

Nursing Leadership and Management

The Advanced Practice Role

Edited by

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Preface

Nursing Leadership and Management: The Advanced Practice Role is the result of working with superb advanced practice professionals in clinical practice settings. Often, these excellent clinicians need additional leadership skills that can assist them in the everyday management and leadership positions that are continuously developing in our changing healthcare system. Advanced practice professional roles include nurses, physical therapists, pharmacists and other health professionals who are obtaining their terminal professional degrees such as the doctorate in nursing practice (DNP), doctorate of physical therapy (DPT), the doctorate in occupational therapy (DOT) or the doctorate of pharmacology (PharmD.). As a result, most educational programs integrate this content but do not provide specific examples or discuss the types of leadership issues that these professionals may encounter. The content of this book attempts to provide advanced practice professionals with the practical approaches needed to be an effective leader in clinical settings. Thus, the purpose of this book is to provide the scientific underpinnings for effective leadership in clinical practice settings and to assist interdisciplinary health professionals with the skills necessary to transform our healthcare organizations.

There are many leadership books available for healthcare professionals, however, most review the basic concepts of leadership such as those associated with the views of business or management. However, the approach offered in this book reflects case studies and references associated with interdisciplinary and inter-professional leadership en-

counters that are realistic cases that occur in clinical practice settings. Each chapter will present a case study depicting the concepts reflective of a clinical issue that involves the application of leadership principles that are necessary to solve the problem.

The book has been divided in six major themes: (1) scientific principles of leadership; (2) understanding leadership in traditional & non-traditional healthcare settings; (3) promoting leadership for quality patient care; (4) developing clinical scholarship; (5) transforming healthcare and (6) inter-professional models of healthcare. Within each chapter, a case study is presented to assist the reader with critical decision making skills needed for effective and safe clinical practice. The ability for the advanced practice professional to acquire increased leadership skills within the clinical practice setting provides a solid foundation for improving patient care. This book provides a practical approach to the application of leadership principles while systematically presenting the content needed for skilled leadership in the clinical setting.

The author's deep gratitude is expressed to all the chapter authors who provided creative case studies and important content for this book. A thanks goes to numerous friends and colleagues who facilitated this effort and provided critique of the content. A special thanks goes to my colleagues Chris Harsell, Jackie Roberts, and Maridee Shogren who were wonderful at assisting with the initial content to understand what newly prepared DNP nurse practitioners needed to be successful clinical leaders. Finally, the constant encouragement of my sister Sandy Korniewicz who always provides indirect encouragement to complete the project and my adopted sister, Margaret Brack, whose positive support helped me to complete this endeavor.

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Exploring Leadership Theories for Advanced Practice Nurses

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The Chapter 1 case study demonstrates current perspectives about leadership theory and focuses on the integration of general leadership principles with the applied clinical sciences, emphasizing the advanced practice healthcare professional.

Case Presentation

Caroline Smart DNP, CNS, RN was a hospital nursing educator until her recent graduation from a Doctor of Nursing Practice Program. Upon graduation, the vice president promoted her to the position of Director of Medical Surgical Nursing Division. This division included a 45-bed medical telemetry floor, a 60-bed telemetry surgical floor, and a 32-bed step down Medical/Surgical ICU. Caroline was excited about the promotion but knew she would have a steep learning curve. She was delighted to discover that each of these units had an assistant director who was responsible for the staffing and day-to-day operations. Caroline would be responsible for budgets, hiring and firing decisions, quality assurance, purchasing, and employee evaluations.

The vice president did have one immediate concern: there had been numerous complaints about quality of patient care (patient complaints), low staff morale, high call out rates, and difficulty recruiting new staff. The hospital had to bring on a small number of agency nurses to meet the demands of these units. This agency was a tremendous financial drain on the hospital and it could not continue. Carolyn was given 6 months to evaluate the units to determine the root cause of the problem and take corrective action.

Caroline's leadership experience so far had been centered on a much smaller scale as a charge nurse and directing educational endeavors.

Caroline recalled how all of her nursing instructors emphasized the need to perform a complete assessment of a situation before determining the cause of the problem or taking any action. She concluded that this advice would also work in the management field. Her plan consisted of observation of the day-to-day operations of each of her units prior to sharing her concerns with her staff. She made herself visible on each shift, participated in patient care, assisted in decision-making, and got to know the staff of each unit. Caroline also had the opportunity to get informal feedback from many of her staff. She discovered that several other key nursing personnel were considering leaving, characterizing the units as "dysfunctional and under staffed" and without leadership to intervene on their behalf. Caroline had never asked what caused the prior director to leave, but she was certainly starting to get the picture.

After 3 weeks of collecting evidence of the issues that existed on each of her units, Caroline found the following:

1. 45-bed medical telemetry floor—Despite having designated day and night assistant directors and charge nurses that had been with the organization for many years, no one was really in charge. The assistant director/charge nurse could be found at the main desk or in the employees lounge on the phone. They made shift and new admission assignments, rarely taking patients of their own. They did not make rounds to evaluate patients' progress. Occasionally, they were asked to see a patient related to a complaint, but there was never evidence of a resolution. The hospital had a policy and documentation system for administrative unit rounds on each patient and each unit for every shift. No documentation could be found that this was being completed. New registered nurse staff (new graduates and new hires) did not appear to use the designated nurse leaders as resources. This explained some physician complaints about "a bunch of novice nurses running the show." Additionally, the nursing administration had received multiple family complaints about the lack of response to call lights, pain medicine requests, and unanswered calls at the nursing station.
2. 60-bed telemetry surgical floor—Caroline spent a lot of her time on this floor, making rounds and working beside the nursing staff. The day and night assistant directors, though only 3 years out from

graduation, appeared to be committed to the unit and to be delivering good patient care. The staff recently began a pilot to do self-scheduling and was trying to develop a modified self-governance model. Unfortunately, there was a serious divide between the registered nurses (RNs) and the nursing assistants (NAs) leading to poor delivery of care. Complaints of delayed call light responses and increased falls was a major concern. Both the RNs and NAs blamed the other group to be at fault for the increase in patient falls. Staff turnover was high, with most new hires leaving before their first year anniversary. There was an obvious need for team building on this unit.

3. 32-bed step down Medical/Surgical ICU—This unit had the strongest mix of nurses. Almost all the nurses had Baccalaureate or Masters Degrees in Nursing or other fields. The nurses had a minimum of 5 years of experience. The staffing ratio was 4:1, with nursing assistants available for the more difficult physical care of patients. It did not take long for Caroline to realize that there was no teamwork or cohesion on this unit. The designated charge nurses had given up trying to lead or develop the staff. Every nurse that worked on the unit believed that their view was the correct one. They continued to practice nursing the way they learned it. Discussions of policy, procedure, evidenced-based practice, and team consensus did not exist.

Caroline had to develop a plan, but needed to prioritize the issues. Even though each of the units had problems, there were common themes across all three. First, there was inconsistent or no strong leadership on each of the units. She had nurses in leadership positions that were not well versed in leadership skills or competencies. With the permission of the VP of nursing, she chose to educate and develop their skills, and then if necessary, replace the leaders who were unwilling or unable to learn and change. To begin the transformation, Caroline developed educational meetings to educate all staff about the definition of leadership, theories of leadership, and how leadership affects healthcare outcomes (based on evidence). In addition, she held focus groups with staff to obtain input about how to resolve the individual unit issues and monitor the progress from within. She began team-building strategies by using the “Core Competencies for Interprofessional Collaborative Practice” (AACN, AACOM, AACP, ADE, and AMC 2011). The VP supported the idea and was interested in using the program system-wide, if the results were positive.

ESSENTIAL PRINCIPLES OF LEADERSHIP

There are several concepts that need to be explored to develop advanced practice nurse (APN) leaders. These principles include an understanding of the definitions of leadership, characteristics of effective leaders and the scientific theories that undergird the principles of leadership. Because the healthcare environment is undergoing massive change, APNs will need to develop additional leadership skills that encompass changes in the clinical environment and will need to provide accountability for quality patient care. Often, APNs are clinical experts but lack proficiency at managing clinical staff. Perhaps one way to further develop the skills necessary for APNs to become the future leaders of population-based clinical care is to provide a leadership framework that balances the theory and application of leadership principles.

Caroline recalled how all of her nursing instructors emphasized the need to perform a complete assessment of a situation before determining the cause of the problem or taking any action. She concluded that this advice would also work in the management field.

Defining Leadership

The literature has a cadre of definitions that have been used to define leadership. Daft (2008) has defined leadership as consisting of six essential elements: influence, intention, personal responsibility, change, shared purpose, and followers. Others have defined leadership as the art or process of influencing people using interpersonal skills that help others achieve their highest potential (Wehrich and Koontz 2005; Sullivan and Garland 2010; ANA 2014) (Table 1.1). Further, the ability to be an effective leader within an organization requires skills associated with collaboration, diversity, empowerment and ethical purpose.

Leaders are often described as powerful, influential, charismatic, dynamic, innovative, clever, autocratic, innovative, and intelligent (Curtis *et al.* 2011). In a recent study (Winston and Patterson 2006), a review of the leadership literature showed that leadership definitions consisted of over 90 variables and focused only on isolated descriptors such as process or behaviors versus encompassing attributes that define the whole of leadership. Reed and Winston (2005) further define leadership as an integrative approach that focuses on the use of critical thinking skills, interpersonal communication, and the ability to be an active listener who can assist others in positive change within an organization.

TABLE 1.1. Definitions of Leadership.

Leadership Reference	Definition
Wehrich, H. and H. Koontz. 2005. <i>Management a Global Perspective</i> , 11th ed., McGraw Hill, Singapore.	"Leadership is defined as influence, that is, the art or process of influencing people so that they will strive willingly and enthusiastically toward the achievement of group goals."
Winston, B.E. and K. Patterson. 2006. An Integrative Definition of Leadership. <i>International Journal of Leadership Studies</i> 1, 2, pp. 6–66.	"A leader is one or more people who selects, equips, trains, and influences one or more follower(s) who have diverse gifts, abilities, and skills and focuses the follower(s) to the organization's mission and objectives causing the follower(s) to willingly and enthusiastically expend spiritual, emotional, and physical energy in a concerted coordinated effort to achieve the organizational mission and objectives."
Sullivan, E.J. and G. Garland. 2010. <i>Practical Leadership and Management in Nursing</i> . Pearson Education Limited; Harlow.	"Leadership involves the use of interpersonal skills to influence others to accomplish a specific goal."
American Nurse Association (ANA). 2014. <i>Leadership Definition</i> . Retrieved May 19, 2014. http://www.nursingworld.org/Main-MenuCategories/ThePracticeofProfessionalNursing/Leadership	"Leaders do more than delegate, dictate, and direct. Leaders help others achieve their highest potential. At ANA, we empower nurses to be professional, competent leaders in healthcare. Through a variety of educational and advocacy activities, our work increases the leadership capacity of nurses to advance health and lead change."

Her plan consisted of observation of the day-to-day operations of each of her units prior to sharing her concerns with her staff. She made herself visible on each shift, participated in patient care, assisted in decision-making, and got to know the staff of each unit. Caroline also had the opportunity to get informal feedback from many of her staff. She discovered that several other key nursing personnel were considering leaving, characterizing the units as "dys-functional and under staffed" and without leadership to intervene on their behalf. Caroline had never asked what caused the prior director to leave, but she was certainly starting to get the picture.

Leaders have a broad range of expectations and roles. Often the roles of a leader have been described as a change agent, problem solver, influencer, advocate, teacher, forecaster (long term view), facilitator, risk taker, idea originator, challenger, and communicator (Curtis *et al.* 2011; Marquis and Huston 2009). Other characteristics of leaders include intelligence, knowledge, judgment, independence, personable, adaptable,

creative, and innovative. However, the leader within the organization may or may not be part of the formal organizational structure, rather, they may use their influence to obtain power and authority to influence others within the organization. What is important about the role of the leader is how their role is perceived within in the organization and what impact they may have on the overall operations within the system. APNs need to be cognizant of their role within a healthcare organization in order to be an effective leader.

Effective Leadership

Research has shown that effective leaders achieve results by influencing, motivating, and inspiring employees over whom they may or may not have direct supervision (Cummings 2008). In fact, leaders that focused on relationships (transformational, supportive, considerate) were associated with higher nurse job satisfaction and increased retention. Noneffective leaders were more inclined to focus on tasks versus the individual employee that resulted in low morale, decreased job satisfaction, and increased staff turnover.

Caroline spent a lot of her time on this floor, making rounds and working beside the nursing staff. The day and night assistant directors, though only 3 years out from graduation, appeared to be committed to the unit and to be delivering good patient care. The staff recently began a pilot to do self-scheduling and was trying to develop a modified self-governance model. Unfortunately, there was a serious divide between the RNs and the NAs leading to poor delivery of care.

Guyton (2012) proposed nine principles that contributed to effective leadership. These principles were proposed to guide clinical nurse leaders and were targeted at leading clinical staff (Table 1.2). APNs could readily adapt these leadership principles when developing an action plan to improve patient care outcomes. For example, by adapting a culture of accountability for patient care and providing evidence-based guidelines, APNs can provide the framework for safe clinical care while increasing both patient and clinical staff satisfaction.

Leadership Versus Management

Marquis and Huston (2009) have observed that there remains some confusion about the relationship between leadership and management. This relationship continues to prompt debate with some viewing leader-

TABLE 1.2. Principles of Successful Nursing Leadership (Guyton 2012).

Principle of Leadership	Action or Outcome
Commitment to excellence	Commitment to excellence begins with the leader.
Measure the important things	Identifies the need to measure patient and employees' satisfaction; quality of care; your employee's progress, unit growth, and development; and the unit's financial well being.
Build a culture around service	Reinforce the need for your staff to appreciate patients and families as customers.
Create and develop leaders	Leaders have a professional obligation to develop future leaders from within their ranks. The benefit to developing clinical nurse leadership is the ability for the unit to run when the senior leader is not present.
Focus on employee satisfaction	Employee satisfaction leads to employee retention. Focus on establishing an ongoing relationship with your employees.
Build individual accountability	Hold all employees responsible for their role/responsibilities within an organization.
Align behaviors with goals and values	Consistent behavioral standards that align with the organizational values, mission, and standards should be enforced.
Communicate on all levels	Communication should be based on an interdisciplinary framework.
Recognize and reward success	A system/program of ongoing recognition and rewards will reinforce the employees' excellence.

ship as one of many skills a manager should possess. Opposing scholars maintain that leadership requires more skills than management. Others argue that management's purpose is one of control and maintaining the status quo, whereas the leader empowers others, inspires innovation, and challenges traditional practice while motivating followers to a common goal (Curtis *et al.* 2011). The two roles are not necessarily exclusive. If a manager can guide, direct, inspire, and motivate they can also lead (Marquis and Huston 2009). Alternatively, leadership without the ability to manage, if in a management role, can also lead to a disaster.

Caroline Smart DNP, CNS, RN was a hospital nursing educator until her recent graduation from a Doctor of Nursing Practice Program. Upon graduation, the vice president promoted her to the position of Director of Medical Surgical Nursing Division. This division included a 45-bed medical telemetry floor, a 60-bed telemetry surgical floor, and a 32-bed step down Medical/Surgical ICU.

APNs are asked to take on added responsibilities within a health-care organization once they obtain their terminal degree (DNP). Often they are assigned to a position and title within the organization (Marquis and Huston 2009) and are asked to manage one or more units. They usually have delegating authority over both willing and unwilling subordinates (Curtis *et al.* 2011; Marquis and Huston 2009). By definition, a nursing leader innovates, inspires, guides, and challenges. Often, APNs are new to a management position and must rely on their clinical experience to develop the skills necessary to manage clinical staff members. Blending the characteristics of a good leader and the attributes of a skilled manager can challenge APNs as they make the transition from providing individual primary care service to providing leadership associated with the overall improvement of patient outcomes within a healthcare organization. Thus, the role of the APN is expanded to beyond that of a direct patient care provider to a supervisor of population-based healthcare by monitoring the work of other clinical staff members.

GENERAL THEORIES OF LEADERSHIP

The desire to develop a theory of leadership that simplifies the conditions that result in exceptional leaders has led to the development of a large number of theories across multiple disciplines. In nursing, APNs are expected to expand their roles as leaders in administration, education, and clinical practice. Today, APNs are challenged to incorporate leadership theories across clinical agencies in order to meet the future needs of healthcare providers and patients. However, the theory and practice of leadership has been developed from other disciplines and applied to the discipline of nursing.

What makes a great leader? Are leaders born with the traits necessary to lead under a variety of circumstances? Can leadership be taught? Are leadership qualities something you are born with? Does it help to read a plethora of books to develop leadership qualities? These questions have generated several theories associated with leadership and have been classified into categories ranging from the historical great man theories to the more contemporary leadership theories of the twenty-first century. The adaptation and use of a leadership theory by APNs as clinical experts depends on the type of position held within the organization as well as the philosophy and mission of the healthcare system.

Spector (2006a) categorized leadership theories in terms of approaches such as trait, behavioral, contingency/situational, and leader/member (Table 1.3). In general, most leadership theories can be categorized as one of these leadership styles. Depending on the definitions

of each of these approaches and the expected outcomes associated with the leadership style, the theoretical underpinnings of each have historically developed as organizations have matured and changed within society.

The *trait approach* is concerned with personal traits that contribute to effective leadership. These include the Great Man Theory and Trait

TABLE 1.3. *Types of Leadership Theories.*

Leadership Theory	Era	Definition
Great Man (Boden 1994)	1930–1940	Proposes that great men are born, not made, leading to the belief that great leaders will arise when there is a great need (Bolden <i>et al.</i> , 2003). This theory has since fallen out of favor. Scholars attempted to identify characteristics of great leaders that were based on the prevailing leaders of the day who were usually male and from the upper classes.
Trait/Behavioral (Taylor 2009)	1940–1980	A softer version of the Great Man Theory, it assumes that certain inherent traits and qualities make an individual better suited to a leadership role. These traits are generally described as personality or behavior characteristics that are shared by current or previous leaders.
Contingency/Situational (Taylor 2009)	1950–1980	Contingency theories are situational by their very nature. There is no one leadership style, quality, or trait that is best for all situations. The emphasis is on the factors that affect a particular situation. This theory chooses to focus on the environment that may influence the situation and that the ability to lead is contingent on the situation, the leader, and the follower. Situational-contingency theories do not recognize any one leadership approach. Fundamental to the theory is that different circumstances will require different types of leadership. Therefore, leaders may be effective in one situation and unable to lead in another.
Leader/Member exchange/ Transformational (Cherry 2014)	1970–today	The focus is on the relationships formed between the leader and their followers as being of critical importance (Boden <i>et al.</i> 2003). A transformational leader will motivate and inspire individuals by facilitating group members to see the importance of the goal at hand. Transformational leaders concentrate on the performance of group members, encouraging each member to fulfill his potential.

Theories that were popular until the mid-1940s. The *behavioral approach*, popular from 1940 to 1980, explores leadership from the perspective of the leader by examining the leader behaviors. Examples of the behavioral approach of leadership include those identified by Lewin (1951) and White (1960). The *contingency approach*, prevalent from 1950 to 1980, is based on Fielder's contingency theory and path-goal theory. This theory suggests that leadership is about the interaction between the leader, his behavior, and the situation. The *Leader-Member Exchange Approach* emerged in the 1970s and is referred to as charismatic or transformational leadership (Table 1.3). In fact, the term transformational leadership is still in use today and is focused on the relationship between the leader and the followers.

Other general theories of leadership include *participative* and *transactional*. Participative theory suggests that the ideal leadership style is to take into account the input of other stakeholders. The leader encourages participation and input from the group and its members feel important, and therefore committed to the process (Taylor 2009). *Transactional* theories are management styles of the role of supervisors in an organization and group performance (Cherry 2014). The theoretical foundation is based on rewards and punishment (Bolden *et al.* 2003). For example, businesses frequently use managerial theory by rewarding employees (money or rewards) who are successful, and conversely, reprimanding (punishing) employees that fail.

Most recently, *transformational leadership* has become widely accepted within organizations since the leader subscribes to high ethical and moral standards (Cherry 2014; Taylor 2009). There is an emphasis on the empowerment of followers, building a shared vision, and encouraging participation and motivation. Transformational theoretical models assert that individual members will follow leaders who inspire them. Transformational leadership qualities include vision, ability to inspire, trust, sharing a bond, and empowering others (Curtis *et al.* 2011). Studies based on the use of transformational leadership theory have demonstrated positive outcomes when compared to transactional leadership styles. In one study, there was a strong positive correlation to leaders' extra effort, leadership satisfaction, and effectiveness in the leaders demonstrating transformational leadership characteristics and that it was a predictor of leadership outcomes (Casida and Parker 2001).

CONTEMPORARY NURSING LEADERSHIP THEORIES

In the current healthcare environment, nursing leaders need to be prepared to respond to the ever changing needs and demands for qual-

ity nursing care. Nurse leaders of the twenty-first century may require more integrated models of leadership theory. Recent research by Stanley (2006b) has demonstrated that the use of transformational theory may be appropriate for administrative nurse leaders, but a different theoretical model may be needed for clinical leaders. Perhaps a combination of concepts from a variety of nursing leadership theories may be used to provide a framework for future APN leaders. These clinical nursing leadership theories have been identified as congruent/authentic, servant, principal agent, human/social capital, and emotional intelligence.

Congruent/authentic leadership theory suggests that leaders must be true to themselves, know their values, and act accordingly (Marquis and Huston 2009). According to Stanley (2006a), “Congruent leaders (clinical nurse leaders) are followed because there is a match between the leader’s value and beliefs and their actions.” The rapidly changing healthcare environment will require clinical leaders to learn new roles and develop new skills at an accelerated pace (Marquis and Huston 2009). Stanley (2006b) has suggested that the future of nursing leadership theory is beyond transformational leadership models because the clinical environment will be even more complicated than today’s. Stanley (2006b) also suggests that the clinical environment of the future is unlike the other business environments, requiring a unique theory to guide its development. Congruent or authentic leadership requires leaders “to be matched (congruence) between the activities, actions, and deeds of the leader and the leader’s values.” APNs will be evaluated for their leadership skills within their work environment. For example, the application of this model will require the APN to integrate everyday clinical occurrence, staff knowledge and skills, and interdisciplinary team outcomes, and to apply their own beliefs in the clinical situation. The congruent/authentic leadership model provides a framework for APNs to adapt and to measure the overall quality of patient care based on their leadership style.

Servant leadership theory argues that in order to be a great leader, one needs to be a servant first (Greenleaf 1977). Although the premise of servant leadership theory was developed over 30 years ago, the theory continues to influence today’s leaders. Greenleaf based his model on his observation that successful leaders lead in a different manner than traditional leaders. Recent work by Marquis and Huston (2009) suggested that servant leaders have 10 qualities that define their success. These attributes include listening on a deep level, truly understanding, being open minded, being comfortable dealing with complex issues, ambiguity, and paradoxes, the ability to involve all parties in challenging situations and requesting their input, being goal directed, demon-

strating the ability to be servant, helper, and teacher first, then leader, thinking before acting, carefully choosing words, possessing foresight and intuition, and looking at the big picture, sensing relationships, and connections. The ability of the APN to incorporate some of the servant theory attributes into their leadership style will enhance their clinical management skills.

The *principal agent* leadership theory was derived from an economic model in the 1960s and was categorized as another interactive theory. The hallmark of this model is the belief that not all followers (called agents) are naturally motivated to support the best interest of the leader or employer (principal). This assumes that in order for the followers to perform, adequate incentives must be provided. Unfortunately, in most healthcare models there are little incentives provided for followers, thus the relationship between the principal (APN) and the agent (healthcare personnel) must be one that fosters compliance with the vision, mission, or goals of the principal. APNs who use this leadership theory may have to develop incentives for healthcare staff such as monetary rewards, promotion, employee recognition awards, or recognition by their peers. Additionally, APNs may influence management changes by adapting new ways to reward patient followers who adapt health compliance or incentives.

The *human capital* theory of leadership recognizes the need for individuals and organizations to invest in employees with the anticipation of future gains. Human capital is usually viewed as the collective education, knowledge, skills, and abilities of an entire group. Human capital theory assumes that these gains can be increased or improve productivity. Thus, longevity in the work place becomes a desirable outcome for valued employees. APNs who invest in employees who foster excellence in the healthcare environment understand that in the long term their initial investment of time, energy, or effort substantially pays off. For example, the motivational basis for providing tuition reimbursement to employees is for their advancement to benefit the organization at a later point in time. A second example in which APNs may influence patients is to invest in educating a diabetic patient about diet and exercise so that over time there is less cost in care because the patient may prevent further health deterioration. APNs familiar with the use of human capital leadership theory can apply these concepts within the clinical environment.

The *emotional intelligence* theory is defined as the ability to perceive emotions, facilitate thinking, and to analyze or understand the relationships of others to one's own emotions (Mayer *et al.* 2000). Studies have demonstrated that an emotionally intelligent nurse leader is an individual who can work in harmony with his/her thoughts and feelings and

are able to better manage stress in the clinical environment (Freshwater and Stickley 2004). Furthermore, nurse leaders who have been high performers have had high emotional intelligence scores. Emotional intelligence has been correlated with improved retention, less burnout, and healthy workplace environments. Nurse managers who understand the concepts associated with emotional intelligence are proactive and problem-focused, thus their ability to facilitate less-stressful clinical environments promotes safer and better patient care.

APNs will experience a variety of leadership roles within the clinical area. Since the role of the APN is continuously changing, it is important for the clinical leader to be knowledgeable about the different leadership theories and their application to clinical practice. Despite the vast array of clinical practice settings and the divergent roles of the APN, the ultimate aim of leadership is to improve patient care outcomes. As APNs engage in a variety of leadership activities, their responsibilities and level of leadership abilities will increase. Therefore, it is important that the APNs are aware of their own limitations and continue to be willing to be effective patient care advocates.

SUMMARY POINTS

- APNs are effective leaders within the clinical environment.
- The application and understanding of leadership theories provide a conceptual framework for APNs who manage patient care.
- APNs must have an understanding of the difference between leadership and management.
- Some of the current leadership theories can be applied to the clinical area.

REFERENCES

- American Nurse Association (ANA). 2014. *Leadership Definition*. Retrieved June 6, 2014. <http://www.nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing/Leadership>
- American Nurses Credentialing Center (ANCC), 2014. *Magnet Recognition Program Model*. Retrieved May 14, 2014. <http://www.nursecredentialing.org/magnet/programoverview/new-magnet-model>
- Boden, D. 1994. *The Business of Talk: organizations in action*. Cambridge, England: Polity Press.
- Casida, J. and J. Parker. 2011. Staff nurse perceptions of nurse manager leadership styles and outcomes. *Journal of Nursing Management* 19, 478–486.
- Cherry, K. 2014. *Leadership Theories: The 8 Major Leadership Theories*. Retrieved May 17, 2014. <http://www.work911.com/cgi-bin/leadership/jump.cgi?ID=10594>

- Cummings, G.G., T. MacGregor, M. Davey, H. Lee, C.A. Wong., E. LO, M. Muise, and E. Stafford. 2008. *Leadership styles and outcome patterns for nursing work-force environment: A systemic review*.
- Curtis, E.A., J. de Vires, and F.K. Sheerin. 2011. Developing leadership in nursing: exploring core factors. *British Journal of Nursing* 20, 5, 306–309.
- Daft, R.L. and P.G. Lane. 2008. *The leadership experience 5th ed.* Mason, OH: South-Western Cengage Learning.
- Fawcett, J. and J. Garity. 2009. *Evaluating Research for Evidenced-Based Nursing Practice*. F.A. Davis: Philadelphia, PA.
- Freshwater, D. and T. Stickley. “The Heart of the Art: Emotional Intelligence and Nursing Education,” *Nursing Inquiry*, Vol. 11, No. 2, 2004, pp. 91–98.
- Guyton, N. 2012. Nine principles of successful nursing leadership. *American Nurse Today* (7), 8, retrieved May 17, 2014. <http://www.americannursetoday.com/article.aspx?id=9372&fid=9326>
- Interprofessional Education Collaborative Expert Panel. 2011. Core competencies for interprofessional collaborative practice: Report of an expert panel. Washington, D.C.: Interprofessional Education Collaborative.
- Marquis, B.L. and C.J. Huston. 2009. *Leadership Roles and Management Functions in Nursing: Theory and Application*. Philadelphia PA: Wolters Kluwer/ Lippincott.
- Mayer, J.D., P. Salovey, and D. Caruso. Models of Emotional Intelligence, 2nd ed., In: Sternberg, R.J. Ed., *Handbook of Intelligence*, Cambridge, New York, 2000, pp. 396–420.
- Reed, M. and B. Winston. 2005. Towards a deeper understanding of hope and leadership. *Journal of Leadership and Organizational Studies*, 12(2), 42–53.
- Sullivan, E.J. and G. Garland. 2010. *Practical Leadership and Management in Nursing*. Pearson Education Limited; Harlow.
- Spector, P.E. 2006. *Industrial and Organizational Psychology: Research and Practice. 4th ed.* John Wiley & Sons: New Jersey.
- Stanley, D. 2006a. In command of care: Toward the theory of congruent leadership. *Journal of Nursing Research* 11(2), 132–144.
- Stanley, D. 2006b. Recognizing and defining clinical nurse leaders. *British Journal of Nursing* 15 (2), 108–111.
- Taylor, R. 2009. Leadership theories and the development of nurses in primary health care. *Primary Health Care*. 19(9), 40–45.
- Wehrich, H. and H. Koontz. 2005. *Management a Global Perspective. 11th ed.*, McGraw Hill, Singapore.
- Winston, B.E. and K. Patterson. 2006. An Integrative Definition of Leadership. *International Journal of Leadership Studies* 1, 2, pp. 6–66.

Improving Clinical Outcomes Through Interprofessional Population-Based Clinical Practice

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Chapter 15 exposes the APN to future ideas related to monitoring, accountability, and providing interprofessional, evidence-based clinical care. Topics include ideas associated with “safe” clinical care within future healthcare systems.

Case Presentation

An 86 year-old, frail woman with diabetes who was experiencing hyperglycemia visited the office of her local provider. A NP met with her and made the usual adjustments to her medications. However this visit was different since she not only met with the NP but talked with a number of others about exercise, diet, and blood glucose self-monitoring, and they discussed what support she would need to make changes in these areas as well. She went home, where she lives alone and independently, to adjust to these new recommendations.

Within a few weeks, a care manager, to whom the woman reported her daily blood glucose levels and other vital diabetes related information, called the woman. This information had been recorded in an online application that the care manager had been trained to use at the office. Based on these results, the NP made further changes to the woman’s medications, and this process was repeated in a few weeks.

Most recently, the woman developed pneumonia and required hospitalization. Fortunately, she had been part of a transitional care program that coordinates her care among providers and delivery settings from home to hospital and back home again. She also is part of patient centered healthcare or medical home (PCMH).

Advanced practice roles have expanded to include multiple specialties, practice sites, and populations. These are described in the Consensus Model for APN: Licensure, Accreditation, Certification and Education (2008). APNs have expanded in numbers and capabilities over the past several decades as they are highly valued and an integral part of the healthcare system. APNs include certified registered nurse anesthetists, certified nurse-midwives, clinical nurse specialists, and certified nurse practitioners. Some of these roles, such as midwifery and nurse practitioner, are strongly rooted in the traditions of community health nurses in meeting the needs of underserved populations and communities. There has been controversy and support for the expanding roles of nurses. Many of the questions regarding the capability of nurses to expand their practice have been answered (Brown and Grimes 1995). The research has indicated repeatedly for over two decades that advanced practice nurses are viewed by the public as capable and highly satisfactory providers (Newhouse *et al.* 2011). The development of the APN role has been questioned by other providers citing a fear for patient safety and care quality. Research has shown that advanced practice nurses meet or exceed physician providers in quality, acceptance and satisfaction (Newhouse *et al.* 2011). The APN is an essential member or leader of a healthcare team in an integrated delivery model of care. The research supports the excellent outcomes of care provided by nurse practitioners individually and as part of interdisciplinary teams.

Fortunately, she had been part of a transitional care program that coordinates her care among providers and delivery settings from home to hospital and back home again. She also is part of a PCMH.

The American Academy of Pediatrics developed the concept of a medical home four decades ago, however, its meaning has evolved. The PCMH is a team approach to primary care that involves better care coordination and information systems (including the EHR) and gives patients greater access to care and to their providers (including e-mail exchanges). The main focus of this model is that the patient is at the center of decision-making. The patient is involved in discussions with all healthcare providers about his or her overall care and the recommendations of each team member. Transitional care targets older adults with two or more risk factors, including a history of recent hospitalizations, multiple chronic conditions, and poor self-health ratings.

One example of a transitional care program is located at the University of Pennsylvania, Transitional Care Model (2012). This program has ten essential elements that integrate the role, functions, and account-

ability for each team member as the patient moves throughout the system. These include:

1. *The transitional care nurse*, a master's prepared nurse with advanced knowledge and skills in the care of this population, as the primary coordinator of care to assure continuity throughout acute episodes of care.
2. *In-hospital assessment*, collaboration with team members to reduce adverse events and prevent functional decline, and preparation and development of a streamlined, evidenced-based plan of care.
3. *Regular home visits* by the Transitional Care (TC) nurse with available, ongoing telephone support (seven days per week) through an average of two months post-discharge.
4. *Continuity of care* between hospital and primary care providers is facilitated by the TC nurse accompanying patients to first follow-up visit(s).
5. *Comprehensive, holistic focus* on each patient's goals and needs including the reason for the primary hospitalization as well as other complicating or coexisting health problems and risks.
6. *Active engagement* of patients and family caregivers with focus on meeting their goals.
7. *Emphasis on patients'* early identification and response to healthcare risks and symptoms to achieve longer-term positive outcomes and avoid adverse and untoward events that lead to readmissions.
8. *Multidisciplinary approach* that includes the patient, family caregivers, and healthcare providers as members of a team.
9. *Physician-nurse collaboration* across episodes of acute care.
10. *Communication* to, between, and among the patient, family caregivers, and healthcare providers.

Transitional care advocate, Mary D. Naylor PHD., RN, FAAN, a professor of gerontology and director of the New Courtland Center for Transitions and Health at the University of Pennsylvania states that the model includes more than discharge planning and care coordination. The role of the APN is to help the patient and family set goals during hospitalization, design a plan of care that addresses them, and coordinates various care providers and services.

The APN then visits the home within 48 hours of discharge and provides telephone and in-person support as often as needed for up to 3 months. Assessing and counseling patients and accompanying them to

medical appointments is aimed at helping patients and caregivers to learn the early signs of an acute problem that might require immediate help and to better manage patients' healthcare. Also essential is ensuring the presence of a primary care provider. In three randomized controlled trials of Medicare beneficiaries with multiple chronic illnesses, use of the TCM lengthened the period between hospital discharge and readmission or death and resulted in a reduction in the number of rehospitalizations (Naylor 1994; Naylor *et al.* 1999, 2004). The average annual savings was \$5,000 per patient. Until now, transitional care has not been covered by Medicare and private insurers. But the Affordable Care Act sets aside \$500 million to fund pilot projects on transitional care services for "high-risk" Medicare beneficiaries (such as those with multiple chronic conditions and hospital readmissions) at certain hospitals and community organizations over a 5-year period.

ADVANCED PRACTICE NURSES PRODUCE QUALITY PATIENT OUTCOMES

There is abundant and consistent evidence that APNs provide high quality care in an expanding array of environments and populations. In a meta-analysis of 38 studies comparing patient outcomes, nurse practitioner, and physician managed patient outcomes, those cared for by nurse practitioners had greater adherence to recommendations, patient satisfaction, and resolution of pathological conditions (Brown and Grimes 1995). The care provided by nurse practitioners has been shown to be consistently equivalent to care provided by physicians in primary care settings. However, research indicates that nurse practitioners demonstrated more time with patients, more complete documentation, and better communication skills (Horrocks *et al.* 2002). A meta-analysis of 16 studies of outcomes of APNs and physicians concluded that measures of quality of care, health outcomes, resource utilization, and costs were equivalent (Lauret). These findings were further supported in a study in which 1,316 patients were randomly assigned to nurse practitioners or physicians for primary care. After 6 months, the ratings for health status, health service utilization, and patient satisfaction were the same for both groups. However, patients treated by nurse practitioners had lower diastolic blood pressure values (Mundinger 2000). These findings were consistent at a 2-year follow-up (Lenz 2004).

Brooten and her colleagues (2002) conducted a review of the results of seven randomized clinical trials with very low birth-weight infants; women with unplanned cesarean births, high risk pregnan-

cies, and hysterectomy surgery; elders with cardiac medical and surgical diagnoses and common diagnostic related groups; and women with high risk pregnancies in which half of physician prenatal care was substituted with APN care. Results indicated that outcomes of care by advanced practice nurses were of high quality with excellent patient outcomes across populations, specialties, and practice settings (Brooten *et al.* 2002).

A systematic review of advance practice nurse outcomes from 1999 to 2008 concluded that NP outcomes are comparable to those of physicians. The outcomes included patient satisfaction, patient perceived health status, functional status, hospitalizations, ED visits, and biomarkers including blood glucose, serum lipids, and blood pressure (Nehouse 2011).

INTEGRATED MODELS OF CARE

The Affordable Care Act provides support for new emerging models, including nurse-led clinics and integrated delivery models. Many of these new models included an advanced practice nurse as a leader or coordinator of care. The federal government has recognized the essential role for nurses and has provided additional funding to test new models of care and to train additional advanced practice nurses to be part of these initiatives (\$15 million for a small demonstration project that will support 10 nurse-managed clinics for 3 years; \$30 million to cover educational expenses to train 600 nurse practitioners; and \$200 million for a clinical training demonstration project designed to increase production of advanced-practice nurses, including nurse practitioners).

New models of integrated care provide comprehensive, patient-centered care using patient-centered healthcare homes and accountable care organizations.

These models include familiar themes to nurse providers, coordinated care, and health promotion.

Bradway *et al.* (2012) investigated a quality cost model for transitional care. The purpose of the study was to describe the development, testing, modification, and results of the quality cost model of APNs for transitional care. The model provides care to clients as they age and move within the components of the healthcare system. The APN has a vital role in the coordinating and in leading this effort. Findings indicated that APN intervention consistently resulted in improved patient outcomes and reduced healthcare costs. Groups with APN providers were rehospitalized for less time at less cost, reflecting early detection and intervention.

OUTCOMES OF PATIENT CARE WITH INTERDISCIPLINARY TEAMS

The presence of APNs on health teams improves patient outcomes in differing delivery settings and populations. A cross sectional study of 46 practices was conducted to determine quality measures of adherence to American Diabetes Association guidelines. Those practices that included NP's performed better on these measures including measurement of glycosylated hemoglobin, lipids, and microalbumin levels (Ohman-Strickland 2008). Long-term care patients managed by teams that include APNs are less likely to have falls, urinary tract infections, and pressure sores. In addition, they demonstrate improved functional status and have more consistent control of their chronic conditions (Bajerjian 2008).

Interdisciplinary, high quality chronic care delivery has been shown to improve the experiences of patients, although the results of the different models have been mixed. A study was conducted to determine patients' experiences and care quality in chronic care. Providers and patients in 17 disease management programs were included, targeting patients with cardiovascular diseases, chronic obstructive pulmonary disease, heart failure, stroke, comorbidity, and eating disorders. Overall, care quality and patients' experiences with chronic illness care delivery significantly improved. After adjusting for patients' experiences with care delivery, age, educational level, marital status, gender, and mental and physical quality of life, analyses showed that the quality of chronic care delivery and changes in care delivery quality predicted patients' experiences with chronic care delivery at a second visit (Cramm). This research showed that high quality interdisciplinary care resulted in more positive experiences of patients with various chronic conditions. The purpose of this study was to describe barriers and facilitators to implementing a transitional care intervention for cognitively impaired older adults and their caregivers lead by APNs. APNs implemented individualized approaches and provided care that exceeded the type of care typically staffed, and reimbursed in the American healthcare system by applying a transitional care model, advanced clinical judgment, and doing whatever was necessary to prevent negative outcomes. Reimbursement reform as well as more formalized support systems and resources are necessary for APNs to consistently provide such care to patients and their caregivers during this vulnerable time of transition.

Boult, Leff, and Boyd (2013) evaluated the outcomes of the guided care model of comprehensive interdisciplinary care that included primary care-based management, transitional care, and support for self management and family care giving. This model included a registered

nurse working with two to five physicians in a practice to provide 50–60 high risk patients with multiple morbidities with eight services: home-based assessments, evidence-base care planning, proactive monitoring, care coordination, transitional care, coaching, and access to community based services. There were 904 high-risk older patients in eight primary care practices participating. After a 32-month test of this model, functional health of the primary care patients did not significantly improve. However, patient ratings of quality of care were higher. Patients increased their access to telephone support but their use of home health declined. The authors suggest that these findings may be due to a defect in the guided model or a difference in application of the model among the eight primary care practices. The authors concluded that the guided care model with the RN and MDs did not lead to control of the use and costs of care. The model incorporates the use of the RN and not the APN. The model may have been more effective by the addition of the APN to the mixed delivery model.

SUMMARY POINTS

- The principles of advanced nursing practice are based on evidence associated with “best practice” guidelines.
- The APN is a vital leader or a complimentary member of an integrated health team.
- The APN focuses on the client or patient and the family caregivers as the center of all care models of delivery.
- APN practice in a collaborative practice model includes the ability to work with other healthcare professionals, to measure outcomes of care, and to redesign care delivery as needed to ensure quality.
- Advanced practice nurses select and design outcome measures that focus on the patient and the effectiveness of care meeting patient needs.

REFERENCES

- Abdus, S. and T. Selden. 2013. Preventive services for adults: How have differences 36 across subgroups changed over the past decade? *Medical Care*, 51(11) (999–1007).
- Bakerjian, D. 2008. Care of nursing home residents by advanced practice nurses: A review of the literature. *Research in Gerontological Nursing*, 1(3) (177–185).
- Bodenheimer, T. and H. Hoangmai. 2010. Primary Care: Current Care: Current Problems and Proposed Solutions, *Health Affairs* 29, no. 5 (799–805).
- Boult, C., B. Leff, and C. Boyd. 2013. A matched-pair cluster-randomized trial of guided care for high-risk older patients. *Journal of General Internal Medicine*, 28(5) (612–621).

- Bradway, C., R. Trotta, M. Bixby, E. McPartland, M. Wollman, H. Kapustka, K. McCauley, and M. Naylor. 2012. *Gerontologist*. Jun 2012; 52(3) (394–407).
- Brown, S.A. and D.E. Grimes. 1995. A meta-analysis of nurse practitioners and nurse midwives in primary care. *Nursing Research*, 44(6) (332–9).
- Ettner, S.L., J. Kotlerman, A. Abdelmonen, S., Vazirani, R.D. Hays, and M. Shapiro. 2006. An alternative approach to reducing the costs of patient care? A controlled trial of the multi-disciplinary doctor-nurse practitioner model. *Medical Decision Making*, 26 (9–17).
- Goodell, S., C. Dower, and E. O’Neill. 2011. *Primary Care Health Workforce in the United States*, Research Synthesis Report No. 22, Robert Wood Johnson Foundation.
- Horrocks, S., E. Anderson, and C. Salisbury. 2002. Systematic review of whether nurse practitioners working in primary care can provide equivalent care to doctors. *British Medical Journal*, 324 (819–823).
- Institute of Medicine. 2011. *The Future of Nursing: Leading Change, Advancing Health*.
- Jiang, B. and S. Jiang. 2013. Hospital cost and quality performance in relation to market forces: An examination of US Community hospitals in the “post managed care era”. *International Journal of Health Care Finance and Economics*, 13 (53–71).
- Kaiser Family Foundation. 2011. *Improving Access to Adult Primary Care in Medicaid: Exploring the Potential Role of Nurse Practitioners and Physician Assistants*.
- Kern, L., R. Kaushel, and S. Malhotra. 2013. Accuracy of electronically reported “meaningful use” clinical quality measures. *Annals of Internal Medicine*, 158 (77–83).
- Lenz, E.R., M.O. Munding, R.L. Kane, S.C. Hopkins, and S.X. Lin. 2004. Primary care outcomes in patients treated by nurse practitioners or physicians: Two-year follow-up. *Medical Care Research and Review*. 61(3) (332–351).
- McDonald, M., B. Matesic., and D. Contopoulos-Ioannid. 2013. Patient safety targets at diagnostic errors. *Annals of Internal Medicine* 158(5) Part 2 (381–389).
- Morrison, F., M. Schubina, and S. Goldgerg. 2013. Performance of primary care physicians and other providers on key process measures in the treatment of diabetes. *Diabetes Care* 36(6) (1147–1152).
- Munding, M.O., R.L. Kane, E.R. Lenz, A.M. Totten, W.Y. Tsai, and P.D. Cleary. 2000. Primary care outcomes in patients treated by nurse practitioners or physicians: A randomized trial. *Journal of the American Medical Association*, 283(1) (59–68).
- Newhouse, R., J. Stanik-Hutt, K. White, M. Johantgen, E. Bass, G. Zangaro, R. Wilson, et al. 2011. Advanced practice nurse outcomes 1999–2008: A systematic review. *Nursing Economics*, 29(5) (1–22).
- Naylor, M. and E. Kurtzman. The Role of Nurse Practitioners in Reinventing Primary Care, *Health Affairs* 29, no. 5 (2010) (893–9).
- Ohman-Strickland, P.A., A.J. Orzano, S.V. Hudson, L.I. Solberg, B. DiCiccio, Bloom, and D. O’Malley. 2008. Quality of diabetes care in family medicine practices: Influence of nurse practitioners and physician’s assistants. *Annals of Family Medicine*, 6(1), (14–22).

- Pohl, J., C. Hanson, J. Newland, and L. Cronenwett. 2010. Unleashing Nurse Practitioners' Potential to Deliver Primary Care and Lead Teams, *Health Affairs* 29, no. 5 (900-5).
- Robert Wood Johnson Foundation. 2012. *Implementing the IOM Future of Nursing Report—Part III: How Nurse Are Solving Some of Primary Care's Most Pressing Challenges*.

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