the nurse's role and practices appear at the beginning of each chapter to help guide students as they read.

Introductions Important concepts and topics covered in each chapter are highlighted at the beginning of the chapter to help focus students' attention on the essential material.

to occur in health care. Consumers are calling for fundamental m, and new models such as the A-ICU call nursing's attention to of the work and how the workforce rethinks patient care delivery, s.
onceptualize the tools and strategies we use to create change. This cond-order change, occurs when there is a fundamental shift in an Frameworks for second-order change, although in need of further nore informative in guiding healthcare transformation. They call quires new learning. A new story is being told.

Changing Time, Location, and Relationship

The forces for change in health care are affecting the critical connection between nurses and patients. Patients no longer come to us as a captive audience. Historically, we have enjoyed a relationship with our patients based on the fact that they depend on us in the hospital at a time of acute vulnerability. Today, 56% of patients in hospitals stay for 4.5 or fewer hours. This has economic implications as well as implications for our survival.

If we want to maintain our signature relationship with patients, we must find ways to stay connected to them personally, but not necessarily in the place where we treat them. We must reimagine our definitions of how we serve patients and believe in them. The need to create work structures, employee work arrangements, and organizations that allow nurses to span episodes of care is critical.

New models, such as the advanced medical home and value-based competition, are built on concepts that have traditionally been in the nursing purview, such as compassionate, culturally sensitive, and coordinated care. These models may provide a venue to support our social contract with patients, but we must be involved in their evolution and testing. Research is needed to demonstrate qualitative and economic value and to evaluate designs that reinvent the role of nurses.

SUMMARY

We are in a new world of health care, and standard operating procedures (SOPs) may no longer serve the patient and the healthcare system. Understanding the organization through different lenses, such as CASs, may provide new tools for enhancing performance. Change, innovation, and infusion of evidence-based practice also contribute to greater efficacy and efficiency in leading. Being armed with an understanding of evidence-based practice and quality indicators improves one's success in creating a safe environment for patients, their families, and the workforce. Without transparent, authentic leadership, there is little hope for real change that can be sustained over time. The health of patients and families who are entrusted to our care depends on our courage to be great and to continually strive for excellence. It is the hope of these authors that increasing knowledge, skills, and abilities can serve this end.

REFLECTIVE QUESTIONS

1. Considering your own practice setting, discuss current trends in healthcare management and their impact on quality, safety, and value-added care (care delivery).
2. What innovative strategies do you envision leading in your own practice setting as you fast-forward to the future?
3. Describe major influences—such as the IOM, AHRQ, IHI, Magnet, Baldrige, and other major stakeholders—in healthcare systems.
4. Identify how ethics relates to managing healthcare services.

Reflective Questions Reflective questions appear at the end of each chapter to engage readers by asking them to apply the principles they have just learned.

Case Studies Case studies provide real-life scenarios for students to consider the nurse's role in the future of nursing.

18 **CHAPTER 1** Forces Influencing Nursing Leadership

CASE STUDY 1-1 Who Speaks for the Patient?

Debbie R. Faulk and Arlene H. Morris

J. E. is the chief nursing officer (CNO) of a midsized regional hospital. One evening an older person was found unresponsive at a nearby long-term care facility, placed on ventilator support, and transferred to J. E.'s hospital. This person is awake and alert and has end-stage chronic obstructive pulmonary disease and severe rheumatoid arthritis with little likelihood of being weaned from the vent. Due to the patient's long-term chronic diseases and limited prognosis secondary to the illnesses, the lifetime Medicare reserve days are nearly exhausted.

J. E. has been informed that the prior long-term care facility has no beds for readmission and that other hospitals or long-term care facilities in the geographic area are reluctant to accept transfer of this patient. Additionally, there is no family willing to care for the patient at home; the only living family members are two stepchildren who live in another state. They have requested that the patient be transferred to a facility that provides ventilator care. The physician assigned to provide care said, "The most humane plan of care is to take the patient off the vent and allow a peaceful death through comfort care after extubation." It is anticipated that discontinuation of ventilator support will result in death, likely within a week.

J. E. believes there are only two options: extubation as suggested by the hospital physician or continuing care for the patient with the ventilator until death. The stepchildren call the case manager, who refers the call to J. E. The stepchildren are informed about the patient's status and the two options. J. E. tells the stepchildren that the physicians are concerned the patient has no quality of life. Although J. E. requests consent to extubate, the stepchildren would not consent, stating they wanted to wait until December 26 to decide. When J. E. asks why they desire to wait and possibly prolong suffering, the stepchildren reply that they do not want to associate the memory of the patient's death with a holiday. The stepchildren ask how to get someone else appointed to make decisions. J. E. had been informed by the case manager that if a state agency appointed a legal guardian, the stepchildren could not have a say in funeral arrangements. J. E. relays this information to the stepchildren, who are upset about no input regarding the funeral, but they ask no other questions.

The stepchildren later call back and consent over the phone to withdraw life support and request to be informed when the patient dies. J. E. is concerned about the phone consent and decides that a consent form would be worded as follows: "We, _________ (name) and _________ (name), understand that if the ventilator is removed, death will likely occur soon, but this is in the best interest of _________ (name of patient)." This consent form is sent electronically to the stepchildren, who sign the form and return it. J. E. then asks the case manager and the primary nurse to sign as witnesses on the form. However, the case manager says that the signing had not been witnessed and asks J. E. if a notary should have been involved and a hard copy of the form sent by mail. J. E. replies that electronic consent forms are part of the healthcare world as long as two people are present. The case manager and primary nurse express concern that the consent could have been coerced and actually provide for the physician to end the patient's life. J. E. asks another case manager and nurse to sign as witnesses for the consent form, and they agree. However, the patient's case manager and other nurses on the patient's unit begin discussing possible legal and ethical implications of these actions and ask if a line had been crossed.

Morris & Faulk, 2012.

Case Study Questions

1. What factors initially contributed to the development of this situation?
2. Do you believe there were other options besides the two presented? Explain your thoughts.
3. Describe the ethical concerns for each of the following:
   The patient
   The family members
   The primary nurse
   The case manager
   J. E.
   The physician(s)
   The case manager and nurse who signed as witnesses
   The hospital as an organization
   The healthcare delivery system

References This section in each chapter lists additional material that is referenced throughout that chapter.

CASE STUDY 1-1 Who Sp

4. Describe the legal implications for eac
5. Who was the advocate for this patient
6. Was a consideration related to the pat
7. What would you have done if you we

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Dedication

We are most appreciative of our contributors and their staff members, patients, families, and students. We thank you for your commitment, tireless work, and passion for safe, quality healthcare environments for our consumers and for those entrusted to our care. What we hope for all nurse leaders, regardless of setting, is that they will find themselves leading dynamic teams and engage in making sense of the many challenges we face in health care.

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Contents

Foreword xxi
Preface xxiii
Contributors xxv
Introduction xxxi

PART I Leading in Times of Complexity and Rapid Cycle Change

CHAPTER 1 Forces Influencing Nursing Leadership **3**
Linda Roussel

Learning Objectives 3
AONE Key Competencies 3
AONE Key Competencies Discussed in This Chapter 3
Future of Nursing: Four Key Messages 4
Introduction 4
Organizational System: Context for Trends and Change 6
Principles to Create Future Care Models 7
Nursing-Sensitive Indicators, Safety Standards, and Quality Indicators 13
Summary 17
Reflective Questions 17
Case Study 1-1 Who Speaks for the Patient? 18
References 19
Selected Websites 21

CHAPTER 2 Leadership Theory and Application for Nurse Leaders **23**
Linda Roussel and Patricia L. Thomas

Learning Objectives 23
AONE Key Competencies 23
AONE Key Competencies Discussed in This Chapter 23
Future of Nursing: Four Key Messages 24
Introduction 24

What Do Leaders Do? 24
Leadership Versus Headship 25
Transformational Leadership 29
Strategic Leadership 34
Leadership and Just Culture 36
Nursing and Leadership Healthcare Policy 36
Future Direction: Quantum Leadership 37
Innovative Leadership 37
Summary 39
Reflective Questions 39
Case Study 2-1 Is a Leader a Leader Only When Paid? 39
Case Study 2-2 Managing Conflict 40
References 42

CHAPTER 3 Professional Practice: A Prototype Linking Nursing in Interprofessional Teams 45

Gay Landstrom and Donald D. Bignotti

Learning Objectives 45
AONE Key Competencies 45
AONE Key Competencies Discussed in This Chapter 45
Future of Nursing: Four Key Messages 46
Introduction 46
The Call for a Different Approach 48
Interprofessional Collaboration 50
Interprofessional Practice Partnerships 51
Summary 53
Reflective Questions 53
Case Study 3-1 Academic–Clinical Partnership and Team Cohesion 54
References 55

CHAPTER 4 Executive Coaching as a Lever for Professional Development and Leadership in Healthcare Organizations 57

Patricia L. Thomas, Micki McMillan, Patricia A. Barlow, and Lesa Becker

Learning Objectives 57
AONE Key Competencies 57
AONE Key Competencies Discussed in This Chapter 57
Future of Nursing: Four Key Messages 58
Introduction 58
Expectations for Nurse Leader Professional Development 59
Systems Thinking as a Framework 60
Qualities and Characteristics of Effective Leaders 60

Emotional Intelligence 61
Burnout and Resilience 63
Mindfulness 64
Learning Organizations and Professional Development 66
Coaching 66
Summary 72
Reflective Questions 72
Case Study 4-1 Chief Nursing Officer Development: Transformational Coaching 72
Case Study 4-2 Group Executive Coaching for Directors of Nursing and Service Line Administrators 74
References 76

CHAPTER 5 Leading in an Era of Change and Uncertainty: Driving Excellence in Practice While Developing Leaders of the Future 81

Lisa Mestas, Sheri Salas, Rita Stockman, Patricia L. Thomas, and Linda Roussel

Learning Objectives 81
AONE Key Competencies 81
AONE Key Competencies Discussed in This Chapter 81
Future of Nursing: Four Key Messages 82
Introduction 82
TeamSTEPPS 83
Population Health 85
Positioning Nurse Leaders for Success 87
AONE Nurse Leader Competencies 88
Complexity Science and Health Care: Implications for Nurse Leaders 97
Summary 97
Reflective Questions 97
Case Study 5-1 Aligning Strengths and Opportunity to Lead Effective Teams 98
References 98

PART II Leading the Business of Health Care: Processes and Principles

CHAPTER 6 Organizational Structure and Accountability in Healthcare Systems 103

Anne Longo and Linda Roussel

Learning Objectives 103
AONE Key Competencies 103
AONE Key Competencies Discussed in This Chapter 103
Future of Nursing: Four Key Messages 104

Introduction 104
Overview 105
Organizational Structures 106
Complex Adaptive Systems 106
Understanding the Internal and External Environment 107
Decision Making and Systems Thinking 108
Delegation 109
Understanding Healthcare Financing 110
Human Resources Management and Development 111
Scope and Standards for Nurse Administrators: Framework for Practice 113
The Nurse Administrator 114
Summary 126
Reflective Questions 126
Case Study 6-1 Future of Nursing 127
Case Study 6-2 Shared Governance 128
Case Study 6-3 Culture of Safety 129
Case Study 6-4 Challenges for a Novice Nurse Administrator 130
References 132

CHAPTER 7 Strategic Practices in Achieving Organizational Effectiveness 135

Patricia L. Thomas and Janet Winter

Learning Objectives 135
AONE Key Competencies 135
AONE Key Competencies Discussed in This Chapter 135
Future of Nursing: Four Key Messages 136
Introduction 136
Background 136
Organizational Effectiveness through Organizational Learning 139
Creating the Strategic Plan 143
Change Leadership and Strategic Planning 148
Summary 150
Reflective Questions 150
Case Study 7-1 Creating a Common Nursing Vision and Strategic Priorities across a System 150
References 152

CHAPTER 8 Procuring and Sustaining Resources: The Budgeting Process 155

Patricia L. Thomas and Linda Roussel

Learning Objectives 155
AONE Key Competencies 155

AONE Key Competencies Discussed in This Chapter 155
Future of Nursing: Four Key Messages 156
Introduction 156
Basic Planning 157
Procedures 157
Managing Cost Centers 158
Budget Stages 159
Types of Expenses and Costs 161
Definitions 164
Responsibility for Creation and Management of the Budget 166
Budgeting Approaches 167
Types of Budgets 168
Negative Cash Flow 169
Developing the Operating Budget 170
Staffing Patterns and Processes 171
Personnel Budget 173
Nonproductive Full-Time Equivalents 176
Supplies and Equipment Budget 177
Capital Budget 177
Controlling Process 180
Monitoring the Budget 180
Cutting the Budget 183
Reimbursement Based on Clinical Performance 183
U.S. Healthcare System 184
Value-Based Purchasing and Bundled Payments 184
Ambulatory Payment Classifications 185
Summary 185
Reflective Questions 186
Case Study 8-1 Budgeting to Enhance Professional Practice and Productivity 186
References 187

CHAPTER 9 Maximizing Human Capital 189

Val Gokenbach and Patricia L. Thomas

Learning Objectives 189
AONE Key Competencies 189
AONE Key Competencies Discussed in This Chapter 189
Future of Nursing: Four Key Messages 190
Introduction 190
Evolution of Leadership in the United States 191
Leadership Approaches 191
A Void of Leadership 193

Accountability Chain of Leadership 193
Creating a Nurturing Culture of Empowerment 194
Magnet Designation and Empowerment 195
Empowerment Model Structures 196
Develop Successful Relationships with Physicians, Practitioner Colleagues, and Other Departments 198
Recruiting Nurses 198
Modern Leadership Competencies 202
Team Management 208
Communication 209
Management of Crucial Conversations 213
Managing a Diverse Workforce 213
Performance Management 216
Employee Support 218
Career Planning 219
Summary 222
Reflective Questions 222
Case Study 9-1 Healthy Work Environments 223
References 224

CHAPTER 10 Managing Performance 227
Kathryn M. Ward-Presson

Learning Objectives 227
AONE Key Competencies 227
AONE Key Competencies Discussed in This Chapter 227
Future of Nursing: Four Key Messages 228
Introduction 228
High-Performance Organizations 230
Complexity Science 232
Authentic Leadership 232
Evidence of Performance Management 234
Leadership Development 234
Succession Planning 235
Mentoring 235
Crucial Conversations 238
Fostering Professionalism 240
Professional Portfolios 240
Nursing Performance Improvement Structure, Dashboards, and Outcomes Reports 241

Summary 242
Reflective Questions 243
Case Study 10-1 Conflict Management 243
Case Study 10-2 The 360-Degree Change 244
Case Study 10-3 Celebrating Generational Differences 246
Case Study 10-4 Mentee Reflections from the Field 246
Case Study 10-5 Lifelong Learning and Professional Development 247
Case Study 10-6 Professional Career Development: Planning for Success 248
References 250

CHAPTER 11 Information Management and Knowledge Development as Actions for Leaders 255

Donna Faye McHaney

Learning Objectives 255
AONE Key Competencies 255
AONE Key Competencies Discussed in This Chapter 255
Future of Nursing: Four Key Messages 256
Introduction 256
Technology in the Nursing Environment 257
Informatics 258
Technology Portfolio 260
Ethical, Legal, and Security Issues 262
Evidence-Based Clinical and Management Practice 263
Advocacy for the Clinical Enterprise and for Nursing Practice 264
Active Membership in Professional Organizations 264
Information Management and Technology 265
Securing Healthcare Information 275
Impact of Technology on Communication in Nursing 278
Summary 280
Reflective Questions 280
Case Study 11-1 Using Information Technology to Improve Workflow 281
Case Study 11-2 Disciplinary Action and Managing Patient Information Breaches 282
Case Study 11-3 Maximizing Communication through Technology 282
References 283
Appendix 11-A Nursing Informatics Council Charter and Bylaws 285
Appendix 11-B Checklists for Effective Security Implementation 287
Appendix 11-C Security Breaches 288

PART III Leading to Improve the Future Quality and Safety of Healthcare Delivery

CHAPTER 12 Laws, Regulations, and Healthcare Policy Shaping Administrative Practice **293**

Carolyn Dolan and James L. Harris

Learning Objectives 293
AONE Key Competencies 293
AONE Key Competencies Discussed in This Chapter 293
Future of Nursing: Four Key Messages 294
Introduction 294
Historical Context of Law 295
Sources of Law 295
How a Bill Becomes Law 297
How a Bill Is Challenged 299
Laws That Affect Health Care 302
Constitutional Law 302
Criminal Law 303
The Board of Nursing 306
Civil Law 306
How Healthcare Policy Shapes Administrative Practice 314
Delivery Systems and Payment Structures 315
Summary 316
Reflective Questions 317
Case Study 12-1 To Report or Not to Report? Joe's Dilemma 317
References 318

CHAPTER 13 Risk Anticipation and Management: Creating a Culture of Quality, Safety, and Value **323**

Linda Roussel and Shea Polancich

Learning Objectives 323
AONE Key Competencies 323
AONE Key Competencies Discussed in This Chapter 323
Future of Nursing: Four Key Messages 324
Introduction 324
Evolving Perspectives in Healthcare Quality Management 325
Measurement for Improvement 336
Components of a Quality Management Program 337
Data Collection 338
Quality Management Tools 339
Problem Identification 343

Monitoring and Feedback 344
Research and Quality Management 347
Summary 347
Reflective Questions 348
Case Study 13-1 Patient Safety 348
Case Study 13-2 Creating a Culture of Safety within a Microsystem 349
Case Study 13-3 Healthy Work Environments 350
Case Study 13-4 Developing a Successful Culture of Safety and Point of Care 351
Case Study 13-5 Patient Safety, Nurse Handover, and Problem Solving 353
Case Study 13-6 Developing Clinical Pathways for Improving Process Flow for Pediatric Cardiothoracic Patients 355
References 356

CHAPTER 14 Leaders Achieving Sustainable Outcomes 359

James L. Harris

Learning Objectives 359
AONE Key Competencies 359
AONE Key Competencies Discussed in This Chapter 359
Future of Nursing: Four Key Messages 360
Introduction 360
Leadership Qualities for Achieving Sustainable Outcomes 360
Sustaining Outcomes 363
Value and Sustainability 364
Managing Variability: An Imperative for Achieving and Maintaining Sustainable Outcomes 365
Managing Sustainable Outcomes 366
Benchmarking 368
Summary 369
Reflective Questions 370
Case Study 14-1 Cultural Awareness and Sensitivity: Imperatives for Healthcare Providers 370
Case Study 14-2 Universal Protocol and Time-Out: What Is Being Measured? 371
References 372

CHAPTER 15 Messaging and Disseminating Excellence in Leadership and Ethical Implications 375

Linda Roussel, Patricia L. Thomas, and Cynthia R. King

Learning Objectives 375
AONE Key Competencies 375
AONE Key Competencies Discussed in This Chapter 375

Future of Nursing: Four Key Messages 376
Introduction 376
Managing Messages 378
Communication and Relationship-Building Competencies 382
Developing a Healthcare Ethics Program 385
Writing an Executive Summary 387
Summary 392
Reflective Questions 392
Case Study 15-1 How Will They Know? 392
Case Study 15-2 Where Do I Get Started? 393
Case Study 15-3 New Director Challenges 394
Case Study 15-4 Effective Communication and Daily Briefings 396
References 397

CHAPTER 16 Leading Implementation for Sustainable Improvement 399

Linda Roussel

Learning Objectives 399
AONE Key Competencies 399
AONE Key Competencies Discussed in This Chapter 399
Future of Nursing: Four Key Messages 400
Introduction 400
Defining Implementation Science and Implementation Practice 401
Implementation Theories, Models, and Frameworks and Their Relationship to Improvement 402
Dissemination Practice and Dissemination Science 406
Knowledge Translation and Processes for Implementation and Dissemination 406
Attributes of Innovation and Their Importance to Implementation, Dissemination, and KT 408
Leadership Competencies Critical to Implementation, Dissemination, and Innovation Practices 409
Successful Strategies for Leading and Facilitating Teams through Implementation and Sustained Improvement 410
Summary 411
Reflective Questions 412
Case Study 16-1 Implementation Practices: Audit, Education, and Leadership Strategies 412
Case Study 16-2 Tailored Purposeful Rounding Implementation on a Hospitalist Unit 413
References 414

CHAPTER 17 Polarity Thinking: A Lens for Embracing Wicked Problems, Conflict, and Resistance in Health Care **419**

Evelyn Clingerman and Patricia L. Thomas

Learning Objectives 419
AONE Key Competencies 419
AONE Key Competencies Discussed in This Chapter 419
Future of Nursing: Four Key Messages 420
Introduction 420
Impetus behind Embracing Polarity Thinking 420
Historical Roots of Polarity Thinking 421
Industry, Education, and Politics 421
Principles of Polarity Thinking 422
State of the Evidence and Empiric Study of Polarities 424
Appling a Polarity Lens: Polarity Thinking and Management 426
Steps in the Polarity Process 427
Metrics for Polarity Assessment 429
Applications for Teams, Interprofessional Education, and Quality and Safety 430
Summary 430
Reflective Questions 430
Case Study 17-1 Applying Polarity Thinking to Interprofessional Teams, Quality, and Management 431
References 432

CHAPTER 18 Future Considerations: Leading and Managing Population Health **435**

James L. Harris and Karen L. Spada

Learning Objectives 435
AONE Key Competencies 435
AONE Key Competencies Discussed in This Chapter 435
Future of Nursing: Four Key Messages 436
Introduction 436
Population Health Versus Public Health 437
The Triple and Quadruple Aims as a Compass for Leading and Managing Population Health Initiatives 437
Influences of Political Systems, Political Culture, Policies, Social Media, and Social and Environmental Factors for Effective Population Health Management 438
Health Factors as Determinants of Population Health 439
Risk Stratification as a Model for Effective Population Health Management 440

The Value of Relationship Building and Care Management in Population Health 441
Summary 441
Reflective Questions 442
Case Study 18-1 Managing Health and Well-Being of Underserved Populations 442
Case Study 18-2 Using Knowledge and Evidence to Advance Care 444
References 447

Appendix Beyond Leadership: Building the Next Generation of Leaders 449

Index 465

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Foreword

The nursing executive role is a complex one requiring rapid responses to forces outside and within ever-changing healthcare environments. Nurse executives must be vigilant to external and internal factors as well as to the subtler nuances influencing healthcare delivery. Seasoned leaders experience ongoing challenges with expectations of urgency, passionate execution, exquisite coaching and mentoring, as well as raising the bar for improvement and innovation. The talents, skills, and competencies of nurse executives encompass evidence-based practices in leadership, organizational dynamics, and strategic planning. An example of an evidence-based practice is environmental scanning, the 30,000-foot view of the signposts for future success. The nurse executive's ability to perform environmental scanning includes systematically surveying and interpreting relevant data in outlining external opportunities and threats. The nurse executive, through observations, executive rounding, and communication with all levels of associates, gathers information about his or her work world. Such information includes data about the economy, new regulation, governmental policies, laws, and demographic factors such as population distribution. Part of this scanning includes understanding competitors, which in turn includes looking deeply at and reflecting on trends, barriers, facilitators, and opportunities for implementation and sustained improvement. Considering outside forces necessitates (as a second phase) an inward focus (internal scan) of the organization's strengths and weaknesses, current strategic position, and future plans. Interviewing or surveying the management team and influential leaders is a useful strategy to get a more holistic perspective. Top nurse executives practice environmental awareness (internal and external) in order to respond intentionally and purposefully. The eighth edition of *Management and Leadership for Nurse Administrators* offers thoughtfully crafted chapters for nurse administrative students and executive leaders to develop and advance their leadership capacity; see in particular "Forces Influencing Nursing Leadership" (Chapter 1), "Executive Coaching as a Lever for Professional Development and Leadership in Healthcare Organizations" (Chapter 4), and "Strategic Practices in Achieving Organizational Effectiveness" (Chapter 7).

An important skill to perfect is enhancement of a leader's peripheral vision. Peripheral vision is constant awareness of the ever-changing environmental challenges and the ability to see objects and movement outside the direct line of vision. This is extremely important in the nurse executive role and can be maximized through the practice of leading in an era of change and uncertainty (Chapter 5).

James McGregor Burns describes leaders and followers raising each other to new and higher levels of motivation and morality. Nurse executives today must be open to learning from each other as well as from their interprofessional team members (Chapter 3). They must recognize that concepts have application beyond what is actually discovered and that the healthcare environment

is an ongoing case study where we learn to share experiences with others (Chapter 4). Nurse leaders drive the culture of quality and safety with empowerment of nursing staff and shared governance at the forefront of patient centeredness (Chapter 6).

The eighth edition of *Management and Leadership for Nurse Administrators* provides new exploration into population health and how nurse executives drive change for an entire subset of persons in the inpatient and outpatient environment (Chapter 18). A new chapter, "Leading Implementation for Sustainable Improvement" (Chapter 16), reinforces nurses' understanding that evidence-based practices are central to safe, quality care and their appreciation of the science and practices of implementation and dissemination research. Using the lens of polarity thinking, the nurse leader can embrace wicked problems, conflict, and resistance in health care (Chapter 17). A polarity considers two different values or points of view that are interdependent. While the values are very different and there is tension between them, they act in opposition to each other. "Both/and" thinking, when there is oscillation between the poles, taps the energy to reach the higher goal.

As you continue your journey armed with the wisdom of your experience, sound evidence, and current knowledge of trends, take the time to reflect on your accomplishments and ongoing efforts to lead and inspire greatness in others. Appreciate your tireless work and scholarly endeavors to bring others along to be their "best selves." Lifelong learning is a commitment, one that is intentional and mindfully pursued. It requires time in an already crowded work and personal schedule and may not readily be available. Discipline, emotional intelligence, and mindful practices are important to take the necessary steps to disconnect from technology and to reflect.

Thanks to developing leaders and to seasoned executives for your interest in making today's healthcare environment a better place to deliver quality care and a joyful place to work. Thank you to the editors for such thoughtful work and for the desire to provide guidance to all committed to patient care.

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Preface

This new edition of *Management and Leadership for Nurse Administrators* is framed around the American Organization of Nurse Executives' (AONE's) competencies, the American Nurses Association's (ANA's) *Nursing Administration: Scope and Standards of Practice, Second Edition,* the Institute of Medicine's (IOM's) *Future of Nursing* report, and current trends in healthcare management and leadership. The American Nurses Credentialing Center's (ANCC's) focus on magnetism, specifically the components of transformation leadership, structural empowerment, exemplary professional practice, new knowledge, innovation, improvement, and quality, is also integrated throughout the text. Quality, safety, evidence-based practice, and improvement science are threaded throughout this new edition.

Management and Leadership for Nurse Administrators, Eighth Edition is suitable as an introductory course in nursing administration graduate programs. This text can be used in upper-level baccalaureate programs in which traditional and accelerated students and registered nurses may obtain a bachelor's or graduate degree. Due to the integrative perspective of this text, doctor of nursing practice programs may also find this text useful in their organizational, leadership, and systems core courses that provide essential content in culture, improvement science, and change theory. Faculty members and students will find this text to be an essential resource in basic courses pertaining to management and leadership. Staff development nurse managers in service settings can access this text when mentoring and developing staff members, specifically from a quality improvement and evidence-based practice perspective. This text can also serve as an important resource for the advanced generalist role of clinical nurse leaders, who consider change, microsystems, complexity, systems thinking, collaboration, and leadership as core elements in their programs of study. Doctor of nursing practice faculty members and students will find this text important to their understanding of organizational and systems leadership for improving patient and healthcare outcomes. Doctoral-level knowledge and skills in these areas can be reinforced as students review content relative to organizational, political, cultural, and economic perspectives. The theory and principles discussed in *Management and Leadership for Nurse Administrators, Eighth Edition* apply to the entire spectrum of healthcare institutions and settings.

This text provides theoretical and practical knowledge that will aid professional nurses in meeting the demands of continually changing patient care services within complex adaptive systems. Because the demand for nurses in some specialties and geographical areas exceeds supply, it is essential that management processes create a culture of innovation, creativity, improvement, productivity, and greatness. Financial considerations and technology have increasingly dominated the healthcare industry, making the job of managing costly human and material resources urgent. Resource management that considers human, financial, physical, emotional, and social capital is strongly emphasized and woven throughout this new edition. Time is of the essence in application and translation of best practices in leadership and management science.

Healthcare institutions have been restructured, trimmed down, and decentralized along with other business and industrial institutions. This text has been revised to provide the best management and leadership concepts and theories of business that are available from the fields of

generic management and nursing management. Application and translation underpin all chapters through the use of reflective questions and dynamic case studies.

Chapters have been updated, streamlined, and synthesized to reflect high-level evidence and best practices in leadership and administration. New chapters reflect changing markets and trends and address the critical need to collaborate, innovate, translate science, and work with clinical and academic partners. Chapters discussing trends, executive summary and portfolio development, risk management, and a culture of magnetism have been revised or added to this eighth edition.

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Nursing Leadership Matters: Managing in the New Age of Health Care

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Linda Roussel, Patricia L. Thomas, and James L. Harris

CONCEPTS

The following concepts are included in the eighth edition of *Management and Leadership for Nurse Administrators*: authentic leadership, interprofessional teams, executive coaching, population health, evaluation, measurement, standards, transformation, laws and regulation, information age, quantum leadership, microsystems, structure-process-outcomes management, safety, risk management, failure mode effect analysis, root cause analysis, performance evaluation and review technique, benchmarking, and evidence-based management.

The past decade in the U.S. healthcare system saw unprecedented challenges and opportunities for improvement and innovation. Current healthcare delivery evolved from the industrial age of the late 18th and early 19th centuries, when separate and distinct departments were formed with defined roles and tasks. The command and control style of management and leading aligned with this mechanistic approach to organizational work. Departments and services were typically arranged in silo structures that increased barriers to interprofessional collaboration; inefficiencies were commonplace, and they led to prolonged hospital stays, medical specialization, and inflated cost for care (Wiggins, 2008). From the 1990s to today, caregivers and managers are challenged to consider multiple strategies to manage complex situations due to biomedical and information technology advances, increases in patient morbidity and mortality, shorter hospital stays, escalating costs, and demands for quality and access (Aiken, Clark, Slone, Sochalski, & Silber, 2002; Long, 2004). Of notable interest are historical markers that continue to have an impact on the healthcare industry, including hospital ratings on technology and safety; the introduction of 10 starter set core measures by The Joint Commission; the Malcolm Baldrige National Quality Award, which was first awarded to a hospital; the Centers for Medicare and Medicaid Services launch of hospital comparisons; the introduction of transforming care at the bedside; the passage of healthcare reform legislation; and the release of *The Future of Nursing* report by the Institute of Medicine (IOM, 2011).

Four generations that have different approaches and work-related behaviors are operating in tandem within healthcare organizations:

1. Veterans (1922–1943): This generation defines the workplace based on military or church hierarchy and respect for authority, with clear privileges given to each level in the organization. They expect and deliver no-nonsense performance.

2. Baby boomers (1943–1960): Self-esteem, passion, the need to make a difference, and happiness are driving forces for this group. They desire social or team environments with personal recognition for their hard work. If they believe in the vision of an organization, they will give 100% of themselves in hours and commitment. This generation invented the 60-hour workweek.
3. Generation X (1960–1980): This generation desires independence and hands-off management. They demand a balance between their personal lives and careers. Individuals see themselves as equal to players of *all* ages, and they want to be evaluated based on merit, not seniority. Respect comes from competency, not hierarchy.
4. Nexters (1980–current): Nexters expect economic prosperity, and they recognize that they are in high demand because there are not enough of them. They are used to a global world and are technologically savvy. They have the ability to access and use information and knowledge quickly. This group values new knowledge and fast-paced environments. (Leitschuh, 2011)

Coupled with potential conflicts and differences that may arise in today's workforce from generational differences, work behaviors, and challenges that are inherent in reforming health care, nurse managers must use a variety of approaches. Managers must be armed with skill sets that are different from those of past decades. Logic, predictability, cause and effect, and linear reasoning are no longer enough. A new way of approaching work is required for success and survival in a chaotic, changing, and evolving healthcare environment.

Researchers describe leadership as an art and a science (Ledlow & Cweik, 2005; Ledlow & Stephens, 2018). For example, as a science, leadership involves technical skills of forecasting and budgeting, decision making based on analysis, expert systems, cost control, and evaluation of value. As an art, leadership is relationship-oriented with a focus on networking, interpersonal skills, decision making based on perceptions, people as experts, image, and customer relationships. From decades of work with chief executives in the world, Daskal uncovered a pattern within each leader and powerful abilities that are hidden impediments to greatness. In *The Leadership Gap*, Daskal (2017) offers a system that leaders can apply to improve their results. Her system begins with identifying distinctive leadership archetypes and recognizing their shadows, including contrasting types. Integrating the work of Carl Jung (archetypes) and Joseph Campbell, Daskal offers insights in bridging the leadership gap. For example, The Rebel, driven by confidence, becomes The Imposter, riddled with self-doubt. The Explorer, motivated by intuition, may become The Exploiter, the consummate manipulator. At the end of each chapter, Daskal outlines reflective questions for further exploration of the archetypes and shadows, which may provide leverage in communication, interpersonal relations, decision making, and problem solving. Understanding your archetype and your shadow self can provide contrasting views that can lead to a deeper meaning of your perceptions, actions, and ways of being in the world. Daskal provides actions to consider in exploring the contrasts within each of us, including being transparent and open, building bridges of trust, being willing to take risks, sharing your leadership, setting the bar high, helping to make dreams come true, and being a good citizen.

ORGANIZATIONAL SYSTEM: CONTEXT FOR CHANGE

Today's nurse managers must position themselves to manage in chaotic and staccato-paced environments. The forces and pressures that require change as an imperative, not an option, coupled with a quest for quality, safety, efficiency, and customer satisfaction, require managers to consider alternatives to past practices and techniques. Talents such as critical thinking, insight, problem solving, and sharp analytic and imagination skills are in great demand. They require organizational climates and cultures to create space so these talents can come together and produce innovative solutions. The pursuit of quality, safety, and efficiency consumes enormous

amounts of time and requires different ways of thinking about work. Developing and adopting new care delivery models is necessary to address financial constraints and is an instrument for change (Morjikian, Kimball, & Joynt, 2007). The multiplicity and complexity of the increasing demands that are being placed on nurse managers can result in leadership blind spots, where the manager is not able to serve the patient population or be the best steward of the organization. Robinson-Walker (2008) asserts that leadership blind spots are significant aspects of institutional life, whereby individuals fail to exercise their best judgment and discrimination. Nurse managers often find themselves in new leadership roles without adequate formal education and support, contributing to a lack of awareness of leadership blind spots. It is imperative that nurse managers possess exceptional organizational agility to know and understand how organizations work, how to get things done, the reasoning behind policy and practice, the value of evidence to guide best practice, and an organization's culture (Lombardo & Eichinger, 2004). Thus, leadership blind spots can be minimized.

In times of chaos and proposed healthcare reform, management requires a new way of thinking and responding to mandates. Managing in light of intense demands for greater quality, improvement, efficiency, and effectiveness of patient care necessitates consideration of alternatives to usual business practices. The unusual becomes the usual; the ordinary becomes the extraordinary. Both have a place in managing and leading organizations and deserve to be considered. Nurse leaders need to be armed with new skill sets to move teams toward increased accountability and transparency. Creating a just culture requires the best thinking available.

Stacey (1996) distinguished ordinary from extraordinary management. Ordinary management applies a logical analytic process to daily operations using data analysis, goal setting, weighing available options against goals, rationality, implementation, and evaluation, which are generally accomplished through hierarchical monitoring. Control is at the center of ordinary management. Cost-effective performance is the measure by which effective and efficient systems are valued and judged.

According to Stacey (1996), extraordinary management is also essential if the organization is to transform itself in situations of open-ended change. Stacey posits that extraordinary management supports the integration of teams from diverse units within a system, encouraging engagement of creative problem solving and decision making from inside and outside the organization. Establishing a culture of openness allows for an exchange of information and social capital through informal structures that develop as needed. The informal structures become the infrastructure in which issues and problems can be readily addressed.

Innovative strategies grounded in structure, process, and outcome measures are needed in today's environment. In the old model, organizations dominated by overly rationalist thinking are driven by predictability, but complexity and chaos theorists posit that the natural world does not operate this way. Stacey maintains that the creative disorder in the universe needs to be an integral part of nurse managers' activities. The consequences of creative disorder turn management practices upside down. Considering complexity theory and organizations as complex adaptive systems, Stacey (1992) postulates the following points:

- Analysis loses its primacy.
- Contingency (cause and effect) loses its meaning.
- Long-term planning becomes impossible.
- Visions become illusions.
- Consensus and strong cultures become dangerous.
- Statistical relationships become dubious.

The list could be endless. Any organization attempting to achieve stable relationships within an unpredictable environment is a recipe for catastrophe. Organizations seeking and expecting linear and predictable outcomes may lag behind others as they continuously engage in work processes that had previously worked. Successful organizations emerge from complex and

continuing interactions among people. According to Stacey (1993), the dominant 1980s approach to strategy, which distanced itself from the strategic planning paradigm of preceding decades, still managed to maintain the aim of strategic management as its intent. Theorists of complexity management underscore process flow; they embrace openness to what may happen, serendipity, and synchronicity.

Innovation and creative approaches in nursing management are required more today than in the past. Thinking differently requires individuals to try new ideas, learn from failures, and be willing to function in an often ambiguous and uncertain environment. This is an essential skill set for nurse managers.

COMPLEX SYSTEMS: REVISITING MENTAL MODELS TO EFFECT CHANGE

Healthcare environments challenge the most skilled managers and often lead them to question their ability and approach to effect change at the micro, intermediate, or macro level. Change resides at the heart of leadership. Appreciative inquiry enhances a system's capacity to apprehend, anticipate, and heighten positive potential (Cooperrider & Whitney, 2011).

The emergence of complexity science offers alternative leadership and management strategies for the chaotic and complex healthcare environment. Survey data reveal that healthcare leaders intuitively support principles of complexity science. Leadership that uses complexity principles offers opportunities in the chaotic healthcare environment to focus less on prediction and control and to focus more on fostering relationships and creating conditions in which complex adaptive systems can evolve to produce creative outcomes (Stacey, 1996).

Zimmerman, Lindberg, and Plsek (1998), in their work with complex adaptive systems, note that complexity theory has much in common with general systems thinking, the learning organization, quality, empowerment, gestalt theory, organizational development, and various other approaches. Conceptualizing complex adaptive systems asserts an understanding of how things work in the real world. The authors provide a number of principles in their work with complex adaptive systems that include working with paradox and tension, being cooperative and competitive in tandem, using chunking to make sense of large projects and information, and being competent enough to take action.

Plsek (2001) stresses that mental models often are so ingrained in one's thinking that it is difficult (without reflection and examination) to embrace other perspectives and viewpoints. Without this much-needed work, it is likely that fads and gimmicks will be espoused that won't lead to real change; thus, new ways of doing business are not likely to last, add value, and spread throughout an organization. Nurse managers have a moral obligation to embrace divergent thinking, stay informed of impending legislation, and lead the dialogue of reform beyond fads and gimmicks.

Change is inevitable in health care. Arming oneself with knowledge and engaging others in meaningful activities results in prolonged and sustainable change. Being open to new venues and embracing differing perspectives drive success and engender collaboration among all healthcare team members.

CREATING INNOVATIVE ENVIRONMENTS TO SUSTAIN CHANGE AND ADD VALUE

In an era of healthcare reform and the quest for quality, safe, and efficient care, creating and sustaining innovative environments where staff members function at their highest potential and add value to an organization are pivotal to ongoing success. The two sides of reform span coverage expansion proposals and payment reform proposals. For example, coverage expansion includes an individual mandate for coverage and no preexisting condition exclusions, to name two. Payment reform proposals include, but are not limited to, no pay for never events, pay for performance, readmission penalties, and bundled payments.

After the publication of *The Future of Nursing* (IOM, 2011), a blueprint was created that positions nursing to lead and effect change, partner with others in redesigning health care in the United States, be transformative, and create environments for lifelong learning while adding value within organizations and communities of interest. The four key messages in the IOM report are:

1. Nurses should practice to the full extent of their education and training.
2. Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
3. Nurses should be full partners, with physicians and other healthcare professionals, in redesigning health care in the United States.
4. Effective workforce planning and policy making require better data collection and an improved information infrastructure. (IOM, 2011, p. 14)

Eight recommendations were also outlined in the IOM (2011) report:

1. Remove scope-of-practice barriers. Advanced practice registered nurses should be able to practice to the full extent of their education and training.
2. Expand opportunities for nurses to lead and diffuse collaborative improvement efforts. Private and public funders, healthcare organizations, nursing education programs, and nursing associations should expand opportunities for nurses to lead and manage collaborative efforts with physicians and other members of the healthcare team to conduct research and to redesign and improve practice environments and health systems. These entities should also provide opportunities for nurses to diffuse successful practices.
3. Implement nurse residency programs. State boards of nursing, accrediting bodies, the federal government, and healthcare organizations should take actions to support nurses' completion of a transition-to-practice program (nurse residency) after they have completed a prelicensure or advanced practice degree program or when they are transitioning into new clinical practice areas.
4. Increase the proportion of nurses with baccalaureate degrees to 80% by 2020. Academic nurse leaders across all schools of nursing should work together to increase the proportion of nurses with a baccalaureate degree [from] 50 to 80% by 2020. These leaders should partner with education accrediting bodies, private and public funders, and employers to ensure funding, monitor progress, and increase the diversity of students to create a workforce prepared to meet the demands of diverse populations across the lifespan.
5. Double the number of nurses with a doctorate by 2020. Schools of nursing, with support from private and public funders, academic administrators and university trustees, and accrediting bodies, should double the number of nurses with a doctorate by 2020 to add to the cadre of nurse faculty and researchers, with attention to increasing diversity.
6. Ensure that nurses engage in lifelong learning. Accrediting bodies, schools of nursing, healthcare organizations, and continuing competency educators from multiple health [professions] should collaborate to ensure that nurses and nursing students and faculty continue their education and engage in lifelong learning to gain the competencies needed to provide care for diverse populations across the lifespan.
7. Prepare and enable nurses to lead change to advance health. Nurses, nursing education programs, and nursing associations should prepare the nursing workforce to assume leadership positions across all levels, while public, private, and governmental healthcare decision[s] should ensure that leadership positions are available and filled by nurses.
8. Build an infrastructure for the collection and analysis of interprofessional healthcare workforce data. The National Health Care Workforce Commission, with oversight from the Government Accountability Office and the Health Resources and Services Administration, should lead a collaborative effort to improve research and the collection and analysis of health data on healthcare workforce requirements. The Workforce Commission and

> [Health] Resources and Services Administration should collaborate with state licensing boards, state nursing workforce centers, and the Department of Labor in this effort to ensure that the data are timely and publicly accessible. (p. 32)

Meeting the recommendations in the IOM (2011) report will require actions and engagement by Congress, state legislators, the Centers for Medicare and Medicaid Services, the Office of Personnel Management, the Federal Trade Commission, the Antitrust Division of the Department of Justice, governmental agencies, professional organizations, communities, accrediting bodies, organizations that are supportive, all stakeholders, nursing programs, and the nursing profession.

In a future in which healthcare environments continuously adapt to change and reform and are responsive to individuals' desires and needs through patient-centered care, innovation will become the hallmark of sustainment and value. Primary care and prevention; interprofessional collaboration; healthy work environments; and affordable, quality care for all will be the norm, not the exception. To ensure that the vision is realized, several drivers are framing meaningful strategies and are the linchpins for success. The drivers are timely and central to the efforts required by all nursing leaders, administrators, and stakeholders. The following paragraphs identify and overview each of the drivers.

A number of industries are error prone and where the slightest mistake can be catastrophic. Health care is not exempt. Although multiple efforts have focused on quality improvement, high-reliability organizations are the next step. A high-reliability organization demonstrates performance at high levels of safety over time (Chassin & Loeb, 2011).

Although the introduction of Medicare improved access to care, the quality of care was not directly improved. What followed were utilization review committees, experimental medical care review organizations, professional standards review organizations, peer review organizations, and multiple improvement activities. Practice guidelines were later developed and adopted in an effort to prompt providers to rely on scientific evidence in providing care. However, Balas and Boren (2000) found that it takes an average of 17 years for research to reach practice.

During the 1990s, a shift from practice guidelines to standardized quality measures and public reporting of the resulting data emerged (Kizer, 2001). Improvements in quality and safety are necessary now more than ever, and nurse managers play a role in this effort. Frankel, Leonard, and Denham (2006) identify three requirements for achieving high reliability: leadership, a culture of safety, and robust process improvement. Each requirement guides the actions of all members of the healthcare team and offers opportunities for nurses to guide processes and evaluate outcomes. High-reliability organization theory is concerned with social and organizational foundations of system safety and accident prevention (Sutcliffe, 2011; Oster & Braaten, 2016). This is supported by evidence-based practice, where nurses are positioned to influence and shape care decisions and improve the delivery of quality care. Newhouse, Dearholt, Poe, Pugh, and White (2007) define evidence-based practice as "a problem-solving approach to clinical decision making within a healthcare organization that integrates the best available scientific evidence with the best available experiential (patient and practitioner) evidence" (p. 27). Nurse managers can coach staff members to use the best available evidence to guide practice. This supports the notion that nursing is a science and an applied discipline. Accountability continues to be the vanguard leading to high quality, safe, and efficient care, and it can be achieved through translating evidence into practice.

Building on initiatives implemented by Medicare in prior years, accountable care organizations are another model set forth to address the inadequacy of the U.S. healthcare system. An accountable care organization is characterized by provider groups that are willing to take responsibility for improving the overall health status, efficiency, and healthcare experience for a defined population (DeVore & Champion, 2011). The success of accountable care organizations is supported by collective efforts with other healthcare reforms that include support for primary care, comprehensive performance measurement, and interfacing with other payment reforms

(McClellan, McKethan, Lewis, Roski, & Fisher, 2010). Additional activities that support and advance accountable care organizations include the following:

- Executive sponsors and participation
- Payer partners
- Data transparency
- Aligned physician networks
- Savvy contracting
- Adequate population base
- Acceptance of common cost and quality metrics
- Data infrastructure
- People-centered foundation
- Leadership
- Population health data management

The U.S. Department of Health and Human Services (2011) launched an incentive, the Hospital Value-Based Purchasing Program, to adjust Medicare reimbursement based on how well hospitals were performing on 12 clinical process measures and 9 patient experience measures relative to a baseline performance period. Hospitals are scored for each measure between an achievement threshold and a benchmark. The achievement threshold is the minimum performance level, and the benchmark is based on the highest level of performance among hospitals during the baseline period. The financial incentives of the Hospital Value-Based Purchasing Program are not the most significant characteristics; the most important are the measurement tools that the program provides. Many hospitals are concerned about meeting and maintaining performance measures, thus increasing the likelihood of reduced operating revenue (Shoemaker, 2011). However, gains in value that are secondary to the program can be realized from prevention, early intervention, and ambulatory management of patients versus emergency department visits and hospital admissions and readmissions (Tompkins, Higgins, & Ritter, 2009). Such gains are supported by nursing activities through patient management and inclusiveness of patients in all care decisions.

The evolving Patient Centered Medical Home model of care is another innovative driver to effect change and add value (Clancy, 2011). The model has two primary goals: to treat patients in the lowest-cost setting and to manage the treatment of patients proactively to prevent acute care episodes. The Patient Centered Medical Home model is an interdisciplinary team approach whereby staff members work to the full scope of their practice and expertise, focus care on holistic health, and enhance access to enable more frequent communication between patients and team members. Patient Centered Medical Homes maximize the capabilities of existing staff members to support the care model. This is another avenue where nurse managers can have a significant impact on enhancing care delivery and placing the patient at the center of care and decision making.

Nurses can play a role in the creation of a standardized, scientifically reliable method to document, measure, and disseminate nursing contributions to safe and efficient patient outcomes in support of healthcare information technology. The U.S. government developed standards for a national electronic medical record. Meaningful use will guide the process, criteria, and terms to direct the collection, recording, and reporting of clinical data in the electronic medical record. Criteria defining meaningful use will rolled out in three stages through 2015; mechanisms were framed to allow the exchange of key information among members of the healthcare team, as well as elements related to privacy and security (Bolla, 2011; Halamka, 2009).

Meaningful use and information are the cornerstones of effective problem solving and making good decisions. Asking better questions leads to better decisions. Diversity and conflict can be used in creating strategic alliances. Heffernan (2015) suggests that rich debate and argument are

essential activities; if well done, they generate ideas and reveal any fears and doubts. Heffernan provides a list of questions that facilitate lively debate and discussion:

- Who needs to benefit from our decisions? How?
- What else would we need to know to be more confident about this decision?
- Who are the people affected by this decision? Who has the least power to influence it?
- How much of this decision must we make today?
- Why is this important? And what's important about *that*?
- If we had infinite resources—time, money, people—what would we do? What would we do if we had no resources?
- What are all the reasons this is the right decision? What are all the reasons it is the wrong decision?

SUMMARY

Change in health care is inevitable, and the various forces affecting care delivery require innovative approaches. Understanding and responding to organizational dynamics and mandates mean that nurse managers approach business from different perspectives and engage others to arrive at decisions. Using evidence to guide actions will accentuate success and result in sustained change that is valued by organizations, employees, and stakeholders. The health and welfare of Americans are entrusted to all managers and providers. True healthcare reform will be accomplished through knowledge attainment and engagement in activities that promote learning environments.

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PART I

Leading in Times of Complexity and Rapid Cycle Change

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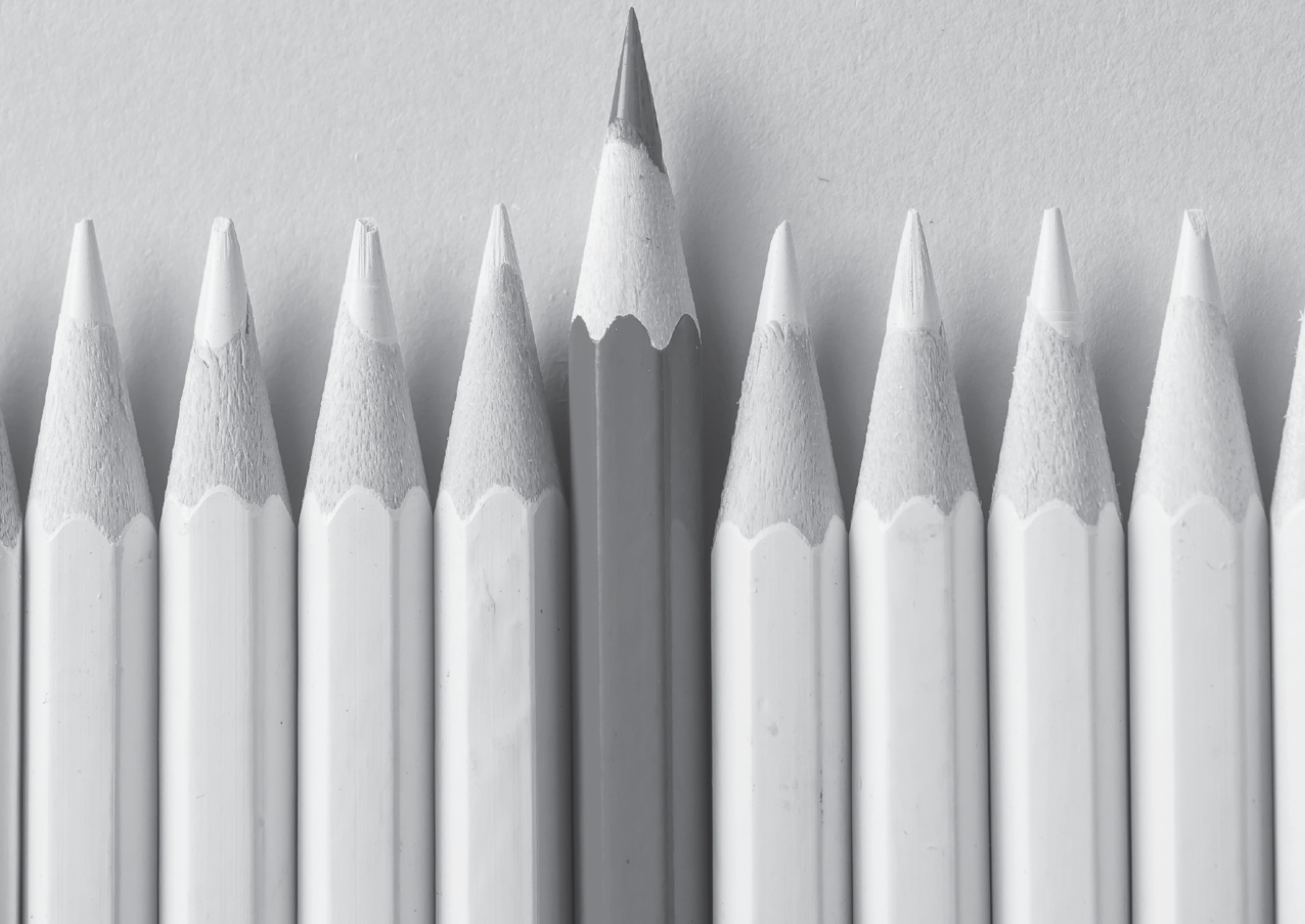

CHAPTER 1

Forces Influencing Nursing Leadership

Linda Roussel

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LEARNING OBJECTIVES

1. Discuss current trends in healthcare management and their impact on quality, safety, and value-added care (care delivery).
2. Envision care delivery systems for the future.
3. Discuss major influences—specifically, Institute of Medicine (IOM), Agency for Healthcare Research and Quality (AHRQ), Institute for Healthcare Improvement (IHI), Magnet, Baldrige, and other major stakeholders—in healthcare systems.
4. Identify how ethics relates to managing healthcare services.

AONE KEY COMPETENCIES

I. Communication and relationship building
II. Knowledge of the healthcare environment
III. Leadership
IV. Professionalism
V. Business skills

AONE KEY COMPETENCIES DISCUSSED IN THIS CHAPTER

II. Knowledge of the healthcare environment
III. Leadership
IV. Professionalism

II. Knowledge of the healthcare environment

- Clinical practice knowledge
- Patient care delivery models and work design knowledge
- Healthcare economics knowledge
- Healthcare policy knowledge
- Understanding of governance
- Understanding of evidence-based practice
- Outcomes measurement
- Knowledge of, and dedication to, patient safety
- Understanding of utilization and case management
- Knowledge of quality improvement and metrics
- Knowledge of risk management

III. Leadership
- Foundational thinking skills
- Personal journey disciplines
- Ability to use systems thinking
- Succession planning
- Change management

IV. Professionalism
- Personal and professional accountability
- Career planning
- Ethics
- Evidence-based clinical and management practices
- Advocacy for the clinical enterprise and for nursing practice
- Active membership in professional organizations

FUTURE OF NURSING: FOUR KEY MESSAGES

1. Nurses should practice to the full extent of their education and training.
2. Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
3. Nurses should be full partners with physicians and other health professionals in redesigning health care in the United States.
4. Effective workforce planning and policy making require better data collection and information infrastructure.

Introduction

According to GOV2020 (n.d.), we can expect a number of changes with the dominant 2020 healthcare trend: health care everywhere. Noteworthy are trends in mobile health applications, telemedicine, mhealth, remote monitoring, and ingestible sensors generating robust streams of data. This data allows providers and patients themselves to track sleep patterns, heart rates, activity levels, and caloric output in real time. GOV2020 identify categories for healthcare leaders to be on the alert for: health care in developing countries, healthcare systems, next-generation care, patient-powered health care, and the data revolution. For example, when considering health care in developing countries, frugal health care is a dominant theme. Specifically, universities, medical technology giants, and even mobile phone companies are developing portable diagnostic tools that can created for just 1% of the cost of traditional medical devices. Good examples include developing countries pursuing a back-to-basics approach to prevent disease, such as washing umbilical cords with antiseptic to reduce infections among newborns. No-nonsense models such as Aravind Eye clinic and Narayana Hrudalaya in India, and franchise "clinic-in-a-box" models such as Unjani in South Africa, provide affordable care augmenting overstretched public healthcare systems (GOV2020, n.d.). Health systems are changing with such examples as communities as healthcare providers and expanded definitions of health. Skilled healthcare professionals are experiencing shortages (around the globe) particularly with an aging population and expanding disease burden. To address these issues, the community is stepping up and increasingly providing community outreach, peer-support initiatives, and greater partnering with patients and families to expand care options. Notable are developing nations who are using community healthcare workers (with minimal training) to provide education and supportive treatments using diagnostic

devices and delivering medicines allowing specialty providers' time to handle complex tasks. Expanding the definition of health is evolving from "sick care" to wellness with nutrition and behavioral, environmental, and social networks serving as vital foundations to health. Specifically, health care cannot only be defined by care that facilities provide but more important by the status of consumers' health. "2020 sees the convergence of allopathic and alternative medicine, and of physical and behavioral medical management. Government promotes wellness care through incentives, requirements and payment models, particularly in countries where it is the primary payer" (GOV2020, n.d.). The category of next-generation care encompasses "futuristic" strategies such as specialized surgeons performing holography-assisted surgery to treat patients remotely and instruct other physicians on operating procedures (think *Star Wars*). Research purports that holography makes surgery less invasive and offers better outcomes for patients while also freeing up surgeon time. For example, Philips and RealView Imaging have developed live three-dimensional (3D) visualizations that can be touched and marked up to help doctors during surgeries. Israeli doctors have piloted a series of cardiac operations guided by live 3D holographic images of the patient's heart (Montgomery, 2013). Patient-powered health care, with increased patient engagement and activation, has gained momentum. For example, Mobile Lifesavers Apps such as PulsePoint and Good Sam affords anyone with a smartphone to locate trained first-aid personnel and dispatch them to nearby medical emergencies. In the future we can expect that this technology will integrate with emergency services systems. When 911 or other emergency services receive a call for help, the apps will automatically locate first-aid personnel in the surrounding area, alert them, and request their response. Responders could be individuals with first-aid training or police officers, firefighters, and paramedics who might use the app when they are off duty. The data revolution continues to evolve with greater patient participation and engagement, particularly with patients using their own health data to make better decisions. For example, patient-centered information networks, such as *Crohnology* for Crohn's disease, assist people to better manage their health, share best practices with fellow patients, and lower medical costs by tapping into the wisdom of the crowd (GOV2020, n.d.).

Health care is a moving target with forces for change having an impact on outcomes for quality, safety, and value-added care. These forces include shifting population demographics, finance reform, consumerism, and personalized medicine. Quality, safety, and translational science are at the heart of future trends, focusing on interprofessional teams and patient-centered care. Based on the evidence, healthcare systems have made limited progress in improving the patient experience and meeting the IHI triple aims (Stiefel & Nolan, 2012).

In the past decade, health care has experienced dramatic swings, including a change in social demographics; advancements in medical technologies; heightened consumer awareness; and greater demand for high-quality, efficient, and cost-effective care. This consumer-driven, competitive environment proclaims a transformation that all healthcare organizations must embrace to succeed and be sustainable. Quality improvement, evidence-based practice, translational science, the patients' experience, and systems thinking are essential to sustaining a competitive edge. The traditional hierarchical, bureaucratic, and insulated organizational models no longer make sense in this new business of health care. An evolving model needs to be flat, innovative, nimble, just in time, and responsive to change. If a healthcare organization is to survive at today's frenetic pace, greater flexibility and the ability to deal with ambiguity are essential (Porter-O'Grady & Malloch, 2015).

Being great, or going from good to great, takes the courage of one's convictions, vision, and energy, according to *Good to Great: Why Some Companies Make the Leap . . . and Others Don't*, a management book by James C. Collins. We are charged with keeping up with trends that affect short- and long-term planning. Collins (2001) contends that visionary companies have better management development and succession planning than comparable companies, thereby ensuring

greater continuity in leadership talent grown from within. Collins's research contends that Level 5 leadership does matter.

According to Collins (2001), a Level 5 leader is a person who harmonizes extreme personal humility with intense resolve. In his 5-year research study, Collins discovered that Level 5 leaders combined traits that served as catalysts for transforming a good company into a great one. Using Level 5 as the highest level in a hierarchy of executive capabilities, Levels 4, 3, 2, and 1 follow in this leveling process. Leaders in the four other levels can have some measure of success; however, it is not enough to move from mediocrity to sustained greatness. Collins contends that a company cannot go from good to great without Level 5 leadership (Executive) at the helm. To better understand Level 5 leaders (builds greatness), it is useful to understand Levels 1 through 4.

Level 4 is described as an effective leader who is able to stimulate teams to high performance standards by demonstrating commitment to aggressive pursuit of a compelling vision. Level 3 has been identified as a competent manager able to organize people and material resources effectively and efficiently using stable objectives, often predetermined by executive leaders. Level 2 illustrates a contributing team member able to add to the achievement of team objectives and to demonstrate effective group work in a variety of cultures and settings. Level 1 leaders are identified as highly capable individuals who demonstrate productive activity through talent, knowledge, skills, and good work habits. Collins (2015) contends that individuals do not proceed sequentially through each level of the hierarchy to reach the top; however, fully evolved Level 5 leadership does require the capabilities of Levels 1 through 4, along with special characteristics of Level 5 (humility, resolve).

Visioning and futuristic thinking embrace an openness to change. In the 21st-century workplace that is driven by innovation and technological transformation, new knowledge, skills, and abilities are demanded from everyone. New roles to address the demands are critical. A high level of trust, encouraging the heart, authentic leadership, and relationship-based care are important in balancing safe and quality health care, efficiency, and costs.

According to Kouzes and Posner (2003), encouraging the heart is about keeping hope alive by setting high standards and by demonstrating authentic interest and optimism about the employee's capacity to achieve meaningful goals. High-performing managers are approachable and embrace diversity through timely feedback and by sharing their thoughts, feelings, and perceptions. Kouzes and Posner go on to describe seven essentials to encouraging the heart and include setting clear standards, expecting the best, paying attention, personalizing recognition, telling the story, celebrating together, and setting positive examples. Telling the story can serve to clarify standards and gives examples of best practices. "Stories are essential means of conveying that we are making progress. . . . Stories put a human face on success" (p. 105).

There is a different emphasis and skill set for nurse administrators today compared to those that dominated the past century. Logic, predictability, and linear reasoning were the order of the day and gave some measure of success in a stable environment. These skills alone are not enough and no longer serve us well in our complex, complicated systems (Porter-O'Grady & Malloch, 2015).

ORGANIZATIONAL SYSTEM: CONTEXT FOR TRENDS AND CHANGE

Considering trends in light of organizations and systems propels the nurse administrator to consider different, innovative ways to structure and redesign processes and outcomes that are necessary to transform care delivery. Organizations must move away from domination by an overly rational thinking machine that is focused on predictability; theorists of complexity and chaos show us that the natural world does not operate this way. Stacey (2010) purports that this revelation of the role of creative disorder in the universe needs to be taken to heart by managers. The consequences, as Stacey summarizes, turn management practices upside down. Considering

complexity theory and organizations as complex adaptive systems (CASs), Stacey (2010) postulates the following points:

- Analysis loses its primacy.
- Contingency (cause and effect) loses its meaning.
- Long-term planning becomes impossible.
- Visions become illusions.
- Consensus and strong cultures become dangerous.
- Statistical relationships become dubious.

The list continues to change. An organization seeking stable relationships within an unpredictable environment is a recipe for failure. An organization expecting predictable outcomes by focusing on its strengths, continuing what it does best, and making limited adjustments will likely be left in the dust by its innovative rivals. Successful strategies, in the long run, do not come by fixing organizational intention and circling around it; they emerge from complex and continuing interactions among people. According to Stacey (2010), the dominant 1980s approach to strategy, which distanced itself from the strategic planning paradigm of preceding decades, still managed to maintain the aim of strategic management as its intent. Theorists of complexity science emphasize the essential nature of openness to accident, coincidence, and serendipity. The emerging result is strategy.

Management in times of chaos requires a new way of thinking and being in the world. Managing in light of intense demands for greater quality, safety, efficiency, and effectiveness of patient care necessitates consideration of alternatives to business as usual. The unusual becomes the usual; the ordinary becomes the extraordinary. Both have a place in managing and leading organizations. Safety has become first and foremost in of healthcare delivery.

Results measurement emphasizes analyzing outcomes to evaluate the value of care. In this model, competition is value-based and therefore focused on outcomes. As a result, process measures and evaluations of specific procedures and episodes of care are not useful unless they provide knowledge to improve outcomes. Value can be determined only if outcomes are measured across the care cycle based on healthcare systems and medical conditions. The principles of value, results measurement, system restructuring, and value-based competition provide a promising framework for transforming health care. Value, rather than procedures, becomes the basis for reimbursement, which eliminates unhealthy competition and cost shifting. Effective outcomes are determined based on the care cycle rather than the episode.

PRINCIPLES TO CREATE FUTURE CARE MODELS

Value-Based Competition

To develop future healthcare models, value-based competition is one of the first principles that needs to be addressed. The concept of value-based competition was introduced by Porter and Teisberg (2006) as an alternative to what they describe as failed incremental changes in both the healthcare system and financing structure. They contend that competition has promoted progress in other industries but not in health care. Health care has fallen victim to zero-based competition, which is defined as winning at the expense of another and operating in a system where cost shifting has benefited neither providers nor patients. Vlasses and Smeltzer (2007) set forth three interrelated principles to drive healthcare transformation:

- Positive-sum competitors
- System restructuring
- Rewards management

A transition to positive-sum competition in health care is based on value or health outcomes per dollar spent. Positive-sum competition incentivizes improved results based on clinical

outcomes, as opposed to volume or length of stay. To restructure the healthcare system, Porter and Teisberg (2007) proposed a system organized around medical conditions and care cycles rather than provider specialties such as cardiology or endocrinology. Medical conditions reflect the set of sequelae commonly seen with a particular diagnosis that is addressed in an integrated way. An integrated care unit is then equipped to deliver care along the continuum based on the patient's experience of the disease.

Safety: Where Are We Now?

Safety and quality go hand in hand, with greater incentives to reduce adverse events and improve the patients' experiences. A study in the *New England Journal of Medicine* reported data from North Carolina hospitals that showed there had been minimal progress in reducing harm from unsafe medical care between 2002 and 2007 (Landrigan et al., 2010). In another study, James (2013) found that between 200,000 and 400,000 Americans die each year from unsafe medical care, making it the third leading cause of death in the United States behind heart disease and cancer. Additional evidence was noted in an eye-opening November 2011 report on adverse events in hospitals. The Office of Inspector General (OIG) in the U.S. Department of Health and Human Services found that 5% of Medicare patients suffered an injury in a hospital that prolonged their stay or caused permanent harm or death. Another 13.5% of Medicare patients suffered temporary harm, such as an allergic reaction or hypoglycemia. Taken together, the evidence purports that more than one in four hospitalized Medicare beneficiaries suffer some type of injury during their inpatient stay, much higher than previous rates. The OIG report also noted that unsafe care contributes to 180,000 deaths of Medicare beneficiaries each year, and that Medicare pays at least $4.4 billion to treat these injuries. Despite all the focus on patient safety, it seems we have not made much progress at all (Committee on Health, Education, Labor, and Pensions, 2014).

Although this is not good news, there are areas in which we have made notable gains, most notably with healthcare-associated infections. These gains have been attributed to the work of Dr. Peter Pronovost, of Johns Hopkins University, and the Centers for Disease Control and Prevention (CDC). Pronovost created a simple five-item checklist that was tested in more than 100 intensive care units in Michigan to reduce rates of central line infections. Pronovost found that each of these infections can incur up to $50,000 in treatment costs, necessitating an average of seven additional days in the hospital. While central line infection is complex and expensive, Pronovost's checklist intervention is simple by comparison. Using the checklist, the hospitals involved in the project reduced their central line infection rates to essentially zero in 3 months. Individual providers were not the focus; rather, the system was the primary focus for improvement. The checklist improved the care delivery system by notably reducing the number of infections. The checklist program was disseminated to more than 1,100 intensive care units across the country and is saving lives and resources daily (Brody, 2008).

The CDC is the other major player in the improvement effort. It established the National Healthcare Safety Network (NHSN), which is a voluntary online system that tracks healthcare-associated infections nationwide. Through the NHSN, the CDC established standard metrics for assessing and reporting healthcare-associated infections (HAIs), affording providers the opportunity to track their own data and report it anonymously and directly to the CDC. These efforts have been instrumental in helping providers, healthcare executives, and policy makers keep up with infection rates and ensure that requisite preventive procedures are carried out. The NHSN allows hospital leaders to benchmark their facilities against others to determine where improvement is critical to better outcomes. The NHSN purports that good metrics, offered in a timely way, make a significant contribution to provider performance. Rates of central line infections from 2008 to 2012 decreased by 44%. Specifically, rates of infection in the 10 most common surgical procedures fell by 20%. All told, there has been progress in reducing infection rates caused by the healthcare system.

In a number of ways, the problems described here do not tell the story of medical errors. Although much attention has focused on acute hospitals, there has been relatively limited attention paid to discharged patients and care transition. In another report, the OIG found that 22% of Medicare beneficiaries in skilled nursing facilities (SNFs) experienced a medical injury that increased their length of stay or caused death or permanent harm. The same report found that an additional 11% suffered a temporary medical injury. The OIG estimates that adverse events cost Medicare roughly $2.8 billion per year, and about half of these events are preventable. The OIG report is cause for concern given that about 20% of hospitalized Medicare patients go to an SNF after discharge. There is a clarion call to improve patient safety as a national priority (Conway, 2013).

With safety front and center, what additional forces and trends can we anticipate as we navigate the future of health care? Forces to consider include technology, healthcare finance, personalized medicine, population-based health care, social networking, and consumerism.

Technology

Technology has far-reaching implications for reform because it affects both processes of care and the way organizations work. Technology also empowers consumers. Although some new technology may increase the cost of care up front, it has the potential to improve health and eventually decrease healthcare costs.

Among the broad-based effects of technology are the development of health information systems and the genomics that are contributing to biotechnical advances in care. Health information systems are increasingly being used to decrease healthcare costs by standardizing and improving data capture to support both billing practices and care decisions. Information systems can potentially reduce the rate of increase in healthcare costs, which were predicted to reach 19% of the gross national product (GNP) by 2014. Information systems enable leaders to more effectively capture cost and quality indicators that are used to improve practice and reward performance, thereby improving the efficiency and efficacy of health care. Users of healthcare services and the technology of health care will continue to be aligned with technology as a major driver of wellness and disease management. Connections between providers and patients will have more virtual and seamless interactions, with supporting technology enabling the provision of clinical services to patients remotely (Porter-O'Grady & Malloch, 2015). Just as technology is increasingly assisting caregivers with diagnosis and treatment, it also enables patients to assume more ownership of their health. Personalized medicine, which will become personalized health care over time, is one of the most exciting aspects of future health care. The continued development of personalized medicine will require not only a time commitment from nurse executives and their colleagues but also a paradigm shift from consumer as patient to consumer as partner.

Automation

Administrators and physician owners who are focused on preparing for the future do not dwell on today's healthcare problems. Although they still see reimbursement cuts and increased administrative tasks, they do not allow these issues to consume their work. Technology can provide greater efficiency. For example, a provider must consider the time it takes to standardize a process and then find the technology to automate the task.

Imaging Technology

New devices make imaging more portable and accessible to patients. For example, the Vscan from GE Healthcare can allow patients to take an ultrasound image of their heartbeat from home and send the visuals to their physician for review. Or a surgeon in a surgery center can use an ultrasound device over a patient's heart and determine abnormal rhythms or other anomalies in real time.